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Senate
State of Minnesota

08 - 0192

February 11, 2008

Robbie LaFleur
Director, Legislative Reference Library
645 State Office Building
St. Paul, MN 55155

Dear Director LaFleur;

It is my pleasure to submit the Health Plan Purchasing Pool Study Group Report as required by statute.

Respectfully,

Mary Olson
Senator, District 04

A Report to the Chairs of the legislative committees and divisions with jurisdiction over health care policy and finance, the Health Care Access Commission, and the Governor

January 2008

Laws of Minnesota 2007, Chapter 147

Health Plan Purchasing Pool Study Group

TO: **Governor Tim Pawlenty**
Senator Linda Berglin
Senator John Marty
Representative Tom Huntley
Representative Paul Thissen

This report was prepared by the Health Care Purchasing Pool Study Group in response to the following charge in Laws of Minnesota 2007, Chapter 147.

Health Care Purchasing Pool Study Group Members:

Senator Mary Olson, Co-Chair
Senator Sharon Erickson Ropes, Co-Chair
Representative Ken Tschumper
Representative Erin Murphy
Representative Laura Brod
Javier Morillo-Alicea, Appointee, Attorney General's Office
Dr. James Young, M. D., Appointee, Office of the Governor
Deborah Jewett, Appointee, Speaker Margaret Anderson Kelliher
Jill Kielblock, AFSCME
Richard Kolodziejski, Minnesota Association of Professional Employees
Paul Mueller, Education Minnesota
Beth Hartwig, Minnesota Business Partnership
Nancy Breymeier, Metropolitan Independent Business Alliance
Dr. Ronnell A. Hansen, Ramsey Medical Society & St. Paul Radiology, P. A.

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Report from the Health Care Purchasing Pool

The following report summarizes the work of the Health Care Purchasing Pool study group which has resulted in proposed legislation to implement a statewide pool that ultimately would be an available healthcare option for everyone in the state. The report reflects the consensus of the study group members when consensus was reached, although opinions differed regarding various components of the plan; for some members, the concepts that determined the framework for the bill were objectionable from the outset, yet these members worked constructively with the group and this proposal is a better one as a result of their input. In an attempt to fairly present opinions that differed with, or wished to qualify, the main body of this report, study group members were encouraged to submit their own comments, which are attached to this report.

The issue of "adverse selection" was most challenging for the study group, especially in light of the technical and other assistance that would be needed to quantify risk exposure, assistance that would require funding not available to this group. Further, the initial membership of the pool will need to be projected before it is possible to determine the extent to which mechanisms to address adverse selection will be necessary. The study group thus decided to draft legislation that would allow the governing structure of the pool as much latitude as possible to address this issue once necessary experts are employed and decisions regarding initial membership criteria are made. The study group acknowledges the pool may only gradually reach its goal of being available to everyone because of "adverse selection" issues.

The study group membership was statutorily directed, and represented a diverse group, including legislative members from both political parties and stakeholder representatives that included labor and business representatives as well as members of the medical community. While perspectives regarding health care reform varied, the group was united in its belief that the benefits of pooling should be available to Minnesota citizens statewide, regardless where a person lives, whether the person is self-employed or works for a large employer.

From a background perspective, the legislation which created the study group was designed to provide an affordable option for many citizens in Minnesota who do not have coverage available through a large pool, which typically can offer more and charge less than individuals or smaller groups are required to pay. This includes many Minnesotans in rural areas, those who work for small businesses or are self-employed, and a growing number who work for businesses of all sizes that no longer offer health insurance benefits. Study group members also believe there is a potential for the pool to offer significant cost savings, which would make it an attractive option for anyone in the state.

Many proponents of the study group's proposed legislation believe our present system is filled with unnecessary expenses and often is geared to reward those involved with health plan administration, rather than geared toward patient care. By designing a system that: "eliminates the middleman" and instead is governed by an independent, membership board (a cooperative model); by paying only for services provided (as opposed to a capitated payment system) and by contracting directly with providers, the legislation's intent is to create a pool different than the products available in the marketplace today.

As health care reform is being discussed in Minnesota and nationwide, there are different philosophies regarding what is causing costs to escalate at the same time health outcomes, in many instances, are declining. There are various approaches to tackle the problem. One approach is to allow insurance companies and HMOs more latitude to offer less comprehensive health care packages (deregulation of healthplan/HMO/insurance requirements) and more latitude to regulate doctors and the care they deliver, (i.e. pay-for-performance type initiatives) allowing the "middleman" an even greater share of the health care dollar to pay for this oversight under the theory it will improve care quality. Under this approach, patients are encouraged to act as consumers, shopping among the various plans to predetermine the type of coverage they think they will need, and comparing health care providers based on outcome measures the plan administrators have determined. Another approach, the one taken by this proposal, reduces unnecessary expenses by greatly reducing administrative costs, putting the responsibility for managing a patient's care (within certain parameters) in the hands of doctors and patients, and providing for the same health care cost, quality and access regardless where a Minnesotan lives or works.

Recommendations for Statewide Pool

While it is very important to address the needs of those who are unable to afford an insurance product in today's market, the quality of the product offered (measured by its real cost, comprehensive nature, portability, quality and accessibility) is as important as whether a person has some type of coverage. The goal of the statewide pool is not only to offer an alternative to Minnesotans who are not eligible for membership in some other type of insurance pool, but also to create an insurance plan framework that moves in a positive direction with regard to COST, QUALITY and universal ACCESSIBILITY, rather than focusing strictly on whether everyone is "covered" under some type of plan.

This proposal is an alternative to the present insurance/managed care driven market. The goal of the proposal is to allow consumers a choice. As the plan grows, consumers will have the opportunity to evaluate the merits of this type of framework. If everyone joins, it will have been through a process of natural selection based on the success of the plan.

The components of the plan, in summary, are:

1. **Designed to be incorporated as a nonprofit, the pool will be governed as a cooperative, with a board consisting of employer, employee/individual and participating provider membership.**

2. **The pool eliminates entirely the need for insurance/managed healthcare "middlemen", in the long term greatly reducing and in some cases eliminating administrative costs associated with marketing, managing/rationing care, underwriting, purchasing provider networks, and other administrative costs. Ultimately, it is anticipated that additional cost savings will be realized by reducing or eliminating the need for the purchase of stop-loss coverage, and costs associated with complex and diverse methods for rate setting, billing and payment.**

3. **Eventually, the pool will be an available option for everyone in the state.**

4. **The pool will use nearly pure "community rating", except that age will be a factor in determining rates.**

5. **The pool will focus on comprehensive coverage, limiting the number of plans offered to two or three.**

6. **The pool will contract directly with providers with respect to participation and rates.**

7. **The pool will provide reimbursement comparable with private plans, adjusting rates a manner determined by the board.**

8. **The pool will pay for medical care on a "fee for service", rather than a "capitated payment" basis, making certain money paid into the healthcare system is actually spent for care.**

9. **The pool will allow for payment of provider-managed care coordination, where it is proven to be medically helpful and economically wise.**

10. **Over time, the pool will use information gained from its billing and payment records to encourage medical treatment that is especially effective for**

particular broad sectors of the public (based, for example, on employment status).

11. The association governing the pool will have the authority to initiate incentives for members to engage in healthy behavior.

12. Elimination of unnecessary expenses, as described above, will result in a plan that is significantly less expensive over the long term, with cost savings increasing as the pool size increases and up front costs have been repaid.

13. Ultimately the pool will be available for everyone, but until the pool is large enough to overcome the phenomenon often called "adverse selection", the association has the authority to enact a number of membership restrictions and other creative methods to address this concern. Depending on the actuarial advice the governing board receives, the study group suggests considering the following methods to address this issue, as determined to be necessary:

    - Initially negotiating with large groups whose membership is based on something other than health care status (for example, large pools of employees)tying membership to something other than health status; i.e. employment status, especially until pool reaches a certain size;
    - Controlling entrance and exit dates;
    - Using financial incentives enter and/or to stay in the pool;
    - Placing temporary limits on admission on an individual basis (individual underwriting) – (This was the option least desired by our group).

14. Finally, the legislation proposes a loan from the health care access fund to provide the initial funds needed to establish a reserve.

Respectfully submitted,

Senator Mary Olson, Co-Chair

Senator Sharon Erickson Ropes, Co-Chair

Rep. Ken Tschumper

Rep. Erin Murphy

Dissent

Rep. Laura Brod

Unable to contact

Javier Morillo-Alicea
Attorney General's Appointee

See addendum

Dr. James Young
Office of the Governor Appointee

Deborah Jewett
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See addendum

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See addendum

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Dissent – see addendum

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Richard Kolodziejski
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Senate District 4
Addendum Report written by Senator Mary Olson:

As a co-chair of the Statewide Healthcare Pool study group, I wanted to take this opportunity to share observations regarding some components of health care reform, some of which were discussed by our group, but which go beyond a presentation of our study group report and which do not necessarily reflect the opinions of others in our group.

General Concepts in our Present Healthcare payment structure

Health care today is paid for through a complex system that combines contributions from individuals, employers, tax dollars and cross-subsidies from the providers themselves. Approximately 40 percent of Minnesotans are covered by what are often called "self-insured" or "ERISA" plans, an option available to large businesses and which are pre-empted by federal law from state oversight and control. The balance of Minnesotans are either: insured through the large employer, small employer or individual private insurance markets, each of which is subject to different rules; covered by MCHA (a statewide pool for high risk individuals that is paid by a combination of higher than normal premiums and subsidies insurers pay so they don't have to cover these individuals); covered by a tax-paid government plan like Medicare, Medicaid or Minnesota Care; or are uninsured. In comparison to other states, according to a June, 2007 report from the Commonwealth Commission, Minnesota's health care system is ranked 11th in comparison to other states, with the following breakdown of some of the categories listed: Access/9th; Quality/12th; Avoid unnecessary hospitalizations/10th; healthy lives/7th; Equity/38th (the equity measure reflects greater than normal disparities in outcome measures between insured and uninsured populations and by race/ethnicity.)

Our study group did not hear testimony comparing the cost of health care in Minnesota to the cost in other states. We did hear, however, that in comparison to other countries, care throughout the United States costs patients, on average, from fifty percent to several times more than the cost in other countries for comparable or better health care outcomes. This cost disparity is important in relation to the toll it takes on individual and family budgets in our country. It is also vitally important to our national economy – if we pay significantly more for a cost that is reflected in the ultimately price of doing business and/producing goods in our country, then we are less competitive in the global economy.

allow salaries to keep pace with inflation, in order to retain health benefits, often at an increased individual cost and with less coverage. This "benefit" is a part of the wage earner's pay, as is illustrated by the many companies offering workers cash payments in lieu of health coverage. In other words, health care contributions paid by businesses are earned by individuals.

Another way individuals pay for heath care is with tax dollars. Tax dollars pay for a large percentage of care in Minnesota through programs for older Americans (Medicare), those with low incomes, the disabled and coverage for government employees. Insurance companies and HMOs don't pay for health care. They take dollars they receive from premiums and taxes, and redistribute the dollars to health care providers, of course leaving a percentage of those dollars in their hands. Finally, individuals pay for their health care directly through premium payments, co-pays, deductibles, and any other costs associated with their treatment not covered by their health care plan (for example, the portion of a bill that a company says is not "reasonable and customary"). And of course those who are uninsured pay entirely with individual dollars to the extent they are able. Costs they are unable to pay are absorbed by medical providers, who must incorporate these losses into the prices everyone else is charged for their care.

While a discussion regarding who pays for health care may seem rudimentary and obvious to some, in considering how we pay for our care, it may be important to remind others that no matter who is paying a particular cost directly, ultimately individuals pay all costs and therefore should be considering the overall value of health care spending. Thus, in considering any measures to reform our health care system, the focus should be on efforts that actually increase the care delivered for the overall cost to the system, as opposed to reforms that simply shift costs from one payer to another, sometimes at a greater overall cost.

<u>Cost savings vs. cost shifting</u>

I next will share my thoughts regarding cost saving reform measures being discussed today in terms of whether they are directed toward an actual overall cost reduction or whether they represent a form of cost shifting.

<u>Examples of cost-shifting "reforms":</u>

- **<u>subsidizing premiums</u> – In an effort to make health care more affordable, usually for those with low incomes, tax dollars are used to pay a portion of the premium cost. While this type of tax subsidy does make care more available to those who can't afford to pay on their own, the cost of the subsidy is transferred to taxpayers as a whole, which of course does not**

actually reduce costs. Similarly, HSAs and other tax credit reforms are simply a reverse method of paying a tax subsidy, except that this form of tax subsidy is more likely to benefit high income individuals.

- **<u>subsidizing insurance company risks</u> - Reforms that require plans to insure everyone (usually accompanied by requirements for mandatory purchase of insurance) may cause some insurance/HMO plans to accept more risk than others; generally these reforms contemplate that tax payer subsidies will insulate the plans from this risk through the payment of subsidies.**

- **<u>cross- subsidizing among medical specialties, geographic areas, plans that pay at differing rates</u> – This occurs when the delivery of a particular medical service is not reimbursed at a rate that pays the cost of that service. Disparities arise because of differences in payment rates that depend on which plan is paying for the service; Medicare & Medicaid, for example, arguably pay at rates that are below the cost of providing certain services. When this occurs, providers must charge individuals paying through others plans a higher amount in order to cover their losses. In some cases, government subsidies are paid to help keep open the doors of providers who serve a high number of individuals covered by plans that don't pay the actual cost of their care. Even with these subsidies, providers in areas with a disproportionate share of low income and/or older patients often face greater challenges attempting to "cross-subsidize" care they provide below cost, impacting the overall level of care they are able to provide. Another form of cross-subsidizing occurs at the provider level, not as a result of who is paying the bill, but because overall certain types of services are reimburse below cost, while others are quite profitable. Hospitals thus will lose money providing one form of care (often in the areas, for example, of mental health and family practice because of the low rates of reimbursement associated with these forms of care) while making up these losses because of high reimbursement rates paid for certain specialized care. Not only is this cross-subsidizing a form of cost-shifting, it sometimes rewards the delivery of high cost care alternatives.**

- **<u>high deductible plans, increased co-pays</u>- In order to offer plans with lower premiums, there has been a trend toward increasing out-of-pocket individual costs. Not only is this simply a form of cost shifting, these types of plans discourage anyone other than the wealthy to forego needed treatment, the lack of which is often associated with higher costs to the overall system when untreated patients end up in the emergency room or otherwise delay treatment until an illness is more serious and expensive to treat.**

- **designer plans and other efforts to eliminate "mandates". Plans that offer limited coverage encourage patients to guess what care they will need and to only pay for that care. Because insurance companies and HMOs are really just cost redistributors, however, if one person pays less because he/she does not require a particular form of care, the person who does require that care will pay more. For example, if an unmarried male purchases a policy that does not factor in the cost of maternity care, then women or families who desire this care will pay more. (Thus, we were told that while mandates only make up a very small percentage of the overall care delivered in this state, eliminating these mandates would not reduce the overall cost of providing care, it would only redistribute these costs.) Another problem with promoting these types of "reforms" is that many people are not shopping for coverage based on an analysis of what they might need (usually a guess), but rather by what they can afford to purchase, leaving them uncovered for many types of potentially needed care and thereby discouraging the utilization of care that is needed at the time it is most cost effective to provide that care.**

Cost saving reforms that address overall system savings:

During our committee meetings, our study group discussed methods by which we could implement true cost savings, using a health plan administration model that is substantially different than what presently is in place in our state. The majority of these cost savings are achieved by reducing or eliminating administrative costs associated with our present system, which utilizes insurance companies and HMOs not only to collect dollars paid into the health care system and redistribute those dollars to providers, but also to "manage" the manner in which that care is delivered. This report also acknowledges that in the many hearings that attempted to quantify the percentage of the health care dollar that is devoted to administrative costs under our present system, it was impossible to define this number exactly because there is no uniformity regarding how these costs are measured. Additionally, it is difficult to impossible to compare old fee-for-service models to "capitated payment models" because of differences between the two systems and a lack of transparency (and some would say accountability) regarding these costs. What we did discover, however, is that arguably unnecessary or inflated administrative costs occur in the following areas:

1. **Costs related to underwriting and bill processing; (a presenter in one committee opined that these costs add at least forty percent to the cost of administrating health care plans in this country, as opposed to administrative costs paid in other countries that include everyone on a community rated basis (eliminating underwriting costs) and streamline billing procedures as a result of utilizing a single billing system.**

2. **"Management costs", including the cost of approving (or disapproving) medical procedures and referrals, together with a growing list of responsibilities assumed by this middle level of administration over time.**

3. **Stop-loss insurance coverage (many companies, and self-insured plans, reinsure themselves to limit their risk exposure, at a cost, we were told, that averages 2- 3 percent of the policy cost.)**

4. **End of year "bonuses" paid to medical providers, not for providing a service but generally for NOT providing care.**

5. **Costs paid to develop and purchase "provider networks", including the cost of separate negotiations with providers by multiple plans regarding participation and payment rates.**

6. **Costs paid by government agencies to oversee health plans;**

7. **Administrative costs paid by healthcare providers (doctors, hospitals), including to receive approval to perform medical procedures, to receive approval for referrals, to process billing documents with a myriad of individual rules, and to fight payment plans for payment when all or part of a submitted bill has been denied. One physician who testified to our committee stated that he believed he could reduce the cost of his individual practice by fifty percent if the need to perform these functions was eliminated. Regardless of the accuracy of this statement, however, it is clear providers shoulder a significant percentage of overall administrative costs, a fact often missed when discussions of administrative spending are limited to health plan expenses.**

8. **Legal and other costs paid to address "subrogation and third party payers". In our present system, we have multiple levels of payers who share responsibility for payment of medical costs, with different rules regarding who has priority to pay that are determined by complex factors including the underlying cause for the need for care, a medical determination that often is arguable and/or isn't made when treatment is needed. Thus, insurance plans have separate departments dedicated to handling what often become legal/administrative battles among plans over who will pay. In cases where this applies (car accidents, work accidents are two examples) it is not uncommon for more to be spent on this effort than the amount of the medical bill in dispute. Additionally, the patient often incurs legal bills, and costs associated with credit implications and lack of access to medical care while the payment status of bills is in limbo.**

9. **Legal costs associated with payment battles between health plans and either physicians or patients. Similar to the situation described in paragraph 8 above, except that the costs involve payment battles between plans and**

either physicians or patients. Because of credit implications and the need for continued care, patients often will simply pay costs out-of-pocket, a "cost-shift" that again is often left out of calculations related to the overall cost of care.

10. **Costs associated with completing report cards and other performance measurement tools. Medical providers testified to our committee that these reports require significant time to complete, are not uniform in either the manner of their completion or their measures, do not accurately reflect a measurement of who is utilizing "best medical practices", provide a motivation to avoid patients and particular socio-economic groups not as likely to provide good measurement outcomes, and are in many cases irrelevant to patients because they do not correspond with the manner in which doctor/patient decisions are made (i.e. medical care is often sought on an emergency basis, is limited by geographic considerations, is based on medical relationships developed with a family doctor. Further, there is a fear that these performance measures can be simply a means of imposing care rationing. Administrative expenses of this type sound like, but are substantively different than, compensating medical care providers spending necessary time with patients to make provide needed information, make appropriate referrals, and otherwise "coordinate care."**

11. **Costs associated with marketing.**

12. **Costs associated with profits, excessive upper management level salaries and perks, and unnecessarily high reserves.**

13. **Lobbying costs.**

<u>Examples of real cost saving reforms</u>:

With the above list of administrative costs in mind, our study group focused on areas in which our proposed plan could ultimately either eliminate or reduce administrative costs. While we are unaware of any study that comprehensively measures all the above administrative costs, anecdotally and by incorporating information regarding various components of those costs mentioned above, it can be extrapolated that a conservative estimate of potential administrative savings, once the health plan is fully implemented, is twenty percent of the overall costs associated with delivering care under the system presently in place in Minnesota. Specifically, administrative cost savings can be achieved by:

1. **Eventually eliminating the need for underwriting.**
2. **Reducing billing-related costs incurred by the payment administrator, the medical provider and the patient.**
3. **Eliminating the need for care "management" by a third party.**

4. **Eliminating costs associated with the purchase of stop-loss coverage, purchase of provider networks, payment incentives for care rationing, third party administrator profits, excess salaries and unnecessary reserves.**
5. **Reducing costs associated with marketing.**
6. **Reducing costs associated with government oversight.**
7. **Eliminating costs associated with lobbying.**

In addition to the reduction of administrative expenses, the health care plan model proposed in our bill is expected to realize additional savings by providing comprehensive care with patient cost-sharing that is on the lower end of the spectrum, to make certain both preventive and acute care is utilized when it is needed. Further, information obtained through the simplified, direct payment system envisioned will provide a more accurate means of evaluating the effectiveness of medical practice choices and will help direct cost-effective wellness measures.

In conclusion, I would like to personally thank everyone who participated in our study group. It was a diverse group who brought many different philosophies to the table. All offered valuable insights; the group's many lengthy discussions covering a broad range of topics was, I believe, part of the healthy process that must take place if we are to truly move toward real reform in health care. Thank you for the opportunity to take part in this process.

Respectfully,

State Senator Mary Olson
Minnesota Senate District 4

Madam Chair, fellow members,

I want to thank everyone for making this opportunity. This has an illuminating look at the inner workings of government. The work we have done has been a great deal of fun for me personally and professionally. I think that this has been a remarkable process and I agree with the comments voiced by the chairs and Rep. Tschumper today that this has the potential to be a great opportunity to bring some meaningful change in health care in Minnesota. I believe that this has a chance to allow market forces and competition to produce reduced costs in health care in our state and bring relief to a number of our fellow citizens who are currently making the difficult decision between health care and other necessities of life.

With this said, however, I do have a few concerns report and legislation that we are presenting to both the Governor and Legislature.

Compensation to Clinics, Hospitals, and Providers of Care:

In the legislation (Section 11, Subdivision 2 a. 3) the association is empowered to provide reimbursement to health care providers for the full cost of each health service provided. This is reiterated in Items 7 and 8 in the summary of the plan. I believe that this is critical.

I am very concerned about any attempt to tinker with this language in any form. Government has an unfortunate track record of not compensating physicians fairly. The Work Group heard testimony regarding the deplorable state of compensation from Medicare and Medicaid at the Federal level and similar testimony regarding the failure of MinnesotaCare to adequately compensate clinics, hospitals, and providers for work that is done. While it may be fashionable to attribute these concerns to physicians seeking to pad salaries, the reality is that this compensation goes to cover the overhead of clinics and hospitals. The harm is not only to physicians and providers of care, but to all those who work within the health care system. Ultimately it is the patients who suffer as services are curtailed or costs shifted.

I believe that it is vital that the legislation ensure that clinics and hospitals are paid for the services that are provided. Appropriate checks should be put in place to prevent fraud and any malfeasance should be punished to the fullest extent of the law. However, this should not be done at the expense of fair compensation for services rendered.

Appropriations:

Section 16, Sub 1 and 2 of the legislation discuss the means by which the pool will be funded and reserves established. There is no firm timeframe established for repayment of the loans to the people of Minnesota. At the end of the day this money is from the people of Minnesota and any endeavor which borrows from the people and says that it will pay them back, must do so in a timeframe which is concrete. Sen. Erickson-Ropes suggests that a timeline might be problematic because of shifting economic

concerns or hardships as yet unforeseen. She cited the recent and devastating floods in her own district. Despite the sheer enormity and magnitude of that disaster, I suspect that the citizens of her district still saw deductions from their paychecks every 2 weeks to the Minnesota Department of Revenue. Any amount that the Department of Revenue believes is owed will be due on April 15. I suspect that loans that they had in their names were still expected to be paid on time. Why should a loan, even to establish something as laudable and commendable as this initiative, not have a concrete timeframe in which that money is repaid to the people of Minnesota. I would propose that the initial costs and reserves taken from the general fund and HCAF respectively be repaid in full no later than 10 years from the first day of operation of the association. If unforeseen economic circumstances arise, disasters befall our state, then the Association can and should be allowed to petition the legislature for an extension, but must show a reason why the loans could not be repaid in full on schedule.

Mechanisms of Cost Savings and Quality Assurance:
The case has been made that there are numerous cost drivers which are responsible for the increasing cost of care. One area which is singled out for mention are administrative costs from the payors. Included in this are programs that are designed to manage care, either through incentives to providers to not provide care or recently to provide care to certain standards which are arbitrarily set by the payors, so called Pay for Performance or P4P. In this system, providers are often given incentives to achieve these standards of care. In order to achieve this much effort is dedicated to data collection on the practices of health care providers, clinics, hospitals and organizations. This effort occurs at the level of the clinic or hospital as well as in the payor organization which together conspire to increase costs. It is entirely proper to point this out as a driver for increasing costs. One of the points raised repeated in the report is how this plan will be different and achieve lower costs by reducing these types of administrative expenses. Item 2 in the summary of the plan states this very clearly and specifically points out that:

> *"The pool eliminates entirely the need for insurance/managed healthcare "middlemen", in the long term greatly reducing and in some cases eliminating administrative costs associated with marketing, managing/rationing care..."*

Yet in item 10 the following is proposed:

> *"Over time, the pool will use information gained from its billing and payment records to incent (with increased rates) medical treatment that is especially effective for particular broad sectors of the public (based, for example, on employment status)"*

I fail to see the difference between this proposal in Item 10 and anything that the private payors are currently doing to manage the means in which health care is provided. Further, while this initiative will increase the administrative costs of maintaining and administering the pool. There is no way around the reality that someone will have to collate the data and issue the reports determining whether the standards set by the Association are being met and whether rates should be adjusted accordingly. Whether

this is done internally or externally, it will not be done pro bono and therefore will increase the costs to the Association and its membership. As additional initiatives are added in, such as wellness promotion, one would expected that costs would continue to increase for each initiative adopted, staffed and administered by the Pool Association. I believe that this fundamental incongruity in the report is not clearly addressed in the legislative language and should be addressed at some point in this process.

Sustainability:
We have heard testimony regarding the failure of other voluntary pools in Minnesota. One pool died and the other is currently on life support. I fear that since we have no idea of the approximate numbers of potential insured lives, acuity of their illnesses, or a myriad of other factors that this plan may meet the same fate as other state sponsored pooling ventures. The legislative language provides for no means of review to determine whether these plans should be continued if failing. Further there is no prohibition to prevent the pool administrative leadership from petitioning the legislature for continued subsidy to support the venture, regardless of its condition.
I would propose an "advanced directive" for this pool. First, I would suggest that there be no heroic measures taken by the legislature to revive the pool should it begin to fail. Second, I would impose a time limit that is reasonable for the plan to become self-sustaining. Third if the pool is not viable in that time frame and is clearly failing, then the pool should be closed down. I think that these steps are necessary to ensure that we are not left with another pooling plan that is perpetually on life support with no hope of recovery.

I want to thank the members of the Work Group and the Task Force for evaluating these recommendations. I would like to further thank you for the opportunity to serve the people of Minnesota in this capacity.

Sincerely,

James Young, M.D.
Member – Health Plan Purchasing Pool Study Group
Appointee from the Office of the Governor

Education Minnesota Addendum to the Report of the Health Plan Purchasing Pool Study Group

Education Minnesota supports the work of the Health Plan Purchasing Pool Study Group. Our union has long been engaged in health insurance reform and the consolidation of our members' purchasing power. We have concluded that the purchasing power and administrative efficiency resulting from the creation of a single large school-employee purchasing-pool promises to stabilize health-care premiums and reduce administrative and other costs. Additionally, the use of claims data from this group can be used to target specific wellness and disease-management needs of the insured population. This is not possible under the current system.

Education Minnesota has concluded that these goals can best be met through the creation of a pool that requires schools that offer employee health insurance to purchase that insurance from the same pool. This is because voluntary participation in the pool will likely attract a high proportion of high-claims groups and individuals. This would result in rapidly escalating increases in premiums which would cause the pool to fail.

We believe that it is important to provide affordable health insurance for all Minnesotans. We support the goal of creating large risk and purchasing pools that promise to achieve this goal. To this end, with our stated reservations about the effect of voluntary pools, we support the goal of establishing a large health insurance pool for all who live and work in Minnesota.

Metropolitan Independent Business Alliance Addendum to the Report of the Health Plan Purchasing Pool Study Group

Twin Cities Metropolitan Independent Business Alliance (Metro IBA) supports the work of the Health Plan Purchasing Pool Study Group. We have endorsed the Minnesota Universal Health Care Coalition Single Payer Plan which we believe is the only to improve the health care of ALL Minnesotans. We have concluded that the purchasing power and administrative efficiency resulting from the creation of a single payer system stabilize health-care premiums and reduce administrative and other costs. This is not possible under the current system.

Metro IBA has agreed to support this "Pool" as a step to the larger goal of Universal Single Payer Health. Understanding that a voluntary pool does have its issues much described by others in the work group.

We believe that it is important to provide affordable health insurance for all Minnesotans. We support the goal of creating large risk and purchasing pools that promise to achieve this goal. To this end, with our stated reservations about the effect of voluntary pools, we support the goal of establishing a large health insurance pool for all who live and work in Minnesota.

To: Chair Olson
From: Representative Erin Murphy
Re: Addendum to Report
Date: January 31, 2008

Thank you for the opportunity to serve on a panel committed to headway in the quest for affordable health care for Minnesotans. I am grateful to be a part of a process to yield thoughtful discussion and a proposal for consideration. Getting to this stage is a feat in itself.

The report articulates a variety of perspectives. While I may not support each perspective, I add my name to the report as I strongly support the notion of a pool as a means to secure health coverage despite employment status. The pairing of a voluntary pool with guaranteed issue remains a problem for this proposal. We have discussed this at length and have not yet resolved the problem.

Finally, the Board, as proposed, must have the flexibility to innovate as new ideas and solutions emerge. In particular, there must be a continued effort to pair payment with evidence and quality. This is both an ideal and an imperative.

Policymakers must continue to engage with providers and citizens to develop this area of policy. The model of provider directed health care home envisions payment for care coordination by an interdisciplinary team. This model, promoted by the American College of Physicians among others, shows promise as it recognizes both the care provided and payment for that care. It proposes payment for care rather than a payment that causes cost shifting. This idea among others does not fit neatly into fee for service or capitation. Such models should be pursued.

I thank Chairs Olson and Erickson Ropes for their dedication to this and to the panel members who gave their time and talent.

MINNESOTA BUSINESS PARTNERSHIP

January 31, 2008

Dissent from Recommendations of the Health Care Purchasing Pool Study Group

Thank you to my fellow study group members for the time and energy each person has dedicated to this study. I appreciate being a part of the discussion, but must express my dissent from the recommended proposals and draft legislation.

The Minnesota Business Partnership supports reform that will provide greater access to affordable health coverage for all Minnesotans through a market-based, patient-centered approach to health care. The solutions for the health care crisis lie in lowering the health care cost trend for the whole system and allowing our health care dollars to be more wisely spent to provide optimal care for everyone.

Specifically, I have the following concerns with the study group recommendations:

Health Care Cost Drivers

This study group discussed a number of ways to address the cost drivers, and the recommendations include some mechanisms aimed at driving down costs in the system, such as care management features to control costs and promote quality, care coordination/medical home concept, wellness programs, and disease management services. However, many of these mechanisms are currently being harnessed within our system, or are being discussed as system-wide reform recommendations.

This voluntary pool is not necessary to implement these ideas.

Pooling

While pooling allows better stability and price predictability to those within that pool, the recommendations do not address the basic problems with voluntary pools.

The recommendations do not identify a likely target market large enough to sustain a voluntary pool without the danger of individuals or groups leaving once a lower rate is offered outside the pool. They do not identify a negotiating strategy that will achieve lower or similar provider costs compared to what is currently achieved in the market. And the recommendations call for issuance of coverage on a guaranteed-issue basis, subject only to vague limitations yet to be determined. This plan will likely be a magnet for ill individuals who have been denied coverage elsewhere because of their high care costs, which will likely lead to higher costs for the pool.

The recommendations do not clearly identify how to overcome these barriers.

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Savings

The recommendations contain no estimates on potential cost savings to either the system as a whole or to the individuals within this newly created plan. While the recommendations call for a less expensive product than is currently available in the market, it has not identified in real numbers how that lower cost would be achieved.

Without identifying concrete savings, it is ill-advised to invest state dollars in a new health program.

Covering the Uninsured

Without specifics on the cost to the individual, there is no estimate of how many currently uninsured people would be able to pay for such coverage as may be created, or how many individuals or groups might choose to join the voluntary pool.

It is unclear if this voluntary pool would lower our uninsured rate.

Administrative Simplification

The recommendations suggest that this plan has somehow eliminated layers of administration, i.e. "eliminate the middleman." However, it is unclear what administrative responsibilities have been removed. The plan calls for a new entity to be created to administer all the basic functions of the pool and to not contract out the responsibilities to existing third party administrators. This entity will still need to perform the basic functions of a health benefit plan such as reporting to the Department of Commerce, negotiating with providers for payment rates and inclusion in a network, marketing the plan to the public, maintaining an adequate reserve, and paying claims.

Conclusion

Throughout the study group discussions, a number of members expressed their interest in ultimately implementing, in Minnesota, a health care system which is commonly referred to as single-payer, and expressed their desire for this voluntary pool be a step in that direction.

The Minnesota Business Partnership supports a competitive marketplace for health insurance and care delivery; we do not support a government-run, single-payer system.

There are significant problems in our system of covering medical costs and delivering health care to the members of our communities. However, I do not believe the plan recommended by the study group is a viable solution for providing greater access to affordable health coverage.

Respectfully submitted by:

Beth Hartwig, Health Policy Director, Minnesota Business Partnership

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January 31, 2008

AFSCME Council 5 Comments regarding the work of the Health Plan Purchasing Pool Study Group

AFSCME Council 5 appreciates the opportunity to participate in these study group discussions regarding establishing a voluntary, guaranteed issue insurance purchasing pool.

We share the concerns of the majority of Minnesotans along with the members of this study group about the current lack of access to affordable health insurance for every citizen of the State. Obviously there are a variety of approaches that can be taken to address this concern.

While in the ideal world a voluntary pool open to employer groups and individuals would be an effective solution we don't live in an ideal world and available evidence leads AFSCME Council 5 to believe that voluntary pooling cannot achieve the laudable goal of affordable and accessible health care for all Minnesotans.

We agree with some of the comments made by the Minnesota Business Partnership that pooling in general seems to provide a level of stability and predictability regarding premiums to those within that pool but that the group's recommendations do not address the basic problems with voluntary pools including: attracting and retaining a product-sustaining population, negotiating clout, and avoiding becoming a risk magnet.

Without more specific information about how to overcome these basic problems associated with the establishment of voluntary pools and how this particular pool would have any more ability to address these issues than other pools that have been tried in the state and either failed or are at best marginally successful (most notably the Public Employer Insurance Plan aka PEIP and the Minnesota Employer Insurance Plan aka MEIP) it is difficult for AFSCME Council 5 to support investment of state dollars in these efforts.

On behalf of AFSCME Council 5

Jill Kielblock

Jill Kielblock
Field Representative
Health Plan Purchasing Pool Study Group Participant

DRAFT

A bill for an act

relating to health; establishing a voluntary statewide pool to provide health benefits to eligible members; providing for the administration and oversight of the pool; appropriating money; proposing coding for new law as Minnesota Statutes, chapter 62U.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **INTENT.**

The legislature finds that the creation of a voluntary statewide pool to provide public and private employers, individuals, and others with the advantages of a large pool for the purchasing of affordable, comprehensive, accessible, and high quality health benefits would advance the welfare of the citizens of the state.

Sec. 2. **[62U.01] DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of this chapter, the terms defined in subdivisions 2 to 11 have the meanings given them.

Subd. 2. **Cost-effective.** "Cost-effective" has the meaning given the term in section 62J.03.

Subd. 3. **Community rating.** "Community rating" means a rating methodology in which the premiums charged by the pool for all enrollees is the same based upon the experience of the entire pool of risks covered without regard to gender, health status, residence, or occupation.

Subd. 4. **Dependent.** "Dependent" means a spouse or unmarried child under the age of 25, or a dependent child of any age who is disabled.

Subd. 5. **Employee.** "Employee" means an employee of an eligible employer. Employee includes a sole proprietor, partner of a partnership, member of a limited liability company, or independent contractor.

Subd. 6. **Employer.** "Employer" means a private person, firm, corporation, partnership, limited liability company, association, or other entity actively engaged in business or public services. Employer includes both for-profit and nonprofit entities and the state of Minnesota and any political subdivision of the state.

Subd. 7. **Guaranteed issue.** "Guaranteed issue" means that the pool must not decline an application for coverage by an employer, individual, or other pool and must not decline to provide coverage in the pool to those eligible for coverage after initial issuance of coverage in the pool.

Subd. 8. **Health benefits.** "Health benefits" means benefits which pay the cost of medical, surgical, hospital, or dental care, and pharmacy benefits offered by the pool to eligible members of the pool.

Subd. 9. **Health care provider.** "Health care provider" has the meaning given in section 62J.70, subdivision 2.

Subd. 10. **Individual.** "Individual" means a person eligible to participate in the pool under the terms established according to section 62U.08.

Subd. 11. **Pool.** "Pool" means the Minnesota health benefits purchasing pool created by this chapter.

Sec. 3. **[62U.02] MINNESOTA HEALTH BENEFITS PURCHASING POOL ASSOCIATION.**

Subdivision 1. **Creation.** The Minnesota Health Benefits Purchasing Pool Association may operate as a nonprofit unincorporated association, but is authorized to incorporate under chapter 317A. All covered lives enrolled in the pool are members of the association.

Subd. 2. **Purpose.** The association is created to establish and administer the Minnesota health benefits purchasing pool consistent with the provisions of this chapter.

Subd. 3. **Exemptions.** The association, its transactions, and all property owned by it are exempt from taxation under the laws of this state or any of its subdivisions, including, but not limited to, premiums taxes imposed under chapter 297I, income tax, sales tax, use tax, and property tax. The association may seek exemption from payment of all fees and taxes levied by the federal government. Except as otherwise provided in this chapter, the association is not subject to the provisions of chapters 13, 13D, 60A, and 62A to 62H. The association is not a public employer and is not subject to the provisions of chapters 179A

and 353. The association and the board of directors are exempt from sections 325D.49 to 325D.66 in the performance of their duties as directors of the association.

Subd. 4. **Powers of association.** The association may exercise all of the powers of a corporation formed under chapter 317A, including, but not limited to, the authority to:

(1) establish operating rules, conditions, and procedures relating to the provision of health benefits offered by the pool to eligible members of the pool, including reasonable temporary enrollment restrictions and other temporary coverage restrictions deemed necessary by the association to ensure the pool's financial health;

(2) impose a membership fee on the terms the board determines are appropriate;

(3) establish procedures consistent with the requirements of this chapter and the needs of the association that promote public access and accountability, including public notice and open meeting procedures, and procedures that allow reasonable public access to information created or maintained by the association;

(4) sue and be sued;

(5) enter into contracts necessary to carry out the provisions of this chapter;

(6) establish operating, administrative, and accounting procedures for the operation of the pool; and

(7) borrow money against the future receipt of premiums.

The provisions of this chapter govern if the provisions of chapter 317A conflict with this chapter. The association shall operate under the plan of operation approved by the board and shall be governed in accordance with this chapter and may operate in accordance with chapter 317A. If the association incorporates as a nonprofit corporation under chapter 317A, the filing of the plan of operation meets the requirements of filing articles.

Subd. 5. **Review and approval of policy forms, contracts, and premiums.** The association's policy forms, contracts, and premium rates are subject to the approval of the commissioner of commerce on the same terms and subject to the same conditions as a carrier regulated under chapters 62A, 62C, and 62D. The association shall notify the commissioner of all association or board meetings, and the commissioner or the commissioner's designee may attend all association or board meetings. The association shall file an annual report with the commissioner on or before July 1 of each year, beginning July 1, 2009, describing its activities during the preceding calendar year. The report must include a financial report and a summary of claims paid by the association. The annual report must be available for public inspection.

Sec. 4. **[62U.03] BOARD OF DIRECTORS.**

Subdivision 1. **Composition of board.** (a) The association shall exercise its powers through a board of 15 directors. Five directors shall be employers who are members of the association; five directors shall be individuals who are members of the association; and five directors shall be health care providers elected from a slate, established by the administrator, that is representative of health care providers from all geographic areas of the state. No more than seven of the directors so appointed may be residents of the seven-county metropolitan area.

(b) The board shall include the following ex officio, nonvoting directors:

(1) one director appointed by the governor;

(2) two directors of the house of representatives, one from the majority caucus and one from the minority caucus, appointed by the speaker of the house of representatives;

(3) two directors of the senate, one from the majority caucus and one from the minority caucus, appointed by the Subcommittee on Committees of the Committee on Rules and Administration.

The terms of these ex officio directors shall be three years and no director may serve more than two consecutive terms.

(c) The following employees of the association are also ex officio, nonvoting directors of the board: the administrator, an actuary, a legal advisor, and the enrollee ombudsman.

Subd. 2. **Appointment of board.** The members of the association shall elect the board of directors in accordance with this chapter and the plan of operation.

Subd. 3. **Term of office.** Each director shall serve a three-year term, except that the board shall make appropriate arrangements to stagger the terms of the directors so that approximately one-third of the terms expire each year. Each director shall hold office until expiration of the director's term or until the director's successor is duly appointed and qualified, or until the director's death, resignation, or removal. A director may not serve for more than two consecutive terms.

Subd. 4. **Resignation.** A director may resign at any time by giving written notice to the board. The resignation takes effect at the time the resignation is received unless the resignation specifies a later date. If a vacancy occurs for a director, the board shall appoint a new director for the duration of the unexpired term.

Subd. 5. **Quorum.** A majority of the voting directors constitutes a quorum for the transaction of business. If a vacancy exists by reason of death, resignation, or otherwise, a majority of the remaining voting directors constitutes a quorum.

Subd. 6. **Duties of directors.** The board shall develop a plan of operation and reasonable operating rules to assure the fair, reasonable, and equitable administration of the

pool. The plan of operation must include the development of procedures and the coverage options to be offered by the pool that are consistent with this chapter. The plan of operation must be submitted to the members for approval at the first meeting of the members. The board of directors may subsequently amend, change, or revise the plan of operation.

Subd. 7. **Officers.** The board may elect officers and establish committees as provided in the bylaws of the association. Officers have the authority and duties in the management of the association as prescribed by the bylaws and determined by the board of directors.

Subd. 8. **Majority vote.** Approval by a majority of the directors present is required for any action of the board.

Sec. 5. **[62U.04] MEMBERS.**

Subdivision 1. **Annual meeting.** The association shall conduct an annual meeting of the members of the association for the purpose of electing directors and transacting any other appropriate business of the membership of the association. The board shall determine the date, time, and place of the annual meeting.

Subd. 2. **Special meetings.** Special meetings of the members must be held whenever called by any five of the directors or upon a petition signed by 25 percent of the members of the association. Special meetings of the members must be held at a time and place designated in the notice of the meeting.

Subd. 3. **Member compliance.** All members shall comply with the provisions of this chapter, the association's bylaws, the plan of operation developed by the board of directors, and any other operating, administrative, or other procedures established by the board of directors for the operation of the association.

Sec. 6. **[62U.05] ADMINISTRATION OF POOL.**

Subdivision 1. **Administrator.** The board shall hire a qualified person to operate and administer the pool. The administrator shall perform all administrative functions required by this chapter. The board of directors shall develop administrative functions required by this chapter and written criteria for the selection of an administrator.

Subd. 2. **Duties of administrator.** (a) The administrator shall perform all functions required by this chapter including:

(1) hiring employees, including actuaries, legal personnel, and an enrollee ombudsman;

(2) preparing and submitting an annual report to the association;

(3) preparing and submitting monthly reports to the board of directors;

(4) paying claims to health care providers following the submission by health care providers of acceptable claim documentation; and

(5) providing claim reports to health care providers as determined by the board of directors.

(b) The administrator shall assist the board in developing the coverage options and the premium rates for the pool.

Subd. 3. **Records of association.** The administrator shall maintain appropriate records and documentation relating to the activities of the association. All individual patient-identifying claims data and information are confidential and not subject to disclosure of any kind. All records, documents, and work product prepared by the association or by the administrator for the association are the property of the association. The commissioner of commerce shall have access to the data for the purposes of carrying out the commissioner's duties under section 62U.02, subdivision 5.

Subd. 4. **Indemnification.** The association shall indemnify directors, officers, employees, and agents to the same extent that persons may be indemnified by corporations under section 317A.521.

Sec. 7. **[62U.06] EMPLOYER ELIGIBILITY.**

Subdivision 1. **Procedures.** All employers are eligible for coverage through the pool subject to the terms of this section. The association shall establish procedures for an employer to apply to, become enrolled in, obtain coverage from, and withdraw from, the pool.

Subd. 2. **Term.** The initial term of an employer's coverage shall be established by the association. After that, coverage will be automatically renewed for an additional term unless the employer gives notice of withdrawal from the pool according to procedures established by the association or the association gives notice to the employer of the discontinuance of the pool. The association may establish conditions under which an employer may withdraw from the pool before expiration of a term, and conditions under which the employer may reapply for coverage. An employer that withdraws from the pool may not reapply for coverage for a period of time equal to its initial term of coverage.

Subd. 3. **Minnesota work force.** An employer is not eligible for coverage through the pool if five percent or more of its eligible employees work primarily outside Minnesota, except that an employer may apply to the pool on behalf of only those employees who work primarily in Minnesota.

Subd. 4. **Employee participation; aggregation of groups.** An employer is not eligible for coverage through the pool unless its application includes all eligible employees

who work primarily in Minnesota, except employees who waive coverage as permitted by section 62U.07, subdivision 4. Private entities that are eligible to file a combined tax return for purposes of state tax laws are considered a single employer, except as otherwise approved by the association.

Subd. 5. **Private employer.** A private employer is not eligible for coverage unless it has two or more eligible employees in the state of Minnesota. If an employer has only two eligible employees and one is the spouse, child, sibling, parent, or grandparent of the other, the employer must be a Minnesota domiciled employer and have paid Social Security or self-employment tax on behalf of both eligible employees.

Sec. 8. **[62U.07] EMPLOYEE ELIGIBILITY.**

Subdivision 1. **Procedures.** The association shall establish procedures for employees and other eligible individuals to apply to, become enrolled in, obtain coverage from, and withdraw from, the pool.

Subd. 2. **Employees.** The association shall determine, when an employer applies to the pool, the criteria its employees must meet to be eligible for coverage under its plan. The criteria must provide that all employees are eligible for coverage unless the association establishes otherwise, and that new employees must elect coverage within 90 days of the start of their employment.

Subd. 3. **Other dependents and individuals.** The association may elect to cover:

(1) the spouse, dependent children, and dependent grandchildren of a covered employee;

(2) a retiree who is eligible to receive a pension or annuity from the employer and a covered retiree's spouse, dependent children, and dependent grandchildren;

(3) the surviving spouse, dependent children, and dependent grandchildren of a deceased employee or retiree, if the spouse, children, or grandchildren were covered at the time of the death;

(4) a covered employee who becomes disabled, as provided in sections 62A.147 and 62A.148; or

(5) any other categories of individuals for whom group coverage is required by state or federal law.

Subd. 4. **Waiver and late entrance.** An eligible individual may waive coverage at the time the employer joins the pool or when coverage first becomes available. The association may establish a preexisting condition exclusion of not more than 18 months for late entrants.

Sec. 9. **[62U.08] INDIVIDUAL ELIGIBILITY.**

All individuals in the state are eligible for coverage through the pool subject to the terms established by the association. The association shall establish procedures for individuals to apply to, become enrolled in, obtain coverage from, and withdraw from, the pool.

Sec. 10. **[62U.09] OTHER POOL ELIGIBILITY.**

Subdivision 1. **Procedures.** All mandatory or voluntary health care pools operating in the state are eligible for coverage through the pool subject to the terms of this section. The association shall establish procedures for a pool to apply to, become enrolled in, obtain coverage from, and withdraw from, the pool.

Subd. 2. **Term.** The initial term of a pool's coverage shall be established by the association. After that, coverage will be automatically renewed for an additional term unless the enrollee pool gives notice of withdrawal from the pool according to procedures established by the association or the association gives notice to the enrollee pool of the discontinuance of the pool. The association may establish conditions under which the enrollee pool may withdraw from the pool before expiration of a term, and conditions under which the enrollee pool may reapply for coverage. An enrollee pool that withdraws from the pool may not reapply for coverage for a period of time equal to its initial term of coverage.

Sec. 11. **[62U.10] COVERAGE.**

Subdivision 1. **Generally.** Subject to any temporary enrollment and other temporary restrictions established by the association, coverage through the pool must be made available on a guaranteed issue basis. No more than three coverage options may be offered through the pool. The association shall provide coverage through contracts directly with health care providers. The association may charge all members a fee for administrative purposes.

Subd. 2. **Health benefits.** (a) The association shall establish health benefits that:

(1) have strong care management features to control costs and promote quality including: (i) financial incentives for patients, in appropriate situations, to select a care coordinator who will coordinate health care services across the continuum of care; and (ii) coverage for cost-effective services, including the use of cost-effective disease management programs;

(2) provide reimbursement to health care providers for the full cost of each health service provided;

(3) promote enrollee wellness and education;

(4) are available in all the geographic areas of the state; and

(5) remove or reduce barriers for enrollees to get needed services.

(b) Health coverage for a retiree who is eligible for the federal Medicare program must be administered as though the retiree is enrolled in Medicare parts A and B.

(c) To the extent feasible as determined by the association and in the best interests of the pool, the association shall model coverage after the coverage provided pursuant to section 43A.23, subdivision 2. Health benefits must include at least the benefits required of a carrier regulated under chapter 62A, 62C, or 62D for comparable coverage.

Subd. 3. **Continuation coverage.** The pool shall provide all continuation coverage required by state and federal law.

Subd. 4. **Technical assistance.** The association may arrange for technical assistance and referrals for enrollees in areas such as health promotion and wellness, employee benefits structure, tax planning, and health care analysis services as described in section 62J.2930.

Sec. 12. **[62U.11] PREMIUMS.**

Subdivision 1. **Payments.** Employers, individuals, and other pools enrolled in the pool shall pay premiums according to terms established by the association. If an employer, individual, or other pool fails to make the required payments, the association may cancel coverage and pursue other civil remedies.

Subd. 2. **Rating method.** The association shall determine the premium rates and use community rating in setting the premium rates. The premium rates may vary depending on the ages of enrollees. The association must recover in premiums all of the ongoing costs for administration and for maintenance of premium stability and claim fluctuation reserve.

Subd. 3. **Taxes and assessments.** The premiums paid to the pool are not subject to the taxes imposed by chapter 297I, and the pool is not subject to a Minnesota Comprehensive Health Association assessment under section 62E.11.

Sec. 13. **[62U.12] MINNESOTA HEALTH BENEFITS PURCHASING POOL RESERVES.**

The association shall establish and maintain adequate reserves:

(1) for claims in process, incomplete and unreported claims, premiums received but not yet earned, and all other accrued liabilities; and

(2) to ensure premium stability and the timely payment of claims in the event of adverse claims experience.

Sec. 14. **[62U.13] STATUS OF AGENTS.**

Notwithstanding sections 60K.49 and 72A.07, the pool may use, and pay referral fees, commissions, or other compensation to, agents licensed as insurance producers under chapter 60K.

Sec. 15. **APPOINTMENT OF INITIAL BOARD.**

The health plan purchasing pool study group, as constituted on the day it expired pursuant to Laws 2007, chapter 147, article 12, section 15, is revived the day following final enactment of this section for the sole purpose of appointing the initial board of directors of the Minnesota Health Benefits Purchasing Pool Association. Notwithstanding Minnesota Statutes, section 62U.03, the health plan purchasing pool study group shall appoint an initial board of directors consisting of 15 members. The study group shall appoint five members who are employers in the state, five members who are individuals residing in the state, and five members who are health care providers in the state. No more than seven directors may be appointed from the seven-county metropolitan area. Two-thirds of the membership of the study group must vote in favor of each appointment made under this section. Initial appointments to the board must be made by August 1, 2008. The initial board shall serve until the pool begins operation, but in no event may the term of this initial board exceed two years. Minnesota Statutes, section 62U.03, subdivisions 4, 5, 6, 7, and 8, apply to the initial board from the date of its appointment. The initial board of directors shall hire an administrator and prepare a plan of operation that allows the pool to begin offering coverage as soon as practicable. The initial coverage options and the premium rates must be established with the assistance of the administrator and presented to the board for approval. The association may initially limit enrollment, coverage options, and availability of coverage in certain geographic areas of the state and to certain individuals or groups, and impose other restrictions that are necessary to ensure that the pool is actuarially sound.

Sec. 16. **APPROPRIATIONS.**

Subdivision 1. **General fund.** $..... is appropriated from the general fund to the Minnesota Health Benefits Purchasing Pool Association for the purposes of this act. This appropriation is effective the day following final enactment and is available until expended. It is intended that the association repay this appropriation when the association determines that it has the financial resources to do so without jeopardizing the financial stability of the pool.

Subd. 2. **Health care access fund.** A sum sufficient but not exceeding $..... is appropriated from the health care access fund to the Minnesota Health Benefits Purchasing Pool Association to establish adequate initial reserves to allow the association to begin offering coverage in the pool on the limited basis as authorized under section 16. The appropriation is available until expended. It is intended that the association repay the health care access fund the amount appropriated under this section when the association determines that it possesses the financial resources to do so without jeopardizing the financial stability of the pool.