Study of HMO Conversions

PRELIMINARY REPORT TO THE MINNESOTA LEGISLATURE 2024

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Study of HMO Conversions – Preliminary Report to the Minnesota Legislature 2024

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Minnesota Senate
Health and Human Services Committee
The Honorable Melissa Wiklund, Chair, 2107 Minnesota Senate Building

The Honorable Paul Utke, Ranking Member, 2403 Minnesota Senate Building

Human Services Committee
The Honorable John Hoffman, Chair, 2111 Minnesota Senate Building

The Honorable Jim Abeler, Ranking Member, 2207 Minnesota Senate Building

Commerce and Consumer Protection Committee
The Honorable Matt Klein, Chair, 2105 Minnesota Senate Building

The Honorable Gary Dahms, Ranking Member, 2219 Minnesota Senate Building

Minnesota House of Representatives
Health Finance & Policy Committee
The Honorable Tina Liebling, Chair, 477 State Office Building

The Honorable Joe Schomacker, Ranking Member, 209 State Office Building

Human Services Finance Committee
The Honorable Mohamud Noor, Chair, 379 State Office Building

The Honorable Anne Neu Brindley, Ranking Member, 251 State Office Building

Human Services Policy Committee
The Honorable Peter Fischer, Chair, 551 State Office Building

The Honorable Debra Kiel, Ranking Member, 203 State Office Building

Commerce Finance & Policy Committee
The Honorable Zack Stephenson, Chair, 449 State Office Building

The Honorable Tim O'Driscoll, Ranking Member, 237 State Office Building

February 2, 2024

To the Honorable Chairs and Ranking Members:

As part of far-ranging discussions on changes in ownership and governance of Minnesota health systems and Health Maintenance Organizations (HMOs), the 2023 Minnesota Legislature directed the Minnesota Department of Health (MDH) to study and develop recommendations on the regulation of financial transactions that may move assets from nonprofit HMOs to for-profit entities via conversions, mergers, transfers of assets, or other mechanisms. The legislature also required MDH to solicit public input on potential regulation of conversion transactions and provide recommendations to address monitoring and regulation of Minnesota-domiciled for-profit HMOs.

This preliminary report provides background information on changes to Minnesota's health insurance market since the establishment of a 2017 law allowing for-profit and foreign-domiciled (HMOs that are incorporated or organized in another state) HMOs to be licensed in the state. It also describes how MDH, the Minnesota

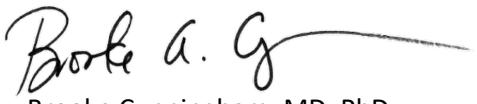
Department of Commerce, and the Minnesota Attorney General's Office currently regulate nonprofit HMOs and their financial transactions, as well as opportunities to strengthen or clarify that oversight. It also provides information about how other states regulated conversions, mergers, and sales involving nonprofit HMOs or insurers.

Key themes from this preliminary report include:

- Three for-profit HMOs have entered the Minnesota health insurance market since 2017 and, as of 2022, provided coverage to approximately 40,000 Minnesotans (2.4% of the total HMO market).
- Public commentary found that respondents place a high value on health insurance coverage (and care) being provided by nonprofits, and value the locally based aspect of nonprofit HMOs; they feel that local nonprofits are more community engaged and responsive to local needs.
- While the value placed on nonprofit and local HMOs is high, minimal data are available to shed light on whether differences exist between nonprofit and for-profit HMOs with regard to day-to-day operations, enrollee satisfaction, and quality of care.
- States that have established robust oversight processes for HMO conversions or similar transactions tend to include requirements for public notice and transparency, processes to ensure that charitable or nonprofit assets continue to be used for their original purpose, and clear authority to set and enforce conditions on the approval of transactions.

The issues addressed in this report are complicated and often highly technical. They are also of significant importance to Minnesotans: access to affordable, comprehensive health insurance coverage is an important factor that contributes to an individual's overall health, and one that has clear financial implications for individuals, families, and employers. Having a robust, transparent regulatory structure for entities that provide insurance coverage is necessary for accountability in meeting all state and federal requirements. The final report from MDH on these issues, due on June 30, 2024, will provide more in-depth analysis of how other states approach regulating HMO conversion transactions, as well as options for legislators to consider related to both the ongoing regulation of for-profit and foreign HMOs in Minnesota and the treatment of conversion transactions.

Sincerely,



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Executive Summary

Introduction

This is the first of two reports the Minnesota Department of Health (MDH) was directed to complete by the 2023 Legislature to study and develop recommendations on the regulation of conversions, mergers, transfers of assets, and other transactions affecting Minnesota-domiciled nonprofit and for-profit Health Maintenance Organizations (HMOs). The legislature also directed MDH to develop recommendations to address monitoring and regulation of Minnesota-domiciled for-profit HMOs, public transparency and input into nonprofit to for-profit conversions, and processes for approval, valuation, and stewardship of public benefits assets that may be generated. A public input process on conversion transactions was also required.

These issues are important to all Minnesotans for a number of reasons. Access to affordable, comprehensive health insurance coverage is an important factor that contributes to an individual's overall health, and one that has clear financial implications for individuals, families, and employers. Having a robust, transparent regulatory structure for entities that provide the coverage is necessary for accountability in meeting all state and federal requirements, including those related to entities' financial health and ability to meet their financial obligations to enrollees and providers.

As the legislature recognized when placing a moratorium on conversion transactions, the colloquial term "conversion" can describe different types of transactions or a series of transactions that serve to move substantial assets and business from one entity to another or involve changes in corporate governance and control. The simple scenario that many people envision – a nonprofit deciding to become a for-profit – is prohibited under Minnesota Statutes, chapter 317A. This type of transition would not be allowed under state law even without the moratorium. But there are several different scenarios or transactions that can result in assets moving from a nonprofit organization to a for-profit one, all at once or over time.

State laws governing Minnesota HMOs dating back to 1973 allowed only HMOs that were both nonprofit and locally domiciled (incorporated in Minnesota) to be licensed in the state. This reflected the high value placed on nonprofit health care; public comment on this study confirmed this is a value that still holds true for many Minnesotans. The law changed in 2017, allowing for-profit and foreign-domiciled HMOs to offer coverage to Minnesotans. At the same time, the legislature also established a moratorium on the conversion of the local nonprofit HMOs to for-profit status.[1] The end date of the moratorium has been extended several times; it is currently scheduled to end on July 1, 2026.[2]

While much of the legislative and public attention on the 2017 changes, and the focus of this report, has been on allowing for-profit HMOs to operate in Minnesota, the new ability of foreign-domiciled HMOs (HMOs that are incorporated or organized in another state) to operate in the state is also significant. State regulators generally have less authority over foreign-domiciled HMOs and financial transactions they make. There are also currently

[1] 2017 Laws of Minnesota, Chapter 6, Article 5, Section 11; www.revisor.mn.gov/laws/2017/1/Session+Law/Chapter/6/.
[2] Minnesota House File 402, 5th Engrossment, Section 11; www.revisor.mn.gov/bills/text.php?number=HF0402&version=latest&session=92&session_number=0&session_year=2023

no HMO regulations that preclude Minnesota-domiciled HMOs from taking their business in whole or in part to another state or moving their domicile to another state. To the extent that any associated assets would be considered public, such a change could result in movement of those public assets out of Minnesota.

Current HMO Landscape

As of January 2024, there are 13 HMOs licensed in Minnesota; of these, 10 are domiciled in Minnesota, meaning Minnesota is the state where the HMO is incorporated or organized (Table 1).[3] Based on the most recent data available, from 2022, these HMOs represent an average of 1.6 million members (28.2% of Minnesota's 5.7 million residents) with over $15.2 billion in total annual revenue.[4]

Since for-profit HMOs were allowed to enter the Minnesota market in 2017, three entities have done so, although their total market share remains small. Minnesota's HMOs are typically part of more complex holding company structures (these can also be known as holding company systems; see Appendix C for details). These holding companies often include both for-profit and nonprofit entities; this corporate structure is noteworthy as it could complicate regulatory oversight and potentially create opportunities to shift assets between nonprofit and for-profit entities within the holding company.

Minnesota's Regulatory Structure and Oversight of Transactions

MDH is responsible for regulating HMOs in Minnesota. Regulation of HMOs in Minnesota has remained largely unchanged since statutes allowing their operation in Minnesota were enacted in 1973, with the exception of updates to conform to federal law and allowing for-profit HMOs to enter the market in 2017. This means no consideration has yet been given to whether nonprofit and for-profit HMOs should be regulated in the same manner or whether there are areas in which they should be regulated differently or whether HMO statutes need to be updated to reflect that for-profit and foreign entities now operate in the state. The same is true of the Minnesota tax structure, which does not distinguish between nonprofit and for-profit HMOs. HMOs, along with nonprofit health service plan corporations, are subject to a 1% gross premium tax that was put in place at a time when HMOs were required to be nonprofit; insurance companies (regardless of profit status) pay a 2% premium tax.

Regulatory oversight of HMO conversion transactions is complicated. Regulatory authority is split across three agencies and could involve not only MDH, but also the Minnesota Department of Commerce, and the Minnesota Attorney General's Office depending on the types of organizations or transactions involved. Some types of

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[3] For purposes of this report MDH is excluding three County Based Purchasers (CBP); IM Care, South Country Health Alliance (SCHA), and Prime West. CBPs are health plans operated by a county or a group of counties that purchase health care services for certain residents enrolled in Medical Assistance and MinnesotaCare. The participating counties are primarily rural. Additional information is available on MDH's website: www.health.state.mn.us/facilities/insurance/managedcare/planinfo/cbpinfo.html.

[4] Total Revenue is the amount of money a business makes from all products and services the business sells, prior to any expenses. HMO enrollment includes all lines of business, even for program types which may not be primary medical coverage (e.g., standalone Part D, Medicare Supplement, and Medicare Select). As such, HMO enrollment may be overstated. Minnesota population based on U.S. Census Bureau, Annual Estimates of the Resident Population for Counties in Minnesota; July 1, 2022.

transactions receive more oversight than others. This is due to the historically unique assumptions and expectations of nonprofit HMOs when regulations were created. The report's analysis of current regulatory oversight reveals areas where gaps exist.

Conversions in Other States

To assist legislators as they consider options for regulating HMO conversion transactions, this preliminary report includes a high-level overview of how such transactions have been handled in other states, to the extent details are public. The experiences of other states suggest core components of a regulatory system should include the following elements:

- Developing requirements for public notice and transparency of significant or substantial transactions.
- Instituting requirements regarding the definition of public benefit assets, and how their value should be quantified.
- Ensuring maintenance of charitable or public benefit assets for their original nonprofit/charitable purposes, often by requiring the establishment of a nonprofit entity or foundation.
- Establishing the regulatory authority to set and enforce conditions for approval, to stop the transaction from occurring, or set conditions on its implementation.

Public Input Process

A large focus of the first phase of the study was gathering information from the public and key informants regarding their recommendations, concerns, and interest in how transactions should be regulated in Minnesota. Input was provided through written comments submitted in response to a Request for Information, a Public Listening session, and interviews with local and national key informants. General themes raised from the public and key informant interviews included the following:

- Many responders continue to place a high value on health insurance coverage (and care) being provided by nonprofit entities. Respondents raised concerns related to motives of for-profit entities around profit margins and the value that comes from nonprofit HMOs generally having their core mission driven by health improvement motives that include serving enrollees rather than shareholders. Some went so far as to suggest rescinding the policy allowing for-profit HMOs to operate in Minnesota.
- Some key informants felt there was little day-to-day difference in how nonprofits and for-profits function.
- Stakeholders also valued the locally based aspect of nonprofits in Minnesota, noting more community engagement, participation in quality improvement collaboratives, and being more responsive to local needs and policies. There was a common sentiment that this local presence and focus of Minnesota-domiciled HMOs has been central to the positive aspects of Minnesota's health care ecosystem.
- Stakeholders, especially providers, anecdotally indicated that for-profits were more difficult to work with for reimbursement, and that utilization review practices, such as prior authorization, were stricter and more challenging to process.
- Stakeholders expressed interest in seeing all HMOs held to the same standards and expectations regarding community benefit and quality of services to enrollees, whether nonprofit or for-profit. Similarly, key informants encouraged establishing a structure that does not disadvantage nonprofit HMOs relative to for-profits.
- There was a strong interest among stakeholders in public notice and transparency, as well as post-conversion monitoring of quality, cost and satisfaction, and assurance that nonprofit assets were maintained for nonprofit/charitable purposes.

- Key informants also noted the degree to which for-profit entrants have already changed the market, including driving nonprofits to increase their product offerings or expand their service areas beyond Minnesota borders, as well as expand their reserves to accomplish these tasks, in order to compete against the economies of scale and financial reserves of larger national for-profit entities.

Conclusion

The analysis in this report demonstrates the complexity of the health insurance market, with intricate holding company structures and regulation that differs across multiple types of transactions, and points to areas where the existing regulatory structures need to be updated to reflect an environment in which both for-profit and foreign HMOs now operate. It provides background information to assist in developing recommendations regarding the effective reporting and regulation of conversion transactions – such as clear definitions and thresholds, advance notification to regulators with the ability to approve or disapprove a transaction, a process that protects public assets for continued nonprofit use in the event of a sale or transfer of substantial assets to a for-profit organization, and a mechanism by which the public can provide input into conversion transactions. The final report will provide more in-depth analysis of how other states approach regulation of HMO conversion transactions, as well as options for legislators to consider related to both the ongoing regulation of for-profit and foreign HMOs in Minnesota and the treatment of conversion transactions.

Introduction

The 2023 Legislature passed a bill[5] (Appendix A) that directs the Minnesota Department of Health (MDH) to complete a study and develop recommendations on the regulation of conversions, mergers, transfers of assets, and other transactions affecting Minnesota-based nonprofit Health Maintenance Organizations (HMOs) and for-profit HMOs. The language requires MDH to address:

- Issues related to public benefit assets held by a nonprofit HMO, including identifying the portion of the organization's assets that are considered public benefit assets to be protected, establishing a fair and independent process to value the assets, and determining how public benefit assets should be stewarded for the public good.
- Providing a state agency or executive branch office with authority to review and approve or disapprove a nonprofit HMO's plan to convert to a for-profit organization.
- Establishing a process for the public to learn about and provide input on a nonprofit HMO's proposed conversion to a for-profit organization.
- Monitoring and regulating Minnesota-domiciled for-profit HMOs (entities for which Minnesota issues the primary license).
- Issues, including statutory language and regulatory implementation, related to a potential statutory requirement that nonprofit HMOs licensed under Minnesota Statutes, chapter 62D, and health systems organized as a charitable organization, upon the sale or transfer of control to an out-of-state or for-profit entity, return to the general fund an amount equal to the value of any charitable assets the HMO or health system received from the state.

These topics are important to all Minnesotans for a number of reasons. Access to affordable, comprehensive health insurance coverage is an important factor that contributes to an individual's overall health, and one that has clear financial implications for individuals, families, and employers. Having a robust, transparent regulatory structure for entities that provide the coverage is necessary for accountability in meeting all state and federal requirements, including those related to their financial health and ability to meet their financial obligations towards enrollees and providers.

Further, regulatory requirements serve the purpose of ensuring corporate transactions related to these entities don't shift resources away from the purposes for which they were intended, and on which their enrollees rely, whether they are nonprofit or for-profit health plans. When an organization that was established as a nonprofit entity transfers or sells substantial assets to a for-profit entity, it may pose a risk to the organization's mission or commitment to the communities it serves. Given the often-complicated structures of insurance holding companies, which can include both nonprofit entities and for-profit entities, there is also a risk that these financial transactions may not even be visible to regulators, much less to covered enrollees and the broader public.

[5] 2023 Session Legislative Language, HF 402, 5th Engrossment – 93rd Legislature (2023-2024); www.revisor.mn.gov/bills/text.php?number=HF402&type=bill&version=5&session=ls93&session_year=2023&session_number=0

Because some or all of a nonprofit HMO's assets have been accumulated due to beneficial tax treatment based on their nonprofit status or related to participation in the state's public health care programs, the state's interest in safeguarding those assets is clear.

This preliminary report summarizes the work MDH has completed to date. It describes the evolution and current landscape of Minnesota HMOs. It also outlines various types of transactions that are in scope for the report, how existing regulatory authorities relate to those transactions, and areas where there may be regulatory gaps or opportunities to strengthen existing oversight. Finally, the report includes themes emerging from public input and key informant interviews. The final report, due to the legislature on June 30, 2024, will expand upon topics introduced in this report by providing significantly more detail, including detailed examples from other states, and a set of more fully developed considerations and options for legislators.

Background Information on Health Maintenance Organizations

The Evolution of HMOs in Minnesota

To understand the current regulatory structure and requirements for Health Maintenance Organizations (HMOs), including the original nonprofit requirement that applied to them until 2017, it is important to understand a bit about their history. The HMO concept in many ways began in Minnesota; the person often referred to as the "Father of the HMO," Dr. Paul Ellwood, promoted a type of insurance in the 1960s and early 1970s that focused, as the name implies, on maintaining and improving health rather than just on paying for medical services. Federal law helped to facilitate the growth of HMOs in 1973[6], and Minnesota passed its own set of HMO regulations in the same year via the Health Maintenance Act of 1973.[7]

The principle behind the original HMO concept, sometimes referred to as "managed care," was that it would provide comprehensive health maintenance services to enrollees based on a monthly per-person amount – otherwise known as a capitation payment. A key feature of the original concept was that care was coordinated through a primary care provider (the "gatekeeper"), and care was generally provided by a defined group of providers (provider network).[8] The theory was that this payment model would incent the HMO to keep people healthy, managing the care to ensure that only necessary services were provided (through utilization management), and further manage costs by providing the care through a contracted, or owned, network of providers. In their original form, HMOs often tried to provide integrated care and focused on prevention and wellness, something that continues to varying extents today.[9]

In contrast to the HMO, conventional health insurance used a fee-for service model (traditional indemnity plan) and independent providers; enrollees would go to a provider, receive care, and the provider would send a claim to the insurance company. If the care provided was covered by the policy, the insurance company would pay the claim. Fee-for-service payments are sometimes viewed as incentivizing the provision of more care than necessary. Conversely, the concern about HMOs was that health plans (and providers) may have an incentive to limit or ration necessary care.[10]

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[6] Public Law No: 93-222 (12/29/1973); www.congress.gov/bill/93rd-congress/senate-bill/14. This also provided additional federal funding in the forms of grants and loan assistance, and required employers with 25 or more employees to offer an HMO plan if a federally qualified HMO was available in the area.

[7] Minnesota Statutes 62D [PDF]; www.revisor.mn.gov/laws/1973/0/Session+Law/Chapter/670/pdf/

[8] An example is what is generally known as a Group HMO model; initially it was one of the most common HMO models. By the early 1980s there were four common types of HMO models, and by the mid-1980s new hybrid models and open-ended models, most common in Minnesota, emerged. Gruber L, Shale M, Polich C. Health Affairs. From Movement to Industry: The Growth of HMOs. Summer 1998.

[9] Healthcare.gov. Health Maintenance Organization (HMO); www.healthcare.gov/glossary/health-maintenance-organization-hmo/

[10] Of note is that some HMO models involve FFS payments, but it may not be part of the primary payment structure, unlike conventional health plans based on a FFS model, particularly in the 1970s/early 1980s. For purposes of this review, MDH is

While initially successful at increasing plan enrollment and limiting health care cost growth, in their purest form, HMOs fell out of favor with individuals and employers.[11] Reasons for this include negative public perception, enrollee-reported problems in accessing health care services due to restrictions on which providers they could see, difficulty responding to employer premium demands and the lack of employer-specific data, and the gatekeeping mechanism of HMOs interfering with individual choice.[12] Ironically, many aspects of the original concept of managed care that were characteristic of HMOs and unwelcome by enrollees and providers – oversight over utilization and authorizing certain types of care, limited provider networks, considerable cost sharing to affect patient choices (and constrain health care spending/shift spending from premiums to individuals), risk and provider performance management – have now largely become commonplace in health insurance, independent of the type of organization holding the insurance risk.

In recognition of the particular focus of HMOs on health maintenance and improvement, and to ensure that access to critical services and the quality of care was not compromised along the way, regulation of HMOs in Minnesota has always been housed at the Minnesota Department of Health (MDH). MDH's regulatory role over HMOs was also established to ensure that HMOs – the entities eligible to offer coverage to Minnesota public program enrollees – met certain quality standards. Insurance companies continue to be regulated by the Minnesota Department of Commerce. Due to the overlap in regulatory requirements between HMOs and insurance companies, the two agencies collaborate in their regulatory efforts.

While federal health insurance reforms, in particular the Affordable Care Act (ACA), have removed some of the distinctions between HMOs and insurance companies by creating standards that all health insurance carriers must comply with, HMOs in Minnesota still have different regulatory requirements than insurance companies. In particular, HMOs are required to have detailed written quality assurance plans that are submitted to MDH for annual review and to conduct ongoing quality evaluations that address services offered; accessibility, availability, comprehensiveness, and continuity of care; and enrollee satisfaction and complaints. MDH ensures these practices are in place through quality assurance examinations conducted every three years. In addition, HMOs are required to submit proposals to participate in the Medicaid (otherwise known as Medical Assistance) and MinnesotaCare programs. For governance, HMOs must include enrollees on the board of directors, have a mechanism for enrollees to provide input on matters of policy and operation, and maintain a conflict-of-interest policy that addresses financial transactions involving board members.

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not accounting for the numerous HMO payment structures that have existed for over the past 60 years. Luft H. Milbank Memorial Fund Quarterly/Health and Society. Health Maintenance Organizations and the Rationing of Medical Care. 1982. [PDF] www.milbank.org/wp-content/uploads/mq/volume-60/issue-02/60-2-Health-Maintenance-Organizations-and-the-Rationing-of-Medical-Care.pdf. Gaynor M, Rebitzer J, Taylor L. National Bureau of Economic Research (NBER) Working Paper No. 8522. October 2001; [PDF] www.nber.org/system/files/working_papers/w8522/w8522.pdf.

[11] Cutler D, Sheiner L. NBER. Managed Care and the Growth of Medical Expenditures. 1998. [PDF] www.nber.org/system/files/chapters/c9824/c9824.pdf. Pinkovskiy M. Federal Reserve Bank of New York. The Impact of the Political Response to the Managed Care Backlash on Health Care Spending: Evidence from State Regulations of Managed Care. April 9, 2014.

[12] Blendon J, et. al. Health Affairs. Understanding The Managed Care Backlash. July/August 1998. Gruber L, Shadle M, Polich C. Health Affairs. From Movement to Industry: The Growth of HMOs. Summer 1998. Grumbach K, et. al. JAMA. Resolving the Gatekeeper Conundrum. July 21, 1999.

Allowing For-Profit HMOs to Operate in Minnesota

Initial Minnesota HMO laws passed in 1973 allowed only HMOs that were both nonprofit and locally domiciled (incorporated/organized in Minnesota) to be licensed in the state. Historically, a main reason for this requirement was a concern that HMOs would have financial incentives to place excessive limits on use of health care services, and that eliminating the profit motive would help to ensure that HMOs acted in the interests of their enrollees and the broader public. That changed in 2017, with the passage of a law that allowed the entrance of for-profit, and foreign-domiciled, HMOs.[13] At the time the new language passed, advocates of the change argued there was a need for increased competition, particularly in the individual insurance market[14], which was experiencing significant premium rate increases. The hope was that competition would drive or keep premiums down.[15]

Minnesota was the last state to repeal its nonprofit requirement for HMOs and to allow for-profit HMOs to do business in the state.[16] The existing regulatory requirements in Minnesota statute and rule did not change when for-profits HMOs were allowed to operate in Minnesota; current HMO laws enforced by MDH do not differentiate between nonprofit and for-profit entities.

While the 2017 change allowed for-profit HMOs to do business in Minnesota, the legislature also established a moratorium on the conversion of the local nonprofit HMOs (and nonprofit health service plan corporations) to for-profit status.[17] Because issues related to management of nonprofit or charitable assets of the HMO in the event of a conversion and ensuring their continued use for the original nonprofit purpose of the HMO were not addressed in the new law, the moratorium allowed for a window in which conversions could not occur, so that any potential unintended effects from a nonprofit HMO conversion could be understood and managed through an updated regulatory structure.[18] The end date of the moratorium has been extended several times; currently it is scheduled to end on July 1, 2026.[19]

While much of the attention on the 2017 changes has focused on allowing for-profit HMOs to operate in Minnesota, the new ability of foreign-domiciled HMOs to operate in the state is also significant. State regulators have less authority generally over foreign-domiciled HMOs and financial transactions they may make. There are

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[13] 2017 Laws of Minnesota, chapter 2, S.F.No. 1, article 2, sections 4-9; www.revisor.mn.gov/laws/2017/0/Session+Law/Chapter/2/

[14] The individual (non-group) insurance market is the health insurance market where individuals purchase health insurance coverage directly; health plan companies can cover one person (single coverage) or dependents (family coverage). It is referred to as the individual or non-group market, because plans are purchased by an individual rather than as part of a group (i.e., employment-based health insurance).

[15] Montgomery D. Pioneer Press. New Law Lets For-profit HMOs into Minnesota — The Last State to Keep Them Out. February 3, 2017.

[16] Gruber L, Shadle M, Polich C. Health Affairs. From Movement to Industry: The Growth of HMOs. Summer 1998.

[17] 2017 Laws of Minnesota, chapter 6, article 5, section 11; www.revisor.mn.gov/laws/2017/1/Session+Law/Chapter/6/

[18] Callaghan P. MinnPost. HMOs Have Always Been Nonprofit in Minnesota. What Happens When That Changes? July 2, 2019. www.minnpost.com/state-government/2019/07/hmos-have-always-been-nonprofit-in-minnesota-what-happens-when-that-changes/

[19] Minnesota House File 402, 5th Engrossment, Section 11; www.revisor.mn.gov/bills/text.php?number=HF0402&version=latest&session=92&session_number=0&session_year=2023

also currently no HMO regulations that preclude Minnesota-domiciled HMOs from taking their business in whole or in part to another state or moving their domicile to another state.

Current Landscape of HMOs in Minnesota

As of January 2024, there are 13 HMOs licensed in Minnesota; of these, 10 are domiciled in Minnesota (Table 1).[20] Based on the most recent data available, from 2022, these HMOs represent an average of 1.6 million members (28.2% of Minnesota's 5.7 million residents) with over $15.2 billion in total revenue.[21]

Table 1: Summary of Minnesota HMOs, 2022

Company (NAIC#)	Domicile	HMO License in MN	Incorporation	Total Average Members (2022)	2022 Total Revenue
Allina Health and Aetna Health Plan, Inc. (17352)	MN	Y	For-Profit	Plan not offered in 2022	Plan not offered in 2022
Group Health Plan, Inc. (52628)[22]	MN	Y	Nonprofit	58,205	$1,200.6M
HealthPartners, Inc. (95766)	MN	Y	Nonprofit	353,806	$2,932.0M
Hennepin Health (52627)	MN	Y	Nonprofit	36,877	$444.3M
HMO Minnesota dba Blue Plus (95649)	MN	Y	Nonprofit	406,804	$2,978.0M

[20] For purposes of this report MDH is excluding three County Based Purchasers (CBP); IM Care, South Country Health Alliance (SCHA), and Prime West. CBPs are health plans operated by a county or a group of counties that purchase health care services for certain residents enrolled in Medicaid (otherwise known as Medical Assistance) and MinnesotaCare. The participating counties are primarily rural. Additional information is available on MDH's website: www.health.state.mn.us/facilities/insurance/managedcare/planinfo/cbpinfo.html.

[21] Total Revenue is the amount of money a business makes from all products and services the business sells, prior to any expenses. HMO enrollment includes all lines of business, even for program types which may not be primary medical coverage (e.g., standalone Medicare Part D, Medicare Supplement, and Medicare Select). As such, HMO enrollment may be overstated. Minnesota population based on U.S. Census Bureau, Annual Estimates of the Resident Population for Counties in Minnesota; July 1, 2022.

[22] Group Health Plan, Inc. surrendered its HMO license in Minnesota effective January 1, 2024. Group Health Plan, Inc. executed an assumption agreement with its parent company HealthPartners, Inc. to consolidate all its HMO Individual business under one license (HealthPartners, Inc.).

Company (NAIC#)	Domicile	HMO License in MN	Incorporation	Total Average Members (2022)	2022 Total Revenue
Humana Wisconsin Health Organization Insurance Company (95342)	WI	Y	For-Profit	2,684	$32.8M
Medica Community Health Plan (95232)	WI	Y	Nonprofit	No MN lives	($0.2M)
Medica Health Plans (52626)	MN	Y	Nonprofit	71,041	$1,300.5M
PreferredOne Community Health Plan (95724)	MN	Y	Nonprofit	Plan ceased December 2021	Plan ceased December 2021
Quartz Health Plan MN Corporation (14202)[23]	MN	Y	Nonprofit	5,597	$38.8M
Sanford Health Plan of Minnesota (95725)	MN	Y	Nonprofit	2,790	$16.3M
UCare Minnesota (52629)	MN	Y	Nonprofit	636,942	$6,075.5M
UnitedHealthcare of Illinois, Inc. (95776)	IL	Y	For-Profit	36,432	$196.7M
TOTAL				**1,611,178**	**$15,215.4M**

Notes: Average members are based on Minnesota Supplement #1 HMO reporting of member months divided by 12 calendar months. Minnesota products only. Excludes Administrative Services, Foundation, and Business Development Net Income and Revenue. Medica Community Health Plans had no Minnesota membership.

Sources: MDH Health Economics Program analysis of Minnesota Supplement #1 HMO report. U.S. Census Bureau, Annual Estimates of the Resident Population for Counties in Minnesota; July 1, 2022.

[23] Quartz Health Plan MN Corporation was known as Gundersen Health Plan Minnesota until the second quarter of 2019.

Each HMO has a distinct footprint in the Minnesota health insurance marketplace, with a range of enrollment by product line. Not every HMO offers plans by each product line (for example, Quartz Health Plan MN Corporation only offers commercial and Medicare Advantage HMO products, whereas Hennepin Health only offers Medicaid, otherwise known as Medical Assistance, and MinnesotaCare HMO products). HMO enrollment accounts for 80.4% of Minnesota Health Care Programs enrollment (Medical Assistance and MinnesotaCare), 16.9% of Medicare enrollment (Medicare Advantage and Cost plans), and 7.5% of commercial market enrollment.[24]

Market Changes Since 2017 Law Change

The health insurance market has changed in several ways since the 2017 law allowing for-profit and foreign or non-domiciled HMOs to operate in Minnesota. Broadly speaking, since January 2017, five major health plan companies entered the market (three being for-profit HMOs) and three health plan companies expanded market space offerings.

HMOs and Health Plan Companies Entering or Leaving the Market Since 2017

Three for-profit HMOs entered the market since 2017; however, as of 2022 these HMOs represent only a small portion of the overall HMO market (2.4% of total HMO members; 0.7% of Minnesota's population; Table 2). None of these plans currently offer plans within the individual (non-group) market, which includes MNsure, Minnesota's health insurance marketplace.

- February 2019: UnitedHealthcare of Illinois, Inc. became the first for-profit HMO licensed in Minnesota. In 2020, it began offering insurance to both small and large group insurance market plans in the commercial market. In 2022, it began offering insurance for Medical Assistance Families and Children (under age 65) – also known as PMAP and MinnesotaCare enrollees – in the seven-county metro area.[25] In 2023, it began offering insurance for all Medical Assistance and MinnesotaCare products in the seven-county metro area and St. Louis County.[26]
- April 2019: Humana Wisconsin Health Organization Insurance Corporation became licensed as a for-profit HMO in Minnesota.[27] In 2020, it began offering Medicare Advantage plans.

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[24] Based on unpublished MDH analysis of estimated 2022 health insurance enrollment. These percentages are calculated using estimated total enrollment in each product line, based on gross enrollment except for the commercial market where MDH only has a net enrollment estimate. These percentages exclude CBPs. Dual-eligible Medicare-Medical Assistance enrollees are included in the Minnesota Health Care Programs percent. Medicare estimates are calculated to include all Medicare enrollees in the denominator (including enrollees in traditional Medicare).

[25] UnitedHealthcare website: www.uhc.com/communityplan/minnesota#:~:text=Starting%20January%201%2C%202022%2C%20UnitedHealthcare,Ramsey%2C%20Scott%20and%20Washington%20counties

[26] UnitedHealthcare. Minnesota Medicaid: New programs launching Jan. 1, 2023: www.uhcprovider.com/en/resource-library/news/2022/mn-medicaid-new-programs-jan.html. MN Department of Human Services. Annual Health Plan Selection (AHPS) for 2024: https://mn.gov/dhs/health-plan-selection/. Health plans offered by county varies; see MN Department of Human Services Maps of health plan service areas by county: www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_141267

[27] MN Department of Health. Health Maintenance Organizations - Health Plan Information: Humana www.health.state.mn.us/facilities/insurance/managedcare/planinfo/humana.html

- June 2022: Allina Health & Aetna Health Plan, Inc. became licensed as a for-profit HMO.

Two additional health insurance companies (not HMOs) entered the market since 2017, one of which has already left the market. Similar to the new for-profit HMOs, these had a minimal impact on the market (1.1% of Minnesota's population, Table 2).

- 2018-2019: Allina Health & Aetna Insurance Company began offering small and large group insurance market plans in the commercial market; in 2019, it began offering Medicare Advantage plans.
- 2018: Effective January 1, 2018, MII Life Insurance, Incorporated, a company under Aware Integrated, Inc., the holding company affiliated with Blue Cross Blue Shield of Minnesota and HMO Minnesota dba Blue Plus, under the terms of a Medicare Part D contract with the Centers for Medicare and Medicaid Services (CMS), offered Basic Blue Rx, a Medicare Prescription Drug Plan (PDP), a stand-alone plan that offered only prescription drug coverage to Medicare beneficiaries.
- 2021: Effective January 1, 2021, MII Life Insurance, Incorporated, terminated its Basic Blue Rx Medicare Part D contract with CMS.

Several other health insurance market changes have occurred since 2017. Some health plans transitioned to or expanded markets, others exited the Minnesota market, or were acquired by another company. Some health plans also made financial transactions between entities within the insurance holding company system. MDH has provided examples of some of these changes in Appendix B; these examples are illustrative and do not include every market change that occurred since 2017. They also do not include management agreements and services within holding company affiliate companies, or transfers to health plan foundations within the holding company structure.

Table 2: Summary of New Market Participants' Average Members, 2022

Health Plan	Commercial Small Group Market	Commercial Large Group Market	Medical Assistance/ MNCare	Medicare Advantage/ Cost	Medicare Supplement	Total Population
Allina Health & Aetna Health Plan, Inc. (NAIC ID 17352)	No enrollment	No enrollment	No enrollment	No enrollment	No enrollment	No enrollment
Humana Wisconsin Health Organization Insurance Corporation (NAIC ID 95342)	No enrollment	No enrollment	No enrollment	2,684	No enrollment	2,684
UnitedHealthcare of Illinois, Inc. (NAIC ID 95776)	297	1,045	35,090	No enrollment	No enrollment	36,432

Health Plan	Commercial Small Group Market	Commercial Large Group Market	Medical Assistance/ MNCare	Medicare Advantage/ Cost	Medicare Supplement	Total Population
For-Profit as % of Total HMO Enrollment	**0.4%**	**6.7%**	**3.0%**	**1.5%**	**0.0%**	**2.4%**
Allina Health and Aetna Insurance Company (NAIC ID 16194)	116	4,186	No enrollment	17,596	No enrollment	21,897
New Health Plans as % of Total Market Enrollment by Line of Insurance	**0.2%**	**0.2%**	**2.4%**	**1.9%**	**No enrollment**	**1.1%**

Notes: Average members are based on Minnesota Supplement #1 HMO or National Association of Insurance Commissioners (NAIC) reporting of member months divided by 12 calendar months. Since data is based on average members it will differ from data reported in the Minnesota Department of Commerce Report of 2022 Loss Ratio Experience. New entrants to the market had no enrollment in the individual commercial market, including plans offered on MNsure, or for Medicare Part D stand-alone prescription drug plans.

Sources: MDH Health Economics Program analysis of Minnesota Supplement #1 HMO, NAIC reports, and unpublished health insurance marketplace estimates. U.S. Census Bureau, Annual Estimates of the Resident Population for Counties in Minnesota; July 1, 2022.

Corporate Structure of Health Plan Companies

The complexity of the corporate structures of health plan companies, including HMOs, has evolved significantly over the decades. Of the 13 HMOs operating in Minnesota, all but two (Hennepin Health and UCare Minnesota) are part of a larger holding company structure (Table 3). Hennepin Health is owned and operated by Hennepin County. UCare Minnesota has three additional entities in its corporate structure – its foundation, a Wisconsin nonprofit insurance company, and an Iowa HMO. Appendix C provides diagrams of the holding company structures, some of which are nonprofit holding companies, within which nonprofit HMOs licensed in Minnesota currently exist. As Appendix C diagrams show, these holding companies include both nonprofit and for-profit entities within their corporate structures.

This complexity of holding company structures is closely related to the topic of conversion transactions. The existence of nonprofit and for-profit entities within the same larger holding company provides opportunities to shift assets between those entities. The potential ways in which assets may be shifted – and the circumstances under which regulators are and are not notified of such shifts - are described next in this report.

Table 3: Holding Companies Structures for MN licensed HMOs, 2022

Health Plan	HMO Incorporation Type	Ultimate Controlling Entity (UCE)	Domicile of UCE	Incorporation type of UCE
Allina Health and Aetna Health Plan, Inc.	For-profit	CVS Corporation	DE	Publicly Traded Company
Group Health Plan, Inc.[28]	Nonprofit	HealthPartners, Inc.	MN	Nonprofit HMO
HealthPartners, Inc.	Nonprofit	HealthPartners, Inc.	MN	Nonprofit HMO
Hennepin Health	Nonprofit	Hennepin County	MN	N/A
HMO Minnesota dba Blue Plus	Nonprofit	Aware Integrated, Inc.	MN	Nonprofit Corporation
Humana Wisconsin Health Organization Insurance Company	For-profit	Humana Inc.	DE	Publicly Traded Company
Medica Community Health Plan	Nonprofit	Medica Holding Company	MN	Nonprofit Corporation
Medica Health Plans	Nonprofit	Medica Holding Company	MN	Nonprofit Corporation
PreferredOne Community Health Plan	Nonprofit	Fairview Health Services	MN	Nonprofit Health Service Provider
Quartz Health Plan MN Corporation	Nonprofit	GHS/UPH/UHC/AHC[29]	WI and IA	Nonprofit Corporations

[28] Group Health Plan, Inc. surrendered its HMO license in Minnesota effective January 1, 2024. Group Health Plan, Inc. executed an assumption agreement with its parent company HealthPartners, Inc. to consolidate all its HMO Individual business under one license (HealthPartners, Inc.).

[29] Gundersen Lutheran Health System, Inc. (GHS), Iowa Health System, Inc. (UPH), University Health Care, Inc. (UHC), and Aurora Health Care Inc. (AHC).

Health Plan	HMO Incorporation Type	Ultimate Controlling Entity (UCE)	Domicile of UCE	Incorporation type of UCE
Sanford Health Plan of Minnesota	Nonprofit	Sanford Health	ND	Nonprofit Corporation
UCare Minnesota	Nonprofit	UCare Minnesota	MN	Nonprofit HMO
UnitedHealthcare of Illinois, Inc.	For-profit	UnitedHealth Group Incorporated	DE	Publicly Traded Company

Sources: Information based on Schedule Y Part 1 – Organizational Chart in the Statutory Financial Filing as of 12/31/2022. Sourced from S&P Capital IQ and NAIC.

Types of Potential Conversion Transactions

The term "conversion" is often used as shorthand to describe a situation wherein a nonprofit organization transitions its assets and/or operations, all at once or over time, into a for-profit organization. But as the legislature recognized when placing a moratorium on conversion transactions, the colloquial term "conversion" can describe any number of transactions or series of transactions that serve to move substantial assets and business from one entity to another or involve changes in corporate governance and control. An overall corporate conversion strategy may involve several steps over time and may include all or only part of an organization's assets. Some transactions could also result in moving enrolled members of a nonprofit Health Maintenance Organization (HMO) to a for-profit entity.

The simple scenario that many people envision – a nonprofit deciding to become a for-profit – is prohibited under Minnesota Statutes, chapter 317A. This type of transition would not be allowed under state law even without the moratorium; a nonprofit entity cannot convert to an entity that is a vehicle for pecuniary benefit, or some economic gain. But there are several different scenarios or transactions that can result in assets moving from a nonprofit organization to a for-profit one. Given that many HMOs and insurance companies are part of complex holding company structures that include both nonprofit and for-profit entities, certain transactions may not involve a sale to a separate corporate entity outside of that structure but may still have the result of moving assets that were accumulated for a public or charitable purpose into a for-profit entity.

Below, we describe the transactions that are in scope for this preliminary report. When the term "conversion" is used in this report, it refers to the range of transactions listed below that are currently allowable under state law.

Asset Sales, Purchases, and Exchanges

Sale of assets from a nonprofit HMO may be made to a for-profit or nonprofit entity, which may include all or part of an organization's assets. The assets included in the sale could include physical assets, intangible assets including the name of the nonprofit organization or other intellectual property, and any accounts. Under an asset sale, the liabilities do not transfer to the for-profit purchaser. Contracts may be assigned to the purchaser. The for-profit purchaser must obtain new licenses to operate as an HMO. Proceeds from the sale to a for-profit should reflect fair market value and may be received by the original nonprofit, or by a new nonprofit foundation established to receive the proceeds.

Asset Transfers

Asset transfers, broadly speaking, happen when an entity moves assets from one portion of a corporate structure or holding company to another. These transactions may take a number of forms, including management agreements, service contracts, loans, or extensions of credit, guarantees, reinsurance agreements, dividends, or investments. Most asset transfers typically represent purchases associated with doing business on a day-to-day basis or payments for services or products rendered. Asset transfers can also take the form of "drop-down conversions," in which a nonprofit transfers assets (and potentially liabilities) to a for-profit subsidiary which may be owned in whole or in part by the nonprofit, with the nonprofit receiving stock in the for-profit in exchange. But asset transfers can also be more substantial transactions that meet a materiality

threshold – such as extraordinary dividends paid or substantial investments or loans that would impact corporate control and governance. Concerns regarding more substantial asset transfers may arise when payments seem excessive or are not tied back to any discernable services or purchases, or otherwise shift funds from a nonprofit to a for-profit entity within a larger company holding structure.

Mergers

In a merger between two entities, all assets and liabilities are merged into a single surviving entity. Under Minnesota Statutes, chapter 317A, mergers involving nonprofit corporations in Minnesota may only be made between two nonprofit corporations (rather than between a for-profit and a nonprofit). A license may survive a merger, eliminating the need to reapply. However, the merged entity must provide verification that it meets all the HMO licensure requirements.

Partial Conversions/Joint Ventures

A new entity is created by two unrelated entities. Prior to 1982, joint ventures between tax exempt nonprofits and for-profits were prohibited by federal law (with the enforcement mechanism being loss of tax-exempt status). Because a joint venture creates a new entity, new licenses and regulatory approvals are required to conduct business.

Movement of Enrollees

In addition to these scenarios, a nonprofit HMO might take actions that move its enrolled members from a nonprofit entity within the holding company to a for-profit affiliate (HMO or non-HMO) within the same system. While such an action might not involve an immediate transfer of assets, it would have the effect of shifting future premium revenue to the for-profit affiliate.

Current Monitoring and Regulatory Structures in Minnesota

The Minnesota Attorney General's Office (AGO), Minnesota Department of Commerce (Commerce), and Minnesota Department of Health (MDH) each have regulatory and monitoring responsibility related to health plans issued by health insurers. Each agency brings a specific lens as they approach regulation and oversight; MDH and Commerce are responsible for licensing, financial oversight, and ensuring the health plans offered meet all state and federal statutory requirements. The AGO is responsible for ensuring nonprofit assets are used appropriately and addressing anti-trust concerns. But each agency's authority is governed by different statutes, nuanced, and sometimes varies based on the specifics of a transaction or the entities involved.

Table 4 provides an intentionally simplified overview of current regulatory authority over transactions of nonprofit Health Maintenance Organizations (HMOs); it also provides a visual of where agencies have no pre-transaction or approval authority (no shading) or partial authority (lighter shading) meaning there is no pre-transaction notice but there may be ability to act after the transaction. Additional detail on each agency's authorities and processes are also described below. The table describes both the complexity of Minnesota's regulatory environment and of the industry itself; it also demonstrates that some transactions are unmonitored.

Table 4: Overview of Regulatory and Monitoring Authority for Nonprofit HMOs by Transaction Type

Organizations involved in an HMO transaction	Between nonprofit HMO** & for-profit (outside holding company)			Between nonprofit HMO** and a nonprofit (outside holding company)			Between a nonprofit HMO** and a for-profit (within a holding company)			Between a nonprofit HMO** & nonprofit (within holding company)		
Asset Sales, Purchases & Exchanges			*			*			*			*
Asset Transfers			*			*			*			*
Mergers						*						*
Joint Ventures			*			*			*			*
Movement of Enrollees			*			*			*			*

*Commerce's authority applies only when the other entity is a domestic insurer.

**Assumes that all nonprofit HMOs are also charitable organizations. Although the AGO has regulatory authority over all nonprofit organizations, distinctions related to "charitable" versus non-charitable impact pre-notice reporting.

Table 4 Legend

	AGO	MDH	Commerce
Pre-notice and ability to intervene when materiality threshold met			
Ability to intervene delayed by no statutory pre-notice requirement			
Transaction type not allowed under state law			
No transaction notice or ability to intervene or unwind transaction in law			

Note: Authority related to health care entities in Minnesota Statutes, chapter 145D is not included in this table.

Table 5: Additional Information about State Agency Regulatory Processes

State Agency	Statutory Authority	Pre-notice Required	Subject Entities and Threshold for Reporting	Level of Authority	Public Notice
Attorney General's Office	317A.813	N/A	▪ Minnesota nonprofit corporations organized under chapter 317A	General powers to investigate and bring proceedings	N/A
	317A.811	Yes, 45 days with possible 30 day extension	▪ Nonprofit entities with charitable assets ▪ Must report dissolution, merger, consolidation, conversion, and transfer of **substantially all assets**	Investigate, intervene and standing to enjoin or sue	N/A
Commerce	60D.20	Yes, 30 days	▪ Insurers subject to registration must report transactions	Approve or disapprove	N/A

State Agency	Statutory Authority	Pre-notice Required	Subject Entities and Threshold for Reporting	Level of Authority	Public Notice
			within a holding company ▪ **Materiality standards**		
	60D.17	Yes, 30 days	▪ Any person seeking to acquire control of or merge with a domestic insurer	Approve or disapprove	Potentially, via public hearing only if planning to disapprove
	60D.18	Yes, 30 days	▪ Any acquisition in which there is a change in control of an insurer authorized to do business in this state	Non-disapprove or disapprove	N/A
	60A.16	Yes, no timeframe	▪ Domestic and foreign insurance companies merging or consolidating	Approve or disapprove	Only to shareholders or members of affected companies
MDH	62D.04 62D.15	N/A	▪ Power to approve, suspend, or revoke certificate of authority	Approve	N/A
	62D.08	N/A	▪ Reporting requirements of major changes of certain types	Non-disapprove or disapprove	N/A

Differences in regulatory authority exist based on a number of factors. In all types of transactions when moving assets from nonprofit HMOs to for-profit entities, state law requires the nonprofit purposes of the assets to be honored for their intended purpose. However, the value of the assets and how the nonprofit purpose is expressed is largely left to the original nonprofit together with the for-profit involved in the transaction. No

government entity is tasked with conducting an independent valuation of nonprofit HMO assets being transferred. Whether, when, and how a regulator is involved in monitoring the transactions depends on several factors including:

- Whether the other entity is a for-profit or nonprofit (and, if so, whether charitable or not)
- Whether it is domiciled in Minnesota
- Transaction type (and/or resulting entity type)
- Size of the entity and of the transaction itself (either in absolute terms or as a percentage of an organization's revenue, assets, or governance)
- Relationship between the parties to the transaction

In addition, none of the regulatory processes for these transactions require an opportunity for the public to be notified of or provide input into whether such a transaction should proceed or whether conditions should be imposed on it.

The Commissioner of Health and the AGO have authority to gather information about entities under their purview which may be used to monitor and regulate HMOs. Annual and quarterly reporting requirements also provide some regular financial information about HMOs to MDH, but only after the fact with regard to transactions and only to the extent those transactions are visible in the data submitted to comply with financial reporting requirements. The Commissioner of Commerce may also receive notice from an insurance company it regulates if the HMO is conducting business with that insurance company and the two entities are part of a larger insurance holding company. A number of other laws provide for a framework in specific situations for the review of transactions involving nonprofit HMOs. Some of these specific statutes are described below.

Transactions Involving HMOs

MDH's regulatory authority over financial transactions involving HMOs is not specifically stated in statute, meaning there is no notice requirement and no direct approval authority. MDH may learn of a transaction in advance in a variety of ways. For example, the HMO may be making changes to organizational documents in conjunction with the transaction, or the HMO may be conducting a transaction with an entity Commerce regulates and provide notice to Commerce. If aware of the transaction, MDH reviews and works with the HMO to ensure compliance. But unlike Commerce, MDH does not have authority to disapprove the specific transaction, unless some aspect of it would call the HMO's license into question.

Minnesota Statutes, section 62D.08, subdivision 1, requires HMOs to file notice with MDH prior to making changes to certain documents and operations included in an HMO license application. This includes organizational documents, articles of incorporation, bylaws, contracts binding major participating entities, and "other information as the commissioner of health may reasonably require to be provided." If MDH does not disapprove of the filing within 60 days, it is deemed approved. MDH must review these changes to ensure that an HMO does not violate any of the licensure requirements in Minnesota Statutes, section 62D.03 and that the HMO maintains continued compliance as required in Minnesota Statutes, section 62D.04, subdivision 4.

Because changes to organizational documents may be required when an HMO is involved in a transaction, HMOs may provide notice of those changes to MDH before the transaction occurs. When this happens, pursuant to the ability to collect "other information" outlined in Minnesota Statutes, section 62D.08, subdivision 1, MDH requests additional information to review the financial aspects of the transaction. However, the ambiguity in the

statute on when the reporting is required in relation to the change in documents means that not all HMOs file information about a transaction before it takes place.

As noted earlier, MDH may also learn of a transaction in advance because the HMO provided notice to Commerce. Several statutes require notice of pending transactions be provided to Commerce, as described later in this report. Those statutes do necessarily read as specific to insurance companies, and it is reasonable for HMOs to interpret those statutes to include them. After receiving notice that includes an HMO, Commerce informs MDH, and MDH reviews the transaction. Because these statutes are ambiguous, not all HMOs may be providing notice to either regulator.

Before 2017, Minnesota law required all HMOs to be nonprofit. The law also prohibited HMOs from paying out dividends and required that all net earnings of the HMO be devoted to the nonprofit purposes of providing comprehensive health care (nonprofit purposes), Minnesota Statutes, section 62D.12, subdivision 9. Under this framework, transactions with a for-profit entity were not allowed because of the nonprofit purposes requirement. Transactions with nonprofit entities could be permitted subject to meeting the nonprofit purposes requirement.

The 2017 legislative changes repealed Minnesota Statutes, section 62D.12, subdivision 9, thereby removing the nonprofit purposes requirement and allowing nonprofit HMOs to enter into transactions without that restriction. At the same time, the legislature enacted a moratorium on conversion transactions for nonprofit HMOs, currently set to sunset in 2026. The moratorium language provides that a nonprofit HMO "may only merge or consolidate with; or convert, or transfer all or a substantial portion of its assets" to a nonprofit entity.

In 2019, the legislature reinstated the nonprofit purposes requirement in Minnesota Statutes, section 62D.12, subdivision 8a. Table 6 shows the ability of nonprofit HMOs to enter into transactions during the relevant timeframes.

Table 6: Nonprofit HMO Transactions Over Time

Nonprofit HMO transaction	Pre-2017	2017 – 2019	2019 - present
With nonprofit entity	Allowed with nonprofit purposes restriction	Allowed	Allowed with nonprofit purposes restriction
With for-profit entity	Not allowed	Moratorium	Moratorium until 2026

Transactions Involving Nonprofit and Charitable Organizations

The AGO has supervisory and investigatory powers of oversight over all nonprofits organized in Minnesota (Minnesota Statutes, section 317A.813). In addition, under current Minnesota law, transactions that involve a wholesale movement of a nonprofit's charitable assets to a non-charitable entity require pre-notice to the AGO, which provides an opportunity for the AGO to review the planned transaction before it occurs. This may include dissolutions and any other transfer of "all or substantially all" of the nonprofit's assets. In this instance, the AGO

receives 45 days' notice of the transaction, with the option to extend the notice period for 30 additional days (Minnesota Statutes, section 317A.811). There is no requirement for the public to be notified about a planned transaction or to provide input on it. There are no requirements specific to HMO transactions versus other types of nonprofit entities.

The notice period allows the AGO to review the planned transaction for potential violations of compliance with the law before the transaction occurs. Following an initial review, the AGO may choose to conduct a further investigation which may extend to use of their formal statutory powers of investigation (Minnesota Statutes, section 8.31 and section 501B.40).

In the process of review of the original notice as well as any follow-up investigation, the AGO may look at several components of the proposed transaction to identify any potential violations of law. The AGO will look at whether the full value of the assets is preserved for charitable purposes and whether any unlawful benefit of the transaction flows to private parties (for example, the HMO's management). While the AGO does not conduct its own valuation of nonprofit assets in each case, it does look for indicators of potential value deficiency. If a potential deficiency or other potential violation of law is found, the AGO may act in a number of ways, up to and including taking action in court to prevent the transaction. While the notice period allows the AGO to act before the transaction takes place, the AGO's lack of action during the notice period does not preclude action after the notice period, including after the transaction has occurred.

The notice provisions for charitable nonprofits are significant, but do not extend to nonprofits that do not have a charitable purpose. For nonprofits that are not 501(c)(3) tax exempt entities, there is some ambiguity that a nonprofit could use to categorize themselves as "noncharitable" and therefore not subject to reporting. For purposes of reporting, it is the entity that makes that determination. These provisions also leave a gap when "conversions" occur over time. For example, a charitable HMO selling off half of its assets to a for-profit, or 20% of its assets per year over a multi-year period, may interpret the statutory reference to "substantially all" assets as not applicable to this transaction and might choose to proceed without notifying the AGO.

Transactions Within an Insurance Holding Company System

The Commissioner of Commerce receives notification of certain transactions within an insurance company holding system 30 days before they occur under Minnesota Statutes, section 60D.20. The 30-day notice to Commerce is triggered for a number of reasons, including the following:

- Sales, purchases, exchanges, loans, or investments that are equal to or exceed the lesser of 3% of the insurer's admitted assets, or 25% of the surplus.
- Loans or extensions of credit to non-affiliated entities that are equal to or exceed the lesser of 3% of the insurer's admitted assets or 25% of surplus.
- Reinsurance agreements or modifications.
- Management agreements, service contracts, tax allocations agreements, guarantees, and all cost-sharing arrangements.
- Guarantees by domestic insurers.
- Direct or indirect acquisitions or investments in a person that controls the insurer or its affiliates in an amount that exceeds 2.5% of the insurer's surplus.
- Material transactions involving 0.5% or more of the insurer's admitted assets.

A domestic insurer within an insurance holding company system must also notify Commerce within 30 days of its investment in a corporation if the investment exceeds 10% of the corporation's voting securities.

In contrast to the AGO's powers in Minnesota Statutes, chapter 317A, which only provides notice with respect to movement of "all or substantially all" of an entity's assets to a for-profit or transfers incidental to dissolution, transactions subject to review by Commerce also include those that are involved in the day-to-day operations within an insurance holding company system.

The notice provisions of Minnesota Statutes, section 60D.20, are not currently applied to HMOs regulated by MDH. However, a holding company system may include a nonprofit HMO; therefore, if a transaction within a holding company system involves a nonprofit HMO and an insurance company, the transaction would be reported to Commerce if it falls into one of the categories described above. Additionally, if an HMO is involved in a joint venture where a parent company is subject to these requirements, the transaction may be reportable.

Commerce's review of the notice is centered on whether the terms of a transaction are fair and reasonable, the charges or fees for services performed are reasonable, expenses and payments are allocated in conformity with customary insurance practices, and whether the transaction will adversely affect the interest of policyholders. The Commissioner of Commerce may disapprove a transaction.

The Commissioner of Commerce has additional authority when an insurance company merges or otherwise experiences a transaction which would result in a change of control of the insurer (Minnesota Statutes, sections 60D.17, 60D.18 and 60A.16). These provisions provide for notice as well as an opportunity to disapprove the transaction. However, an HMO is not subject to these notice provisions unless the other party to the transaction is an insurance company subject to these laws.

Transactions Involving a Health Care Entity

Effective May 23, 2023, Minnesota Statutes, section 145D.01 expanded the AGO's pre-transaction review process to health care entities, including those that are not charitable. If at least one entity involved in the transaction, or the entity that will result from the transaction, has an annual revenue of $80 million or more they are subject to the notice provisions of Minnesota Statutes, section 145D.01 and notice to both the AGO and MDH is required.[30] Health care entities are prohibited from engaging in any transaction that substantially lessens competition or tends to create a monopoly or monopsony. The AGO has authority to take action to enjoin a transaction from being executed if it does not comply with the public interest and other requirements of the law.

Standing alone, an HMO is not a health care entity under this section of statute. However, an HMO that is controlled by, or exercises control over, an entity which is itself a health care entity, is included in the statute's provisions. For example, if an HMO owns or controls a hospital involved in an applicable transaction, the HMO is a "health care entity" for the purpose of the law. The transaction may also be subject to the law based on the other entity's status as a health care entity. The law does NOT apply to transfers which occur between

[30] Information on the Attorney Generals' reporting requirements can be found here: http://www.ag.state.mn.us/Health-Care/Transactions/

companies when one has control of the other. See Appendix D for more information regarding health care entity transactions.

Potential Gaps in Minnesota's Regulatory Structure

MDH's initial analysis of existing regulatory authorities shows that while Minnesota regulators have significant regulatory authority in some areas, there are some types of transactions for which regulatory sightlines or ability to act are limited due to a lack of pre-notice requirements, limited reporting requirements, or definitional ambiguity in statute. Some of these gaps may allow conversion transactions to occur without a sufficient opportunity (or, in some cases, any opportunity) for a state regulator to understand and evaluate the transaction, ensure reasonable values are assigned, prevent it from occurring, or attach conditions to it. Gaps in regulatory authority may occur in the following situations:

- When a nonprofit HMO considers itself a noncharitable entity
- When a nonprofit HMO transfers less than "all or substantially all" of their assets
- When a nonprofit HMO subsidiary of an insurance holding company system transfers assets outside of the holding company system
- When a holding company moves products offered through its nonprofit HMO to another HMO within the holding company system
- When a nonprofit HMO expands or moves business to other states

In addition to the above gaps, it should be noted there is no mechanism in place to monitor the cumulative impact over time of assets that have been transferred from nonprofit HMOs to for-profit entities. Although individual transactions may be related to the normal course of business, reviewing the totality of smaller or routine transactions over a multi-year period – as well as on the necessary case-by-case basis when each is proposed – would provide an opportunity to observe whether and to what degree these smaller transactions result in meaningful shifts of assets to for-profit entities over time.

Because original HMO regulations were created on the foundation that all HMOs were nonprofit, the statute did not anticipate an environment in which financial transactions would need to be regulated; therefore, direct statutory oversight of financial transactions is quite limited in current law. The most significant oversight occurs when the HMO happens to trigger regulation for some other reason. Therefore, a noncharitable HMO will avoid the Minnesota Statutes, chapter 371A notice. An HMO conducting business outside of an insurance company holding structure will avoid the Minnesota Statutes, section 60D.20 pre-notice. An HMO that is not a "health care entity" will avoid the Minnesota Statutes, chapter 145D pre-notice. Some significant HMO transactions will avoid all these conditions. In that case, knowledge of the transaction would occur only after it has taken place unless the HMO has voluntarily reported. Due to the historical context of HMOs in Minnesota and as demonstrated in Table 5, MDH does not have the same explicit authorities over HMOs that Commerce has related to insurance companies in monitoring of financial transactions.

Asset Value and Public Interest in Nonprofit Assets

The laws related to nonprofit organizations and to transactions involving health care entities in Minnesota are an expression of the importance of, and intent to, ensure that assets or earnings continue to be bound by their original purpose: pursuant to Minnesota Statutes, section 317A.671, the assets of a nonprofit corporation, ”may not be diverted from the uses and purposes for which the assets have been received and held, or from the uses and purposes expressed or intended by the original donor.” That existing restriction should guide regulatory thinking with regard to some of the key policy questions related to Health Maintenance Organization (HMO) conversions. But the issues that arise when a nonprofit HMO intends to shift assets in any of the ways described earlier in this report are also related to three central questions: 1) how should public benefit assets be defined; 2) what method of valuation should be used; and 3) who determines the value of the assets?

In the event of a proposed transaction, it is essential to have a clear definition of public benefit assets in order to know what assets need to be included in a valuation. However, the public benefit assets of HMOs are not defined under current law. How to go about this in the context of Minnesota’s nonprofit HMOs is a complex undertaking. Nonprofit HMOs have benefitted from preferential tax treatment over time due to their nonprofit status and also had decades-long exclusive access to provide coverage to Minnesota public health care program enrollees. A significant portion of their current assets, including investment incomes derived from those assets, are likely due to the accumulation of benefits from lower taxes, and profit margins associated with providing coverage to public program enrollees over a long period of time. Logically, these factors should be considered in the definition of the nonprofit HMO’s assets. In addition, depending on the nature of a transaction, it may make sense to include other factors – such as potential future enrollee premiums in the event a transaction involves the movement of enrollees.

Quantifying the value of public benefit assets is a complicated undertaking, requiring technical expertise in forensic accounting, finance, and economics. It requires assigning value to the various components of assets determined to be public benefit assets. It may also require consideration of different time frames, taking into account previous movements of assets to for-profit entities during a look-back period; current value of other assets; and future value of still other assets, such as estimated future premium revenue associated with movement of enrollees and other, potentially significant, tangible and intangible assets.

Under current law, nonprofit entities provide asset valuations as part of any transaction they need to report to the Attorney General’s Office (AGO). Although the AGO conducts a review to see if there are signs the nonprofit organization may have undervalued the assets, they do not conduct an independent valuation. The Minnesota Department of Commerce (Commerce) relies on information prepared by the insurance company in accordance with statutory accounting practices, which provide a standard process for insurance companies to value assets in their financial statements, when reviewing transactions. Commerce also reviews annual audits prepared by certified public accounting firms to validate whether the insurance company’s financial statements accurately reflect the financial position of the company. Similar financial transactions made by HMOs are not currently reported to the Minnesota Department of Health (MDH).

Because a nonprofit organization moving assets to a for-profit entity would likely have a conflict of interest in valuing those assets – at minimum, it creates the perception of a conflict of interest – a more robust process of valuation would involve a neutral party to conduct such a valuation to ensure all relevant components of assets

are included and their fair market value is reasonably calculated. The extent to which the details of these calculations can be shared with the public for transparency may sometimes be limited by state or federal laws, but the public's trust in the process would be aided by broad transparency. It should be noted that when assessing public benefit assets associated with a conversion transaction, assumptions on which those valuations are made may differ widely, as has been demonstrated in other state conversion transactions.

Current State Taxes and Treatment

There are several state-based taxes that Minnesota HMOs (both nonprofit and for-profit), health insurance companies, and their holding companies, are required to pay. This is important baseline information because it helps policymakers understand similarities and differences in state taxation policies across nonprofit and for-profit HMOs, as well as between HMOs and insurance companies. It also serves to understand the financial incentives present in tax treatment for entities that operate under both HMO and insurance licenses to locate books of business with one or the other organizational types. For purposes of this section, the Minnesota Department of Health (MDH) is only focusing on a handful of these taxes (Table 7) that can vary across insurance company by type. It does not discuss taxes such as the MNsure Premium Tax, the MinnesotaCare Tax, and any other state and federal taxes/assessments.

Table 7: Summary of State Taxes and Treatment

Tax	Description	Statutory Reference	Location of Funds
1% Gross Premium Tax	Tax on gross premium revenues on HMOs, Community Integrated Service Networks (CISN)[31] & nonprofit health service plan corporations	chapter 297I, section 297I.05, subdivision 5	Health Care Access Fund (HCAF)
2% Gross Premium Tax	Tax on gross premium revenues on domestic and foreign insurance companies	chapter 297I, section 297I.05, subdivision 1	General Fund
Medical Assistance Surcharge on HMOs and CISNs[32]	0.6% surcharge on total premium revenues of HMOs and CISNs	chapter 256, section 256.9657, subdivision 3	Medical Assistance Account
Corporation Franchise Tax	Commonly referred to as the corporate income tax	chapter 290	General Fund

[31] As of January 1, 2024, there are no Community Integrated Service Network (CISN) licensed in the State of Minnesota.
[32] For purposes of this report, MDH is not including the Medical Assistance Nursing Home License Surcharge, Hospital Surcharge, and ICF-DD License Surcharge.

Gross Premium Tax[33]

This tax applies to insurance premiums and is reported to the Minnesota Department of Revenue for all property and casualty, title, surety, life, health, and township mutual insurance companies and risk retention groups. For purposes of this report, MDH will only discuss this tax in relationship to HMOs and other health insurance companies.

The amount of premium tax applied to HMOs compared to other health insurance companies varies:

- 1% gross premium tax on HMOs (both nonprofit and for-profit), Community Integrated Services Networks (CISN), and nonprofit health care service plan corporations (such as Blue Cross Blue Shield of MN).[34] Total amounts collected are deposited into the Health Care Access Fund (HCAF).
- 2% gross premium tax on domestic and foreign insurance companies; these include other for-profit insurance companies (such as Medica Insurance Company and HealthPartners Insurance Company) and may include some health plan holding companies.[35] Total amounts collected are deposited into the General Fund.
- A different gross premium tax may apply to health plan holding companies or affiliates that do not meet the above definitions, meet a different definition (e.g., mutual property and casualty company, surplus line) or may not have any gross premium tax apply if they satisfy an exemption (for example, the State Employee Insurance Program or Federal Employee Health Benefit Program (FEHBP).[36]

HMO and CISN Surcharge ("Medical Assistance Surcharge")

The Commissioner of Human Services is paid a "surcharge of six-tenths of one percent" (0.6%) of the total premium revenues of HMOs or CISNs[37], otherwise known as the "Medical Assistance Surcharge." This surcharge excludes non-HMOs, meaning that other health insurance companies and holding companies would not pay this surcharge; currently there are no non-HMOs offering Medical Assistance comprehensive medical benefits. The surcharge on premium revenues excludes HMO or CISN premiums paid for FEHBP and certain Medicare revenues; however, it includes premium revenues from a prepaid basis from individuals and groups for specified health services over a defined period of time, Medicare supplemental coverage, Medicare revenue (as a result of an arrangement between an HMO or a CISN and CMS for services to a Medicare beneficiary), and Medical Assistance revenue (as a result of an arrangement between an HMO or a CISN for services to a medical assistance beneficiary).[38] The only HMOs and CISNs that pay this amount are:

- HMOs with a certificate of authority issued by the Commissioner of Health under Minnesota Statutes, chapter 62D. This means both for-profit and nonprofit HMOs, regardless of where the HMO is domiciled – in

[33] For purposes of this report, MDH refers to the Gross Premium Tax as the HMO Premium Tax and Insurance Premium Tax.
[34] Minnesota Statutes, section 297I.05, subdivision 5; www.revisor.mn.gov/statutes/cite/297i.05
[35] Based on Minnesota Statutes, chapter 297I.05, subdivisions 1 and 5; www.revisor.mn.gov/statutes/cite/297i.05; the tax is equal to the percent of the gross premiums less "…return premiums on all direct business received by the insurer or agents of the insurer in Minnesota, in cash or otherwise, during the year."
[36] Minnesota Statutes, section 297I.15; www.revisor.mn.gov/statutes/cite/297I.15
[37] As previously footnoted, there are not any CISNs currently operating in Minnesota.
[38] Minnesota Statutes, section 256.9657, subdivision 3; www.revisor.mn.gov/statutes/cite/256.9657

Minnesota or another state. Furthermore, it appears this also applies to all HMOs, regardless, if they offer Medical Assistance or Medicare Advantage/Cost lines of business.

- CISNs licensed by the Commissioner of Health under Minnesota Statutes, chapter 62N.

Corporation Franchise Tax[39]

The Corporation Franchise Tax[40] is commonly referred to as the "Corporate Income Tax" and applies to companies that file federal tax returns as C Corporations, as long as they meet one of three conditions: they are located in Minnesota, have a Minnesota business presence, or have a Minnesota gross income.

Generally, based on Minnesota Statutes, section 290.05, insurance companies (including for-profit and nonprofit HMOs) and exempt nonprofit health service plan corporations[41] are not subject to this tax. Companies that may be subject to this tax include[42] disqualified captive insurance companies, non-insurance companies, such as service companies that are affiliated with a health insurance company's holding company, and other organizations that are not exempt from income taxation under Subchapter F of the Internal Revenue Code (IRC).

[39] Additional information can be found on the Minnesota Department of Revenue Corporation Franchise Tax website: www.revenue.state.mn.us/corporation-franchise-tax; Minnesota House of Representatives, House Research Department Short Subjects: Corporate Franchise Tax, Updated June 2015, [PDF] www.house.mn.gov/hrd/pubs/ss/sscorpft.pdf.

[40] Minnesota Statutes, chapter 290; www.revisor.mn.gov/statutes/cite/290; Minnesota Department of Revenue Corporation Franchise Tax, www.revenue.state.mn.us/corporation-franchise-tax

[41] Nonprofit health service plan corporations are exempt from this tax if they are exempt from income tax under Subchapter F of the Internal Revenue Code (IRC). This statute does not include any reference or definition to HMOs; therefore, for purposes of this tax, HMOs would most likely be included as an "insurance company".

[42] For additional information refer to Minnesota Department of Revenue, Disqualified Captive Insurance Companies, Corporation Franchise Tax; www.revenue.state.mn.us/disqualified-captive-insurance-companies.

Approaches to HMO Conversion Regulation in Other States

Other states have grappled with the same issues confronting Minnesota as nonprofit health plans in their states have, or have attempted to, move charitable assets to for-profit entities over time. As Minnesota was the last state to allow for-profit Health Maintenance Organizations (HMOs) and still has a moratorium on conversions, it can be instructive to learn about other states' experiences with similar types of transactions. To the extent states had regulatory structures in place to oversee conversion transactions prior to transactions taking place, they were generally able to exert more control over nonprofit and charitable assets and ensure those assets were stewarded in the public's interest.

As part of an initial environmental scan of state approaches to HMO conversions, the Minnesota Department of Health (MDH) worked with an actuarial consulting firm to review how proposed or actual historical transactions (including conversions, mergers, and sales) were overseen or regulated in a selection of other states at the time of the transactions (Table 8). In the final report, MDH will identify how select states' *current* laws would deal with examples of certain types of transactions if those transactions were to be proposed today.

Table 8: Select Summary of Historical HMO Conversions in Other States

State	Impacted Company	Transaction Type	Year of the Transaction	Amount of Charitable and Public Assets in Millions
New Mexico	Blue Cross and Blue Shield of NM	Acquisition by HCSC (Nonprofit mutual)	2001	$20
Ohio	Community Mutual Insurance Company	Merger with Associated Group Insurance Companies (Nonprofit mutual)	1995	$28
North Carolina	Blue Cross Blue Shield of NC	For-Profit Conversion	Attempted in 2002 but withdrawn	None
New York	Empire Blue Cross and Blue Shield	For-Profit Conversion	2002	$4,600 (2006-2010)
New York	Fidelis	Asset Sale	2018	$2,000

State	Impacted Company	Transaction Type	Year of the Transaction	Amount of Charitable and Public Assets in Millions
California	Blue Cross of California	For-Profit Conversion	1993	$3,200
Virginia	Blue Cross Blue Shield of VA	Demutualization[43]	1997	$175 (public) & $159 (charitable)
New Jersey	Horizon	For-Profit Conversion to Domestic Stock Company	Latest Application: 2008	Full fair market value
Colorado	Rocky Mountain HMO	Acquisition by UnitedHealth Group[44]	2017	$36.5

Source: Unpublished information from actuarial consultant. Findings are based on initial research from actuarial consultant, sometimes from secondary sources that have not been verified for accuracy. As appropriate, MDH will follow-up up to learn more details and fact check.

Table 9 summarizes key aspects of the regulatory process, including the laws, approach for determining charitable public assets, and the regulatory entity and public notice requirements that were in place in each of the selected states at the time a transaction was proposed or finalized. In terms of determining charitable public assets, about half used fair market value, and most others had the amount determined in settlements. In all but one state (North Carolina), at least two state entities were involved in reviewing the transaction. Most states included the Attorney General as one entity involved in the review process. The next most common state agency involved was the state department responsible for licensing the health plan, and the approval or disapproval authority often rested with this agency, rather than the Attorney General. Public notice requirements and timelines varied, but in general both public notice and a comment period and/or public hearing were part of the process.

[43] For purposes of this report, demutualization is defined as conversion from a mutual insurance company to a stock corporation.
[44] Including For-Profit Conversion.

Table 9: Summary of Historical Transaction Review Processes

State	Impacted Company / Transaction Type	Entity/ Transaction - Regulation and Laws	Approach for Determining the Charitable and Public Assets	Regulatory Entity for the Specific Transaction and Approval/Disapproval Authority	Public Notice and Timeline
New Mexico	BCBSNM / Acquisition by nonprofit (2001)	▪ Nonprofit Corporations Act Section 53 ▪ Mutual Insurers: Chapter 59A under Insurance Code Article 34[45]	Regulation does not prescribe specific approach; final amount was determined through settlement	▪ Superintendent of Insurance & Attorney General Office ▪ Superintendent has authority to approve merger/consolidation of mutual insurer after a hearing	▪ Merger or consolidation of mutual insurers: Two weeks in newspapers and two of the four cities with largest population
Ohio	Community Mutual Insurance Company / Merger with nonprofit (1995)	▪ Title 39, Chapter 3941 Operation of Mutual Insurance Companies ▪ Charitable Law Section[46]	Fair market value described in regulation; final amount determined through settlement	▪ Department of Insurance & Attorney General ▪ Disapproval authority by Superintendent of Insurance	▪ Within 90 days after filing of the petition for approval

[45] Certain New Mexico law references can be referenced through Justia US Law. Nonprofit Corporations Act Section 53 https://law.justia.com/codes/new-mexico/2021/chapter-53/article-8/section-53-8-48/; Mutual Insurers: Chapter 59A under Insurance Code Article 34 https://law.justia.com/codes/new-mexico/2021/chapter-59a/article-34/; Chapter 8, Article 5 https://law.justia.com/codes/new-mexico/2021/chapter-8/article-5/section-8-5-2/; Chapter 59, Article 47 https://law.justia.com/codes/new-mexico/2021/chapter-59a/article-47/section-59a-47-22/

[46] Relevant Ohio law references can be referenced through Ohio Laws & Administrative Rules, Legislative Service Commission. Section 3941.38 https://codes.ohio.gov/ohio-revised-code/section-3941.38; Section 109.34 https://codes.ohio.gov/ohio-revised-code/section-109.34; Section 109.35 https://codes.ohio.gov/ohio-revised-code/section-109.35; Section 3941.40 https://codes.ohio.gov/ohio-revised-code/section-3941.40

State	Impacted Company / Transaction Type	Entity/ Transaction - Regulation and Laws	Approach for Determining the Charitable and Public Assets	Regulatory Entity for the Specific Transaction and Approval/Disapproval Authority	Public Notice and Timeline
North Carolina	BCBSNC / For-Profit Conversion (attempted in 2002, withdrawn in 2003)	▪ Chapter 58-65-1 for Hospital Service Corporation ▪ House Bill 346 in 2023: transfer of assets to nonprofit holding company[47]	100% of fair market value, estimated at $950 million in 2001[48]	▪ Department of Insurance ▪ Commissioner has power to approve a conversion with conditions and limits on the conditions	▪ Public notice within 20 days after receiving conversion plan ▪ Public hearings to be completed within 60 days
New York	Empire / For-Profit Conversion (2002)[49]	▪ Insurance Law Article 43 (non-profit medical corporation) ▪ Insurance Law Article 42 (for-profit) ▪ Insurance Law section 7317[50]	100% of fair market value, estimated at $1.0 billion in 2001	▪ Department of Insurance and Attorney General ▪ Approval by Superintendent	▪ Requirement to hold one or more public hearings along (within the geographic area) with public notice related to public hearings

[47] North Carolina law references: Chapter 58-65-1 for Hospital Service Corporation [PDF] www.ncleg.gov/EnactedLegislation/SessionLaws/PDF/2021-2022/SL2021-169.pdf (Chapter 58-65-1 law modified in 2021 and no longer directly comparable to laws in 2022); Chapter 58-65-131 www.ncleg.gov/enactedlegislation/statutes/html/bysection/chapter_58/gs_58-65-131.html; House Bill 346 in 2023 [PDF] www.ncleg.gov/Sessions/2023/Bills/House/PDF/H346v6.pdf

[48] Beard A. StarNews Online. "N.C. Blue Cross ends plan to seek a for-profit status". July 9, 2003. www.starnewsonline.com/story/news/2003/07/09/nc-blue-cross-ends-plan-to-seek-a-for-profit-status/30475692007/

[49] For background on the New York Empire / for-profit conversion, visit Robinson, J. Health Affairs. The Curious Conversion Of Empire Blue Cross. July/August 2003. www.healthaffairs.org/doi/epdf/10.1377/hlthaff.22.4.100

[50] New York Empire / for-profit law references: Insurance Law Article 43 https://newyork.public.law/laws/n.y._insurance_law_section_4301 (changes to law occurred in 2001); Insurance Law section 7317 https://newyork.public.law/laws/n.y._insurance_law_section_7317

State	Impacted Company / Transaction Type	Entity/ Transaction - Regulation and Laws	Approach for Determining the Charitable and Public Assets	Regulatory Entity for the Specific Transaction and Approval/Disapproval Authority	Public Notice and Timeline
New York	Fidelis / Sales of Assets (2018)[51]	▪ Insurance Law Article 44 (Employee Welfare Funds) ▪ Not-for-Profit Corporation Law Section 510 and 511-a[52]	Amount determined through settlement	▪ Department of Financial Services and Attorney General ▪ Approval authority by Attorney General	▪ Under discretion of Attorney General public comment period was provided ▪ Attorney General concurrent with the approval provided responses to the public comments
California	Blue Cross of CA / For-Profit Conversion (1993)	▪ Knox-Keene Act ▪ California Revenue and Taxation Code Sec. 23701(d)[53]	100% of fair market value	▪ California Department of Commerce and Director of Managed Health Care ▪ Authority to approve/disapprove not identified	▪ Not identified

[51] Attorney General approval of Fidelis Transaction [PDF] https://ag.ny.gov/sites/default/files/oag-approval-of-fidelis-transaction.pdf

[52] New York Fidelis / sales of assets law references: Insurance Law Article 44 https://newyork.public.law/laws/n.y._insurance_law_article_44; Not-for-Profit Corporation Law Section 510 and 511-a; https://newyork.public.law/laws/n.y._not-for-profit_corporation_law_section_511-a

[53] California law references: Knox-Knee Act www.dmhc.ca.gov/aboutthedmhc/lawsregulations.aspx#:~:text=The%20Knox%2DKeene%20Health%20Care%20Service%20Plan%20Act%20of%201975,(HMOs)%20within%20the%20State. California Revenue and Taxation Code Sec. 23701(d) [PDF] https://oag.ca.gov/sites/all/files/agweb/pdfs/gambling/revtaxcode.pdf

State	Impacted Company / Transaction Type	Entity/ Transaction - Regulation and Laws	Approach for Determining the Charitable and Public Assets	Regulatory Entity for the Specific Transaction and Approval/Disapproval Authority	Public Notice and Timeline
Virginia	Trigon / For-Profit Conversion (1997)	▪ Code of Virginia, Title 38.2, Chapter 10 ▪ Code of Virginia, Title 32.1, Health Chapter 20[54]	Public: Estimated tax break for specific period prior to the demutualization	▪ State Corporations Commission and Attorney General (for both)	▪ Requirement to give notice and an opportunity to be heard to the policyholders of the domestic mutual insurer ▪ Attorney General "shall cause" public notice of transaction within 10 days of entity notice (published in newspaper) ▪ 40 days prior to disposition of assets, nonprofit shall convene public meeting
New Jersey	Horizon BCBSNJ / For-Profit Conversion (2008)	▪ Chapter 17:48E of Title 17 of the New Jersey Revised	100% of fair market value to nonprofit foundation	▪ Commissioner of the New Jersey Department of Banking and Insurance and Office of Attorney General	▪ Public hearing within 30 days after filing; notice provided in publication

[54] Virginia law references: Title 38.2, Chapter 10 https://law.lis.virginia.gov/vacodefull/title38.2/chapter10/; Title 32.1, Health Chapter 20 https://law.lis.virginia.gov/vacodefull/title32.1/chapter20/

State	Impacted Company / Transaction Type	Entity/ Transaction - Regulation and Laws	Approach for Determining the Charitable and Public Assets	Regulatory Entity for the Specific Transaction and Approval/Disapproval Authority	Public Notice and Timeline
		Statutes (Conversion Act)[55]		▪ Approval by Commissioner of Banking and Insurance	
Colorado	RMHMO / For-Profit Conversion & Acquisition (2017)[56]	▪ Colorado Revised Statutes (CRS) Title 10- Insurance Section 10-3-803 and Section 10-3-803-5 ▪ CRS Title 10- Insurance, Section 10-16-324 ▪ Colorado Code, Section 6-19-403 ▪ Colorado Code, Section 24-31-101[57]	100% of fair market value	▪ Colorado Commissioner of Insurance and the Attorney General ▪ Conversion approval by Attorney General	▪ Commissioner provides public notice of the application filing of within five business days ▪ Commissioner review required to include public hearing or public written comments

Source: Unpublished information from actuarial consultant. Findings are based on initial research from actuarial consultant, sometimes from secondary sources that have not been verified for accuracy. As appropriate, MDH will follow-up up to learn more details and fact check.

[55] Certain New Jersey law references can be referenced through Justia US Law. Title 17 https://law.justia.com/codes/new-jersey/2022/title-17/

[56] For additional background on Colorado transactions, visit the Colorado Department of Regulatory Agencies, Division of Insurance. https://doi.colorado.gov/for-consumers/consumer-protection/proposed-mergers-acquisitions

[57] Certain Colorado law references can be found through FindLaw and Justia Law. Colorado Revised Statutes (CRS) Title 10- Insurance Section 10-3-803 https://codes.findlaw.com/co/title-10-insurance/co-rev-st-sect-10-3-803.html; Section 10-3-803-5 https://codes.findlaw.com/co/title-10-insurance/co-rev-st-sect-10-3-803-5/; CRS Title 10-Insurance, Section 10-16- 324 https://law.justia.com/codes/colorado/2022/title-10/article-16/part-3/section-10-16-324/; Colorado Code, Section 6-19-403 https://law.justia.com/codes/colorado/2022/title-6/article-19/part-4/section-6-19-403/; Colorado Code, Section 24-31-101 https://law.justia.com/codes/colorado/2022/title-24/article-31/part-1/section-24-31-101/

The experiences of states included in this initial scan suggest core components of a robust regulatory framework to allow for sufficient public awareness of proposed transactions, a fair valuation of public or charitable assets, and the appropriate assurance that those assets continue to be used for their nonprofit purpose include the following[58]:

- Inclusive pre-notice requirements for all transactions exceeding a predetermined threshold to state regulators. It is important to identify a meaningful level of materiality for transactions subject to regulatory review and public input.
- Clear authority and responsibilities for each regulator with regard to review and ability to stop any relevant transactions involving HMOs.
- Mechanisms and defined timelines for public input and transparency in any approval process, including the valuation of public/charitable assets involved in the conversion.
- Explicit definitions of public assets, a method to attribute fair market value (valuation) and ownership, and a requirement that such assets continue to be used for their nonprofit or public benefit purpose.
- Conditions for allowing for the approval of, or non-objection to, transactions, along with clear authority for the appropriate entity for their monitoring and enforcement.

Some additional considerations around how to handle charitable assets after the transaction are also important. For example, it is ideal to have a provision for public benefit assets to be safeguarded and dedicated for continued charitable use aligned with their original purpose. This could include requiring that they be placed in one or several foundations independent of any newly formed stock corporation and ensuring the independence of the directors of the foundation. Similarly, it will be important to develop mechanisms to ensure that commitments related to community benefits continue to be met post-transaction. In all cases, mechanisms for ongoing monitoring of the terms and conditions of the transaction should be considered.

Over the past 30 years, several other states have overseen transactions similar to the types that might occur in Minnesota in the future. The clear similarities across regulatory frameworks – including the entities involved, charitable asset valuations, and public notice requirements – provide a strong set of principles for Minnesota to consider.

[58] This includes through legislation, proactive regulation, and/or expanded authority. Additional considerations will be included in the final report.

Soliciting Input from the Public and Subject Matter Experts

The Minnesota Department of Health (MDH) solicited both public and subject matter expert input on key issues to be considered in future recommendations through three mechanisms: a Request for Information (RFI), a virtual public meeting, and a set of key informant interviews with subject matter experts representing a variety of perspectives. This summary captures the key themes and selected quotations (noted in blue text boxes throughout this section) from the public input, even though some input may have been based on assumptions that do not accurately reflect the current regulatory landscape; it is included here to reflect the underlying perspectives of those who took the time to provide input.

Summary of Feedback Formats

Table 10 provides an overview of the methods of input sought. Responses from public comments and subject matter experts are summarized by topic beginning on page 47.

Table 10: Public and Subject Matter Expert Feedback Timeline

<table>
<tr><th>October 2023</th><th>November 2023</th><th>December 2023</th></tr>
<tr><td colspan="2">Request for Information: October 2 to November 30</td><td></td></tr>
<tr><td></td><td>Public Meeting – November 15</td><td></td></tr>
<tr><td colspan="3">Key Informant Interviews</td></tr>
</table>

Request for Information

MDH published the RFI on October 2, 2023, and accepted feedback through November 30, 2023. MDH posted the RFI on its website, disseminated it through GovDelivery to approximately 7,500 subscribers and informed a wide range of stakeholder groups about this opportunity to provide input. The RFI was structured as eighteen questions related to five broad topics (please see Appendix E for full list of questions).

- Value and behavior of nonprofit HMOs
- Conversion limitations or conditions
- Transparency and public input
- Public benefit assets of HMOs
- General comment

MDH received eighteen responses to the RFI. Some respondents provided input on all questions on the RFI, while other respondents focused their feedback on a subset of the topics.

Public Meeting

MDH held a public meeting on November 15, 2023, to obtain feedback from interested individuals or groups as part of the public input process. The meeting was hosted on WebEx; participants also had the opportunity to provide written feedback. Twenty-two members of the public attended the meeting. At the beginning of the meeting, MDH explained the purpose of the study and the topics on which MDH was required to develop recommendations. Meeting attendees then had the opportunity to provide feedback; themes from their comments are included in the summary below.

Key Informant Interviews

Seventeen key informants were interviewed by MDH. Informants represented former state agency leadership, Minnesota and national academics, industry experts, former health insurance executives, and providers.

Although MDH prepared a list of questions to use as the basis for key informant interviews, MDH staff encouraged a free-flow of dialogue during these discussions. Some key informants had more subject matter expertise in certain areas; others were simply more interested in focusing on a subset of potential discussion topics. As a result of these dynamics, MDH tended to hear more about the purpose of nonprofit HMOs and the value (or lack thereof) of nonprofit status during the key informant interview process and less about some other potential discussion topics.

Summary of Stakeholder and Key Informant Input

Feedback on Nonprofit Status

Members of the public and key informants provided a wide range of feedback with respect to the importance of HMOs being nonprofit. Those strongly supporting HMOs being nonprofit generally thought a nonprofit mission was important in the context of health care, even if they also perceived nonprofit HMOs sometimes or frequently act in a manner that seems inconsistent with their nonprofit mission. Respondents also suggested the state's nonprofit HMOs vary with respect to their level of community engagement and mission-driven behavior. Conversely, representatives of for-profit HMOs pointed out the presence of for-profit HMOs gives consumers more choices and enhances competition across insurers.

Members of the public commented that nonprofits better serve their members and broader communities compared to their for-profit counterparts, which translates into stronger perceptions of trust with nonprofit HMOs and distinct distrust for for-profit HMOs. Both members of the public and many key informants expressed strong concern about pressure on for-profit companies to extract profits for shareholders and executive pay rather than reinvesting them for their members and the broader community. They viewed nonprofit HMOs as more aware of connections between broader community issues and impacts on enrollees' health. Some public comments suggested the presence of for-profit HMOs exacerbates a growing problem of lack of access for Minnesotans to the health care they need.

> *"Allowing insurance companies to make unlimited profits isn't going to improve our health care. The motivation of the for-profit will be profits."*

Respondents expressed concern about perceived differences for both enrollees and providers across nonprofit and for-profit HMOs. For example, respondents believed that denials for claims payment and coverage are less common in nonprofit HMOs as compared to for-profit payers. Respondents and key informants raised concerns about coverage of specialty care among for-profit HMOs and more narrow provider networks to which consumers have access. Providers expressed concern about reimbursement rates for their services declining with the introduction of for-profit HMOs and said it was more difficult to work with for-profit HMOs for reimbursement and prior authorization reviews.

"The advantage is that nonprofits at the top of the food chain are governed by Boards reflecting the community they serve."

Some members of the public and key informants, however, were skeptical about whether there are meaningful distinctions in behavior across nonprofit and for-profit HMOs. With this perspective, these commenters doubted whether it is important for HMOs to remain nonprofit. Key informants and members of the public expressed concern about nonprofit HMOs accumulating very high levels of reserves and whether their executives earn excessive salaries. However, key informants also expressed these issues were less egregious among nonprofit HMOs as compared to for-profit HMOs extracting profits for shareholders and substantially greater executive pay. Other key informants acknowledged nonprofit HMOs have been slowly moving assets to for-profit affiliated companies within larger corporate holding company structures for as long as 20 years, which reduces assets available to support the HMO's nonprofit mission; in that sense, these market experts did not see a meaningful difference between nonprofits and for-profits.

"If you are a nonprofit and have a 1-2% margin that is fine. If you are a for-profit, that is not fine, it has to be higher."

Value in Minnesota-Based HMOs

Many key informants emphasized the importance of Minnesota's longstanding legal framework allowing only nonprofit HMOs domiciled in Minnesota to operate in the state; they said it created a culture in which these companies were locally based with their executive leadership living in Minnesota. In essence, many key informants felt the presence of local leadership and a nonprofit mission combined to naturally make the nonprofit health plans more attuned to Minnesota's needs as compared to larger, national for-profit health plans. For example, key informants attributed Minnesota's tradition of health plan participation in multi-stakeholder collaborative efforts, such as health care quality measurement, to this focus on Minnesota issues. Some key informants emphasized the value of locally based HMOs was equally important as their nonprofit orientation and expressed concern the increased presence of large national plans would undermine this local focus.

"If we have a big multinational nonprofit come in, whose CEO and Board lived in Atlanta, for example, fundamentally, it will be different."

The need for nonprofit HMOs to act differently in the face of additional competitive pressure may have varied effects on both nonprofit HMOs and the Minnesota health care market. Key informants said the presence of large national for-profit HMOs in Minnesota is already changing the state's marketplace by incenting local HMOs

to act more like for-profit HMOs to stay competitive. They opined nonprofit HMOs are focused on investing in other states and product lines, which means nonprofit HMOs are less focused on Minnesota than historically has been the case. Key informants also pointed to examples of for-profit companies buying out other types of nonprofit health care entities (such as larger national for-profit companies' acquisition of nursing homes and assisted living facilities) and their concerns about negative broader market impacts associated with these changes in control and ownership.

Measuring Differences Between Nonprofit and For-Profit HMOs

Key informants acknowledged little to no data are available to assess whether differences across for-profit and nonprofit HMOs exist. They offered different ideas about data that would be needed to compare nonprofit and for-profit HMO behavior and performance. Their suggestions included gathering, analyzing, and publishing data on utilization management practices, quality of care metrics, enrollee complaints, financial performance, and provider rates. They also suggested requiring all HMOs to report on how they invest in the community.

> *"If we have both for-profit and nonprofits what would good behavior look like to be good for Minnesotans, and do we have the information we need about performance to allow this comparison? What else would we need to know and share publicly about financial performance, quality performance, complaints, utilization review issues, … what metrics would we need?"*

Standards for Nonprofit and For-Profit HMOs

Commenters generally expressed a desire for for-profit HMOs to be held to the same standards as nonprofits. They said for-profit HMOs should be required to provide transparency related to business operations and impacts on tax, profit, valuation, and pricing. Commenters advocated that for-profit HMOs should be required to have affordable premiums. Other respondents said that if for-profit HMOs are to continue operating in the state, all regulations need to be examined to ensure a level playing field exists locally, as well as nationally.

Many respondents indicated that all HMOs – whether nonprofit or for-profit – should be required to provide some type of community benefit. There are no such requirements to provide community benefit in state law for either nonprofit or for-profit HMOs today. Examples included making upstream community investments to improve population health and health care. Other respondents thought community benefit could be demonstrated by HMOs consistently acting in the best interests of their members through broadly inclusive primary care networks, negotiated drug prices, timeliness in claims processing, and ensuring coverage of promised benefits without undue restrictions. Another respondent said that specific community value/benefit requirements are unnecessary and may have unintended negative consequences, though did not provide examples.

Most respondents generally supported state policies incenting local HMOs to maintain their nonprofit status, although some worried this might result in less regulation of nonprofit HMOs as compared to current regulation. Some respondents believe the best way to accomplish this is to revert to the state's prior policy of prohibiting for-profit HMOs. Others suggested for-profit HMOs should pay a higher premium tax and should not be exempt from state corporate taxes.

Stakeholder Input on Conversion Transactions

The subsequent questions posed through public comment processes and to key informants focused on issues directly related to conversion transactions and how they should be regulated.

Defining, Valuing, and Treatment of Public Benefit Assets

Most members of the public supported a broadly inclusive definition of a nonprofit HMO's public benefit assets and an independent valuation of them. A key informant suggested there should be an extended look-back period to identify whether assets were slowly moved over time from the nonprofit side of a holding company to a for-profit side; if so, this commenter suggested they should be identified and stewarded for the public good.

Both members of the public and key informants expressed strong opinions about how public benefit assets should be treated. Most members of the public stated that assets should be given to a public benefit entity to support the health of Minnesotans. Key informants suggested potential uses of public benefit assets should include investments in population health and public health.

Potential Limitations or Conditions on Conversions

Members of the public offered varying perspectives about whether potential limitations or conditions should be imposed on conversions, as well as what those limitations might include. Feedback focused on the circumstances under which conversion transactions should not be permitted to proceed, including when they constitute a breach of charitable trust or fiduciary duty, or if it would result in no competition that keeps the market fair, equitable, and sustainable. Members of the public also commented that conversions should not be allowed if there is reason to be concerned patient care may be compromised or if conversion transactions may negatively impact public health. Another commenter expressed concern imposing limits on conversions would be excessive regulation that risks hurting Minnesotans.

Ongoing Monitoring Following a Conversion Transaction

Respondents suggested a variety of post-transaction information should be monitored and available to the public, including the value of the nonprofit assets that were transferred; any subsequent changes to provider reimbursement rates, wages, and collective bargaining agreements; cost of care to consumers; changes to geographic areas of the state in which HMO coverage is offered; changes to enrollee demographic characteristics, such as race and ethnicity; quality metrics related to enrollee satisfaction and clinical processes and outcomes; profit and loss; executive compensation; and information related to utilization management and coverage denials. Another respondent suggested all post-conversion information should be public except that which is proprietary or non-public.

Stakeholder Input on Need for Public Transparency

Respondents to MDH's RFI were split on the importance of public transparency related to potential conversion transactions, generally depending on whether they were members of the public or industry participants. Respondents representing consumers or private citizens generally felt strongly the public should be made aware of potential conversion transactions and have an opportunity to provide input or share concerns. These

respondents suggested time periods ranging from 150 days to a full year for such notice to occur. Respondents representing the insurance industry took a different view, saying that while there may be a need for notice related to a nonprofit entity converting to a for-profit entity, transfers of assets do not rise to the level of needing to provide notice to members or the public. One respondent took the view that appropriate public notification already occurs because nonprofit HMOs must report any potential conversion to the Minnesota Attorney General and this process in itself constitutes appropriate public notification.

Respondents offered varying ideas about the information they felt should be included in a public notification about significant transactions or changes. Suggestions included potential changes to the HMO's structure and/or staffing, planned distribution of assets, quality metrics on care versus nonprofit benchmarks, what the conversion process entails, why the HMO is proposing the conversion, the impact it may have on HMO members, the duration of the conversion process, and what impacts are likely to materialize over time. Commenters also suggested information related to the history/rationale for why HMOs were originally required to be nonprofit entities should be included in information for the public to help provide context for why public input is being solicited.

The majority of public input and key informants voiced support for the public having input into whether and how a potential conversion transaction should occur. Members of the public suggested a public input process should include one or more of the following elements: public hearings, written statements, open forums, opportunities to provide feedback online, listening sessions, and/or community outreach. Other respondents said no public input process is necessary.

Discussion

When Minnesota's law governing the types of organizations that are eligible to be licensed as a Health Maintenance Organization (HMO) in Minnesota changed in 2017, it marked the end of a decades-long restriction that reflected a general preference for local, nonprofit health care. Since that time several for-profit HMOs, most not domiciled in the state, have entered the Minnesota market, and provided coverage to approximately 40,000 Minnesotans across different sectors of the insurance market in 2022. But during this time period, state regulatory requirements for HMOs have not changed.

The legislature directed the Minnesota Department of Health (MDH) to study the issue of nonprofit to for-profit HMO conversions out of a recognition that there is a strong public interest in ensuring the assets of charitable or nonprofit organizations that provide health care coverage are not diverted to activities that do not further the organization's original nonprofit mission in the event of a sale, conversion, or merger. To the extent that these assets may have been accumulated via preferential tax treatment for nonprofit organizations, or because of the exclusive participation of HMOs in Minnesota's public programs, the state also has an interest in how those assets are used.

The state's regulatory structure for nonprofit HMOs involves three state agencies – with MDH and the Minnesota Department of Commerce (Commerce) responsible for regulating HMOs and other insurers respectively, with varying levels of authority based on the types of transactions and entities involved, while the Attorney General's Office (AGO) reviews nonprofit transactions that meet certain criteria and can bring legal action. There is significant complexity embedded in the state's regulatory structure, the industry it oversees, and the types of financial transactions that are the focus of this report. Identifying the "right" type and level of financial transactions that are appropriate for regulators to examine or for the public to learn about or weigh in on – and balancing those considerations with the needs of regulated entities to conduct day-to-day business operations in a timely manner – is a key consideration and may require different approaches based on the nature and relative magnitude of the transaction. In considering how the assets of nonprofit HMOs are used in the context of conversion transactions, it may also be important to assess the cumulative impact of smaller financial transactions over time and how they may result in movement of assets from nonprofit to for-profit entities. Minnesota's regulatory structure is not currently designed to include monitoring of this cumulative impact over time or considering issues of public benefit assets in this context.

The preliminary analysis in this report highlights several areas where the basic building blocks of effective regulation of conversion transactions – clear definitions and thresholds, advance notification to regulators and the ability to take action related to approval of the transaction – are not yet in place when it comes to transactions involving HMOs. The variation in, and in some cases absence of, regulatory oversight of transactions for nonprofit HMOs indicates a need to update oversight of these transactions due to the increased complexity of holding company structures and assumptions made about the need for oversight of HMOs when they were only allowed to be nonprofit and domestic. Minnesota nonprofit law is clear that in situations involving mergers, conversions, assets sales, or transfers, the assets of a nonprofit organization must continue to be used for their original nonprofit purpose. That principle should guide any new oversight process that is developed related to HMO conversions that may lead to charitable or public benefit assets being diverted to purposes that are not aligned with the nonprofit mission of the organization. In addition, the legislature should ensure that any oversight process includes:

- Setting clear pre-notice requirements for all transactions exceeding a determined threshold to the AGO and MDH.
- Providing authority and responsibilities for the AGO and MDH for review and approval of/non-objection to any relevant transactions involving HMOs, with a notice and review timeline that is sufficient to allow for robust review and public input.
- Developing mechanisms for meaningful public notice, public input, and transparency in any approval process, including the valuation of public/charitable assets involved in the transaction. Requirements for public notice and input allow opportunities for the broader public to be informed of and provide feedback on potential transactions; providing notice to a regulator does not constitute public notice.
- Creating definitions of public benefit assets and a method to attribute value and ownership.
- Allowing the ability to apply conditions to approval of transactions, along with clear authority for the appropriate entity for ongoing monitoring and enforcement.
- Establishing, as a principle, that fair market value be obtained for public assets, that an independent valuation be conducted, and that any appraisal or other analyses supporting asset values be made available to interested parties.
- Instituting mechanisms for confirming the community benefits being provided by the converting entity in any new form or via any new entities (e.g., a public foundation) created pursuant to the transaction, and tracking to ensure that commitments related to community benefits continue to be met post-transaction.

While the legislature directed MDH to examine a set of very specific questions in this study, the questions posed also illuminate complex issues related to how health care and coverage are delivered and paid for in Minnesota, who benefits from the provision of coverage, and the state's values and expectations of the entities who deliver those services. Throughout the process of obtaining public input into this study, MDH has heard loud and clear that Minnesotans continue to see value in the principle of nonprofit coverage and care, and feel strongly that the entities that provide health care coverage should be primarily motivated by a desire to maintain and improve the health of individuals and communities, rather than by a desire to produce a strong profit margin for owners, shareholders, or company executives. The public input also distinguished between "local HMOs" (Minnesota-domiciled companies) that are more engaged in state-specific quality improvement, community prevention, or data-sharing activities versus national entities with a multi-state footprint that might be less able or willing to be engaged in those state-specific activities and less community-connections or responsiveness overall. The fact that most of the for-profit HMOs now operating in Minnesota are also national entities that operate in multiple states makes these two issues difficult to untangle.

Minnesota largely lacks data on whether or not those nonprofit and local ideals play out in terms of performance of nonprofit versus for-profit entities, or foreign-domiciled versus local HMOs, both because these HMOs are still fairly new to Minnesota and because reporting and data collection mechanisms do not exist to illuminate some of these value assessments. The standards to which HMOs – regardless of domicile or profit status – are held do not always align with what consumers most value.

At the same time, there may remain some meaningful differences between nonprofit and for-profit HMOs. Anecdotal feedback in the public input process, particularly from providers, indicated that there may be differences in the ways that nonprofit versus for-profit entities handle utilization management processes like prior authorization, with for-profit entities being more restrictive or more difficult to work with. However, no process exists to compare them on these types of activities, nor to assess whether enrollee experiences differ across the two types of entities.

Looking Ahead to the Final Report

The Minnesota Department of Health's (MDH) final report will include information on the following topics:

- Identification of possible and/or recommended regulatory practices for nonprofit conversion transactions, including the identification and valuation process for public benefit assets and their stewardship for the public good.
- Recommendations for ongoing monitoring and regulation of Health Maintenance Organizations (HMOs) by MDH in an environment where both for-profit and foreign-domiciled HMOs are operating in Minnesota.
- Assessment of whether and how other states differentiate between nonprofit and for-profit HMOs in their regulatory structure.
- Additional detail on the approach other states take to HMO conversion transactions.
- Considerations related to potential return of charitable assets to the general fund.

Appendix A: 2023 Session Legislative Language

HF 402, 5th Engrossment – 93rd Legislature (2023-2024)

Section 6. STUDY AND RECOMMENDATIONS; NONPROFIT HEALTH MAINTENANCE ORGANIZATION CONVERSIONS AND OTHER TRANSACTIONS.

(a) The commissioner of health shall study and develop recommendations on the regulation of conversions, mergers, transfers of assets, and other transactions affecting Minnesota-domiciled nonprofit health maintenance organizations and for-profit health maintenance organizations. The recommendations must at least address:

(1) monitoring and regulation of Minnesota-domiciled for-profit health maintenance organizations;

(2) issues related to public benefit assets held by a nonprofit health maintenance organization, including identifying the portion of the organization's assets that are considered public benefit assets to be protected, establishing a fair and independent process to value the assets, and determining how public benefit assets should be stewarded for the public good;

(3) providing a state agency or executive branch office with authority to review and approve or disapprove a nonprofit health maintenance organization's plan to convert to a for-profit organization;

(4) establishing a process for the public to learn about and provide input on a nonprofit health maintenance organization's proposed conversion to a for-profit organization; and

(5) issues, including statutory language and regulatory implementation, related to a potential statutory requirement that nonprofit health maintenance organizations licensed under chapter 62D, and health systems organized as a charitable organization, upon the sale or transfer of control to an out-of-state or for-profit entity, return to the general fund an amount equal to the value of any charitable assets the health maintenance organization or health system received from the state.

(b) To fulfill the requirements under this section, the commissioner:

(1) may consult with the commissioners of human services and commerce;

(2) may enter into one or more contracts for professional or technical services; and

(3) notwithstanding any law to the contrary, may use data submitted under Minnesota Statutes, sections 62U.04 and 144.695 to 144.703, and other data held by the commissioner for purposes of regulating health maintenance organizations or data already submitted to the commissioner by health carriers.

(c) No later than October 1, 2023, the commissioner must seek public comments on the regulation of conversion transactions involving nonprofit health maintenance organizations.

(d) The commissioner shall submit preliminary findings from this study to the chairs of the legislative committees with jurisdiction over health and human services by January 15, 2024, and shall submit a final report and recommendations to the legislature by June 30, 2024.

Appendix B: Other Health Insurance Market Changes Since 2017

Since 2017, there were other health insurance market changes that occurred, outside of plans that entered the market. Some plans transitioned to/expanded to new markets, while others exited the market completely, were acquired by another company, or made financial transfers between health plan companies (sometimes transfers were between nonprofit and for-profit companies). The information below provides a short summary of some of these changes by HMOs, health insurance companies, and year. These examples are illustrative and do not capture all market changes that occurred since 2017, nor do they include management agreements and services within holding company affiliate companies, or transfers to health plan foundations within the holding company structure.

HMOs

Medica Health Plans and Medica Community Health Plan (formerly known as Medica Health Plans of Wisconsin)

- 2017: Medica Health Plans withdrew from Minnesota's Medical Assistance program for Families and Children (Prepaid Medical Assistance Plan (PMAP) and MinnesotaCare, effective April 30, 2017. This did not affect the Special Needs Basic Care (SNBC), Minnesota Senior Health Option (MSHO), or Minnesota Senior Care (MSC+) products.[59]
- 2017: Medica Health Plans transferred money ($90 million) from its nonprofit HMO to its nonprofit holding company, Medica Holding Company, to support affiliate companies.[60]
- 2019: Medica Community Health Plan, formerly known as Medica Health Plans of Wisconsin, changed its license from a nonprofit health service plan corporation to an HMO.
- 2022: Medica Health Plans again offered Medical Assistance program enrollment for Families and Children (PMAP) and MinnesotaCare.

PreferredOne Community Health Plan

- 2021: PreferredOne Community Health Plan (PCHP) exited the commercial market in December.
- 2023: UCare Minnesota and Fairview Health Services entered into an agreement for UCare Minnesota to acquire the PCHP nonprofit HMO license in May 2023, and Fairview Health Services to terminate its sole membership and any rights in PCHP. UCare will operate the license under the name UCare Community Health Plan and has no rights to use the name of PreferredOne. PreferredOne's for-profit affiliate,

[59] Medica. Medica MHCP membership to change after April 30. May 2017. https://partner.medica.com/providers/news/connections-archive/2017/05_2017_medica-connections

[60] NAIC Health Annual Statement for the Year Ended December 31, 2017 of the Condition and Affairs of the Medica Health Plans, page 26.8. [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={D759BFC1-8058-4867-B0F4-1B1D9DB980A4}; NAIC Health Annual Statement for the Year Ended December 31, 2017 of the Condition and Affairs of the Medica Insurance Company, page 26.12. [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={A62B1C64-3B18-4CC4-9B23-17F99D669186}

PreferredOne Insurance Company, had previously been acquired in 2021 by United Health Group Incorporated and United HealthCare Services, Inc.

Group Health Plan, Inc. and HealthPartners, Inc.

- 2019 & 2020: Group Health Plan, Inc. received $168 million and $100 million, respectively, as a net asset transfer from HealthPartners, Inc. to "increase the Plan's [Group Health Plan, Inc.] net assets to approximately 400% of the Risk Based Capital requirements".[61]
- 2022: HealthPartners, Inc. transferred $115 million of capital and surplus to Group Health Plan, Inc.[62]
- 2023: Group Health Plan, Inc. moved its individual (non-group commercial) insurance market membership to its parent company's HMO, HealthPartners, Inc. The Group Health Plan, Inc. HMO license remained active in 2023 for the Medicare line of business.
- 2024: Group Health Plan, Inc. surrendered its HMO license in Minnesota effective January 1, 2024. Group Health Plan, Inc. executed an assumption agreement with its parent company HealthPartners, Inc. to consolidate all its HMO Individual business under one license (HealthPartners, Inc.).

Quartz Health Plan MN Corporation

- 2018 and 2019: Gundersen Health Plan Minnesota (now known as Quartz Health Plan MN Corporation) received $1 million in a capital contribution from its holding company, Gundersen Health Plan, Inc. in May 2018 and again in August 2019.[63]
- 2019: Gundersen Health Plan Minnesota changed its name to Quartz Health Plan MN Corporation and its holding company, Gundersen Health Plan, Inc. changed its name to Quartz Health Plan Corporation on May 20, 2019.

Sanford Health Plan of Minnesota

- 2018 and 2019: Sanford Health Plan of Minnesota received $1 million in 2018 and $1.3 million in 2019 in the form of a capital infusion from Sanford Health to satisfy Sanford Health Plan of Minnesota's minimum capital requirements.[64]

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[61] NAIC Health Annual Statement for the Year Ended December 31, 2020 of the Condition and Affairs of the Group Health Plan, Inc., page 26.1. [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={F1C70B6D-30C3-4F59-9A89-E6E38024D0B4}

[62] NAIC Health Annual Statement for the Year Ended December 31, 2022 of the Condition and Affairs of the HealthPartners, Inc., page 26.2. [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId=%7bBE5F7F9B-5912-423E-B33F-1B4BA757FD85%7d

[63] NAIC Health Annual Statement for the Year Ended December 31, 2018 of the Condition and Affairs of the Gundersen Health Plan Minnesota. [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={4CAC2D9A-ACA0-4069-BF35-CAF534B22B52}; NAIC Health Annual Statement for the Year Ended December 31, 2019 of the Condition and Affairs of the Quartz Health Plan MN Corporation, page 26.2. [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={77B130F8-F8A7-48D9-8EEC-04B097896202}

[64] NAIC Health Annual Statement for the Year Ended December 31, 2019 of the Condition and Affairs of the Sanford Health Plan of Minnesota. Page 26.8. [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={F8FB8121-C8AA-4812-9712-473A94BD7E30}

- 2021 and 2022: Sanford Health Plan of Minnesota received $0.5 million in 2021 and $6 million in 2022 in the form of a capital infusion from Sanford Health to satisfy Sanford Health Plan of Minnesota's minimum capital requirements.[65]

UCare Minnesota

- 2022: "UCare Minnesota formed UCare Iowa, a nonprofit HMO with UCare Minnesota as its sole corporate member," and contributed $5.5 million in capital "to establish initial capital required by the Insurance Commissioner of Iowa."[66]

Health Insurance Companies

- 2021: United Health Group Incorporated and United HealthCare Services, Inc. (for-profit) purchased PreferredOne Insurance Company (for-profit) and all of its subsidiaries, with the exception of PreferredOne Community Health Plan (PCHP), whose HMO license was acquired by UCare Minnesota.[67]

[65] NAIC Health Annual Statement for the Year Ended December 31, 2022 of the Condition and Affairs of the Sanford Health Plan of Minnesota. Page 26.15. [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={AE98E587-E8BC-47C8-9972-88D45F14EE57}

[66] NAIC Health Annual Statement for the Year Ended December 31, 2022 of the Condition and Affairs of the UCare Minnesota. Page 26.3. [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={9B0AA21E-5C27-443D-AB2D-4F0E6FE63376}

[67] Snowbeck C. Star Tribune. UnitedHealthcare Acquires Golden Valley-based health plan PreferredOne. August 16, 2021. https://www.startribune.com/unitedhealthcare-acquiring-golden-valley-based-preferredone/600088298/

Appendix C: Holding Company Structures

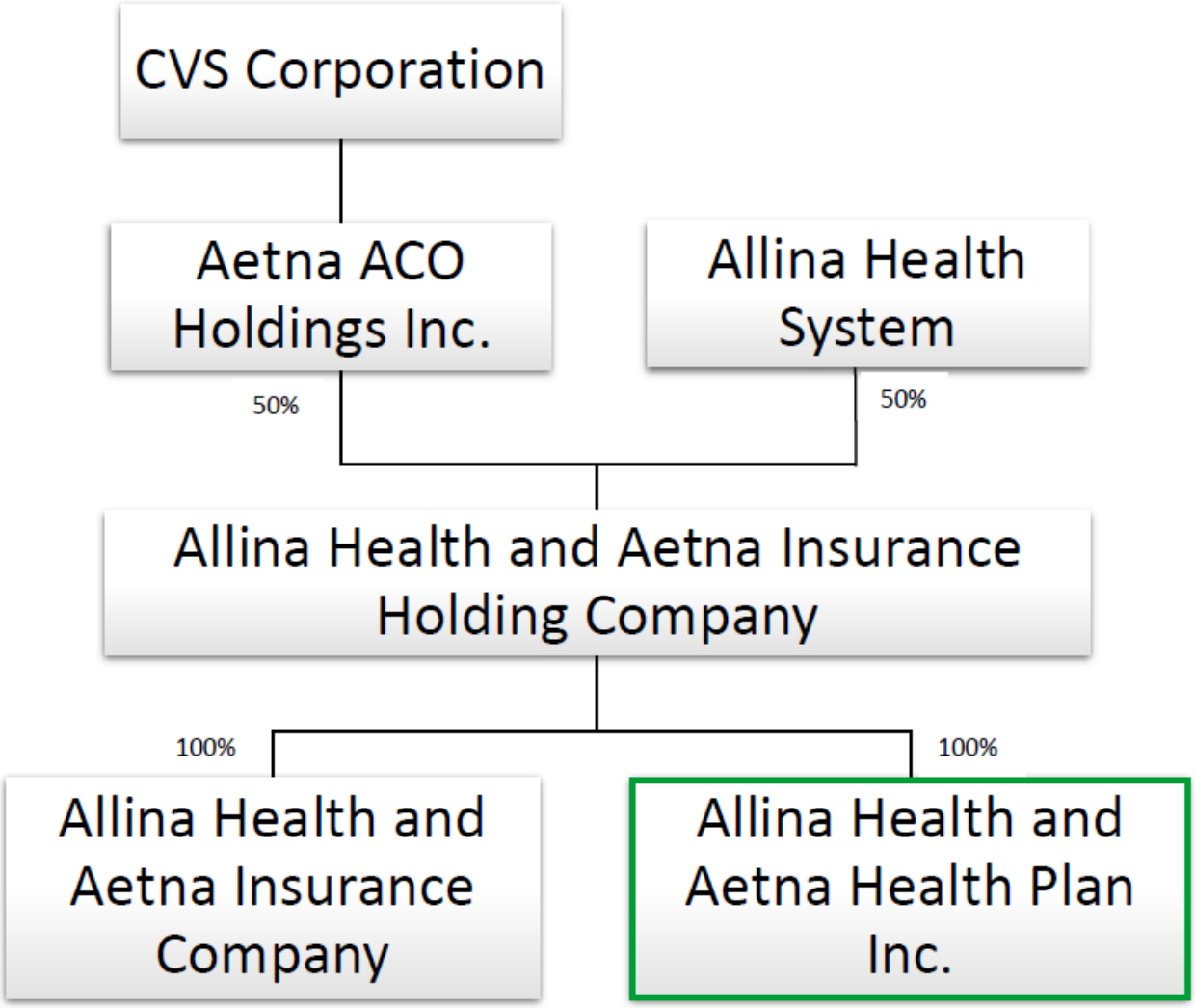
The following Appendix provides diagrams of each HMO's holding company structure, as of December 31, 2022, unless otherwise noted:

- Allina Health and Aetna Health Plan, Inc.
- Group Health Plan, Inc. and HealthPartners, Inc.
- Hennepin Health
- HMO Minnesota dba Blue Plus
- Humana Wisconsin Health Organization Insurance Company
- Medica Health Plans and Medica Community Health Plan
- PreferredOne Community Health Plan
- Quartz Health Plan MN Corporation
- Sanford Health Plan of Minnesota
- UCare Minnesota
- United Healthcare of Illinois, Inc.

HMOs of interest in each structure are identified with a green bolded box around the company name.

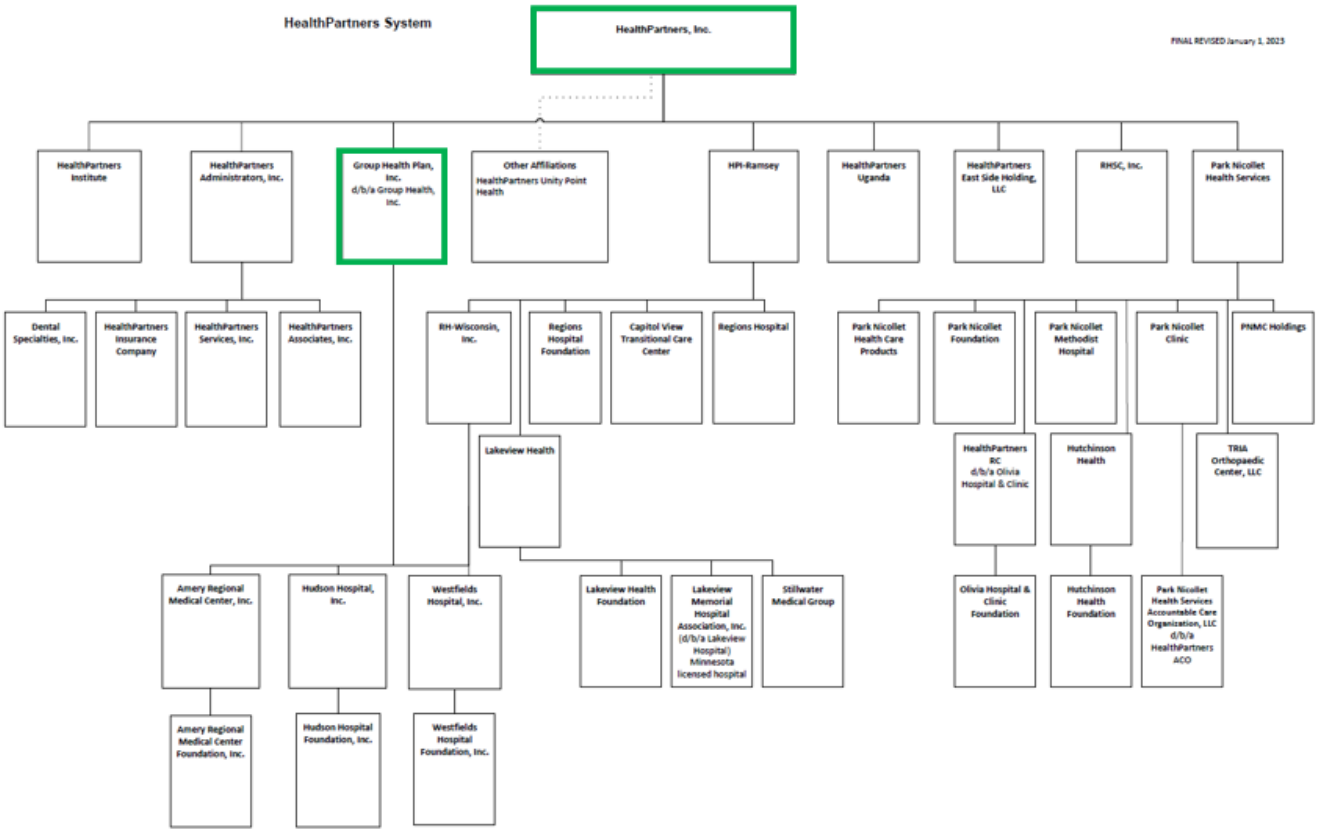
HMOs of Interest

Allina Health and Aetna Health Plan, Inc.



Source: MDH organizational chart based on communication with Allina Health and Aetna Health Plan, Inc. as of January 18, 2024; provided on January 18, 2024.

Group Health Plan, Inc. and HealthPartners, Inc.[68]



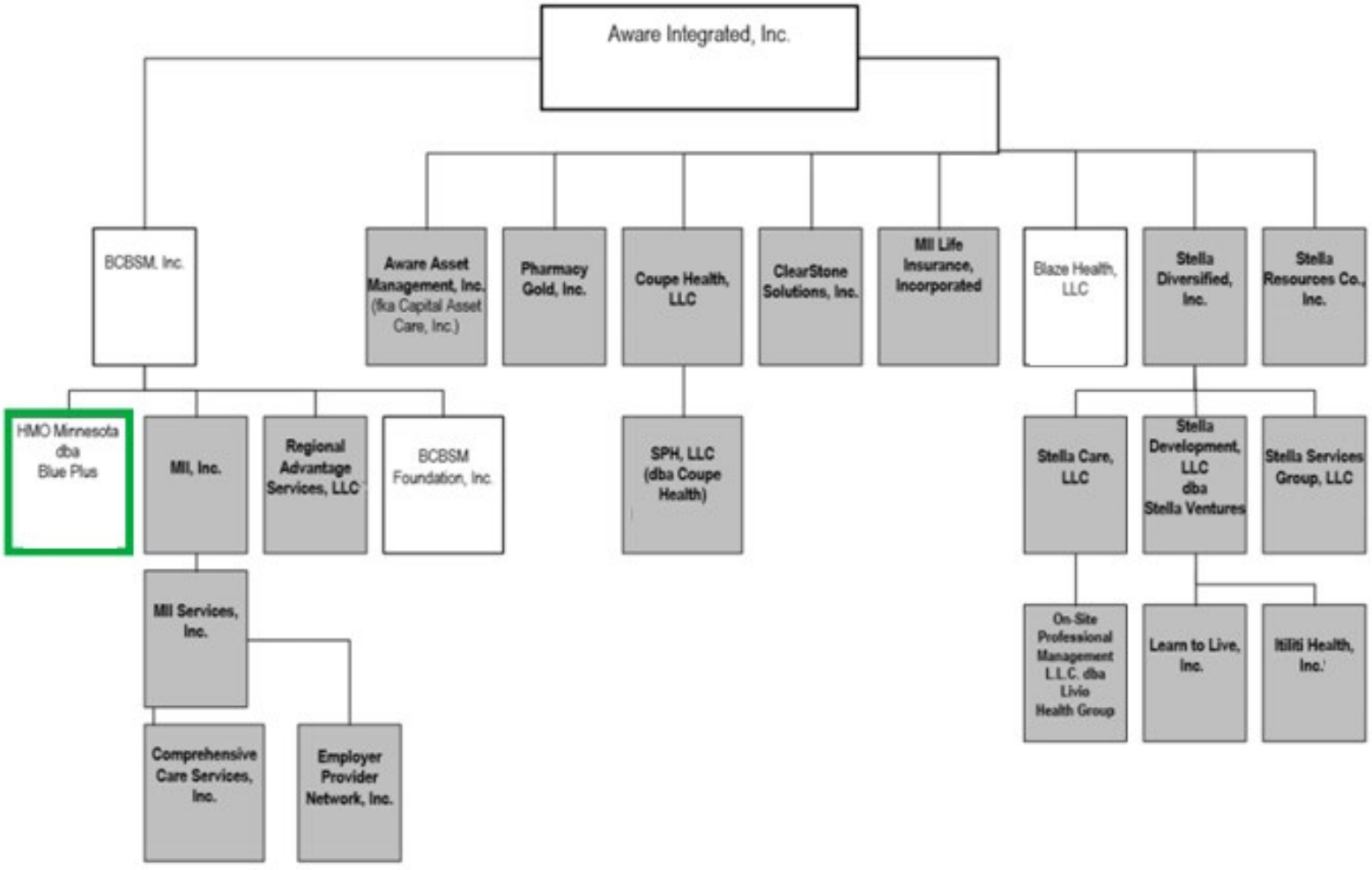
Source: HealthPartners, Inc. revised organizational chart as of January 1, 2023; provided on January 23, 2024.

[68] Group Health Plan, Inc. surrendered its HMO license in Minnesota effective January 1, 2024. Group Health Plan, Inc. executed an assumption agreement with its parent company HealthPartners, Inc. to consolidate all its HMO Individual business under one license (HealthPartners, Inc.).

Hennepin Health

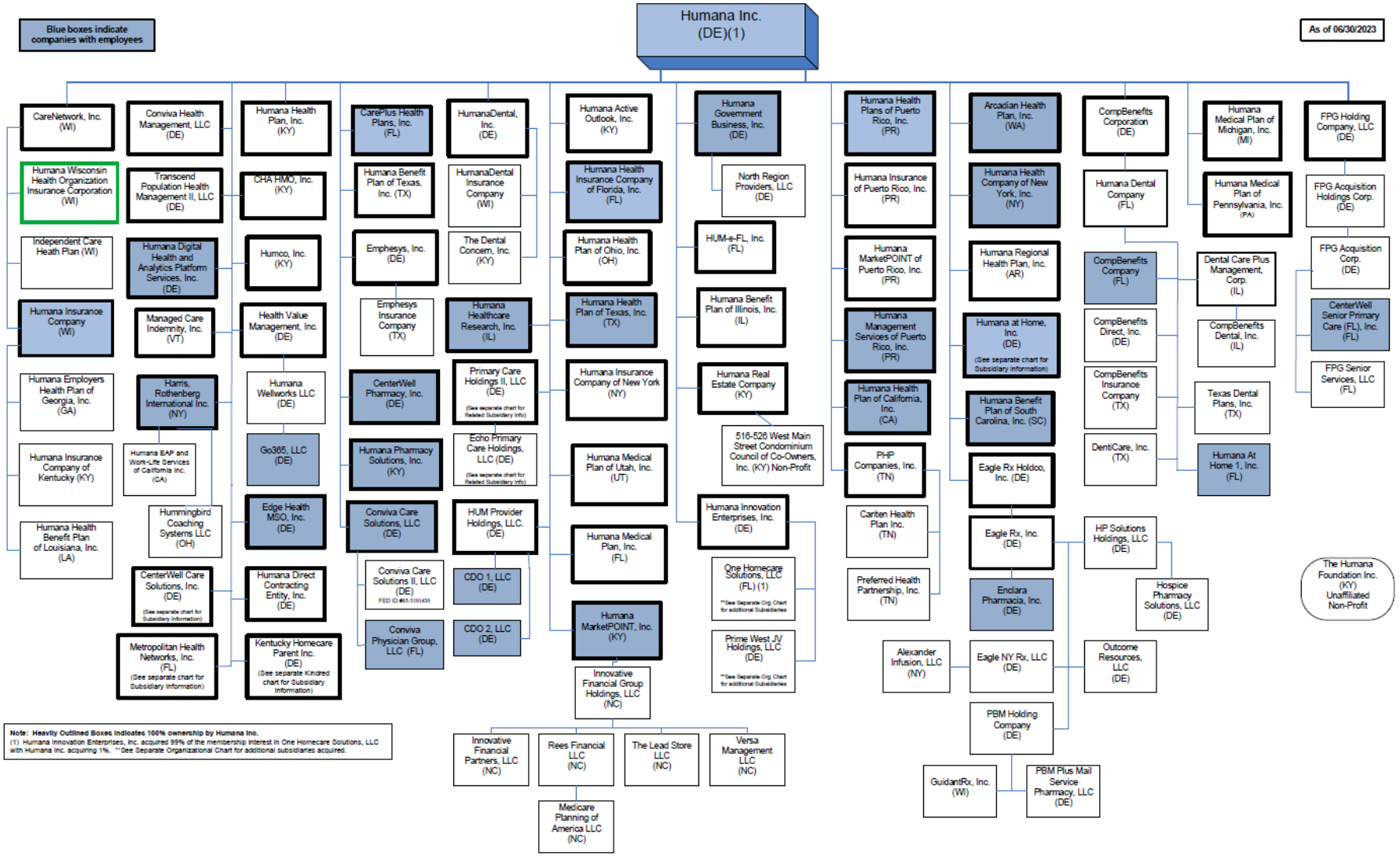
Hennepin Health is directly owned through Hennepin County. As a result, there is no corporate ownership diagram.

HMO Minnesota dba Blue Plus



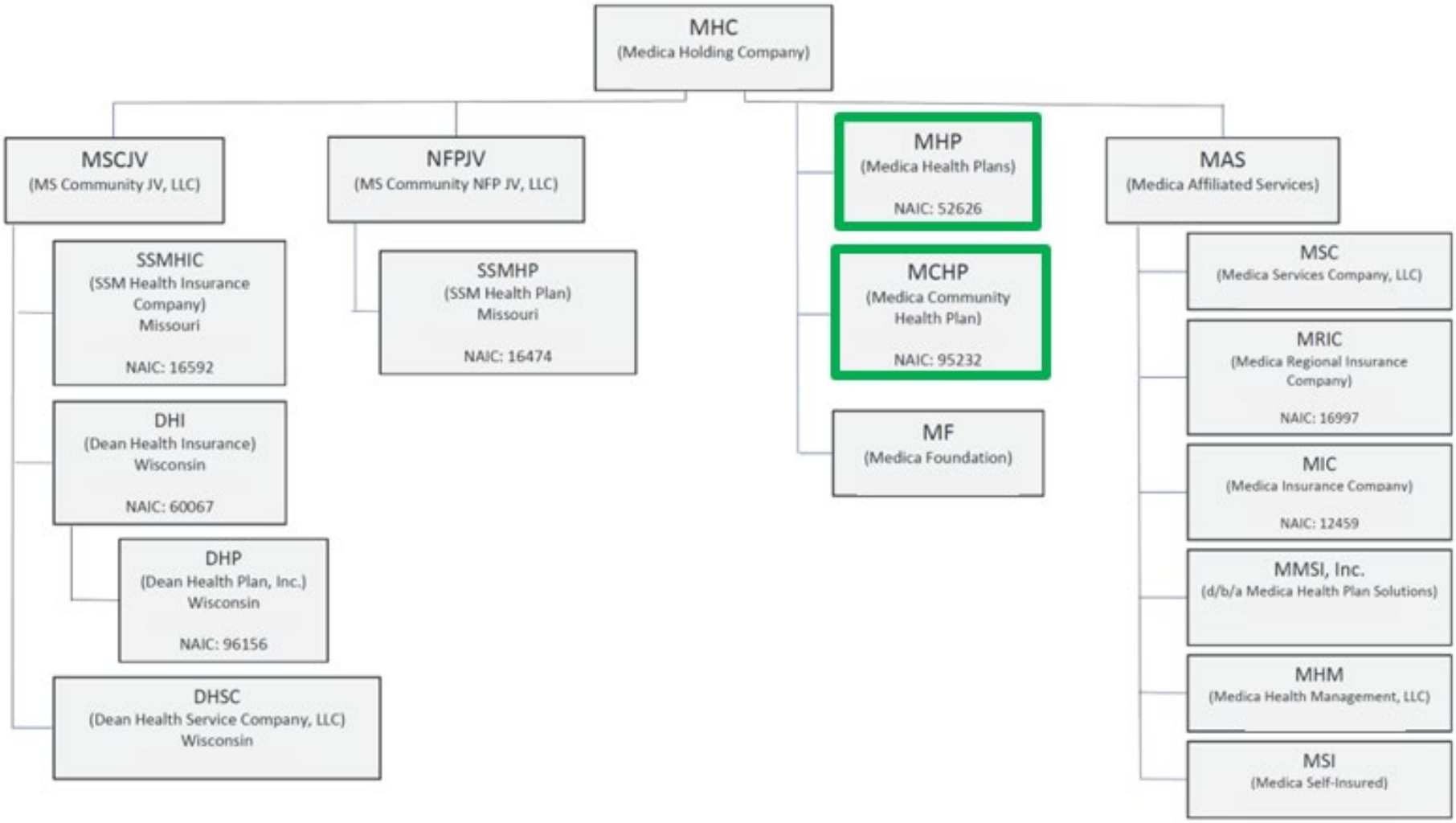
Source: [NAIC Health Annual Statement for the Year Ended December 31, 2022 of the Condition and Affairs of the Blus Plus [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={76BBB4A6-B13E-4403-8DAB-874B2FBBB6E9}]

Humana Wisconsin Health Organization Insurance Company



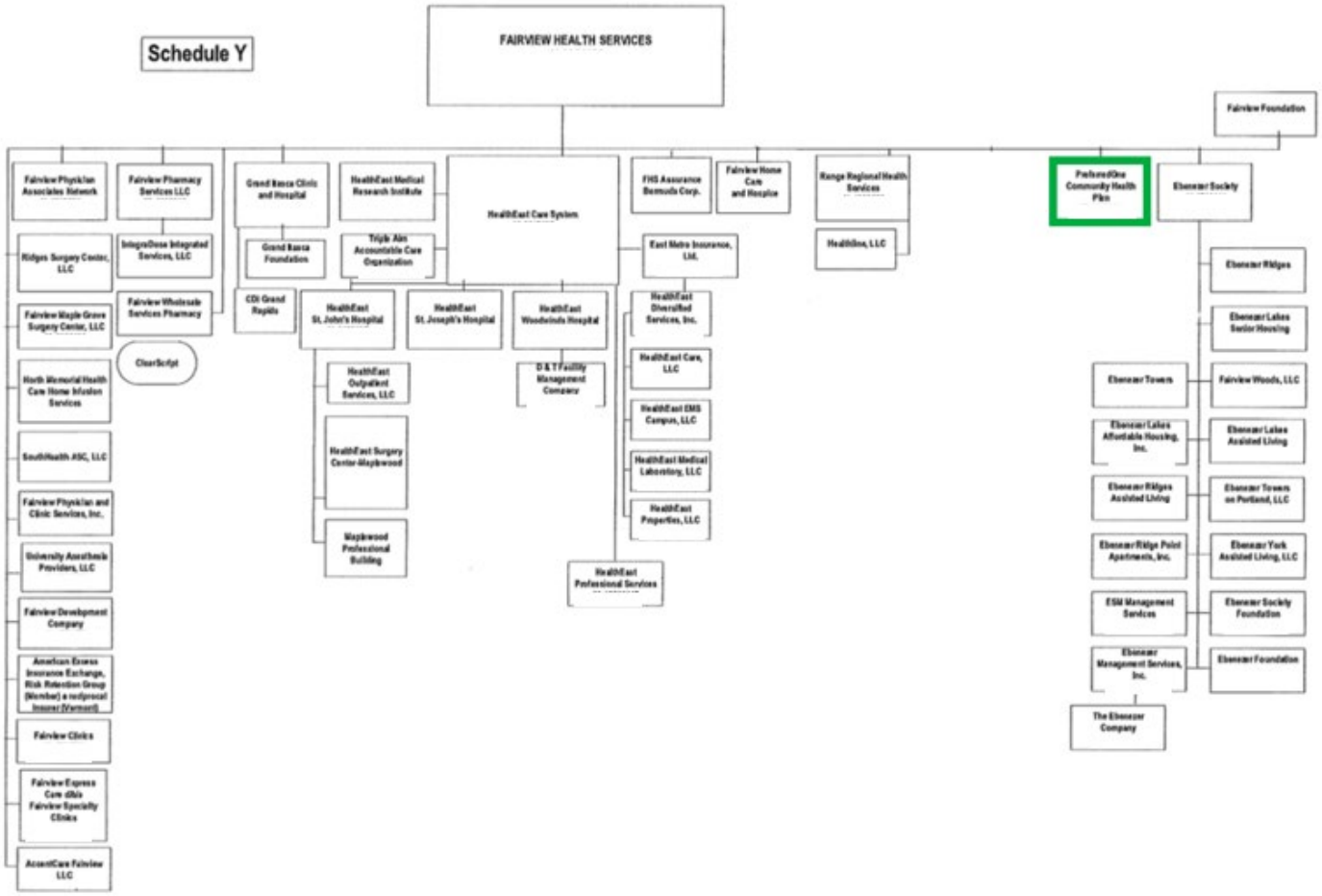
Source: Humana Wisconsin Health Organization Insurance Company organizational chart as of June 30, 2023; provided on January 19, 2024.

Medica Health Plans and Medica Community Health Plan



Source: NAIC Health Annual Statement for the Year Ended December 31, 2022 of the Condition and Affairs of the Medica Health Plans [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={7CC669B4-7E27-4B77-9C5E-2A664A5D32C5}

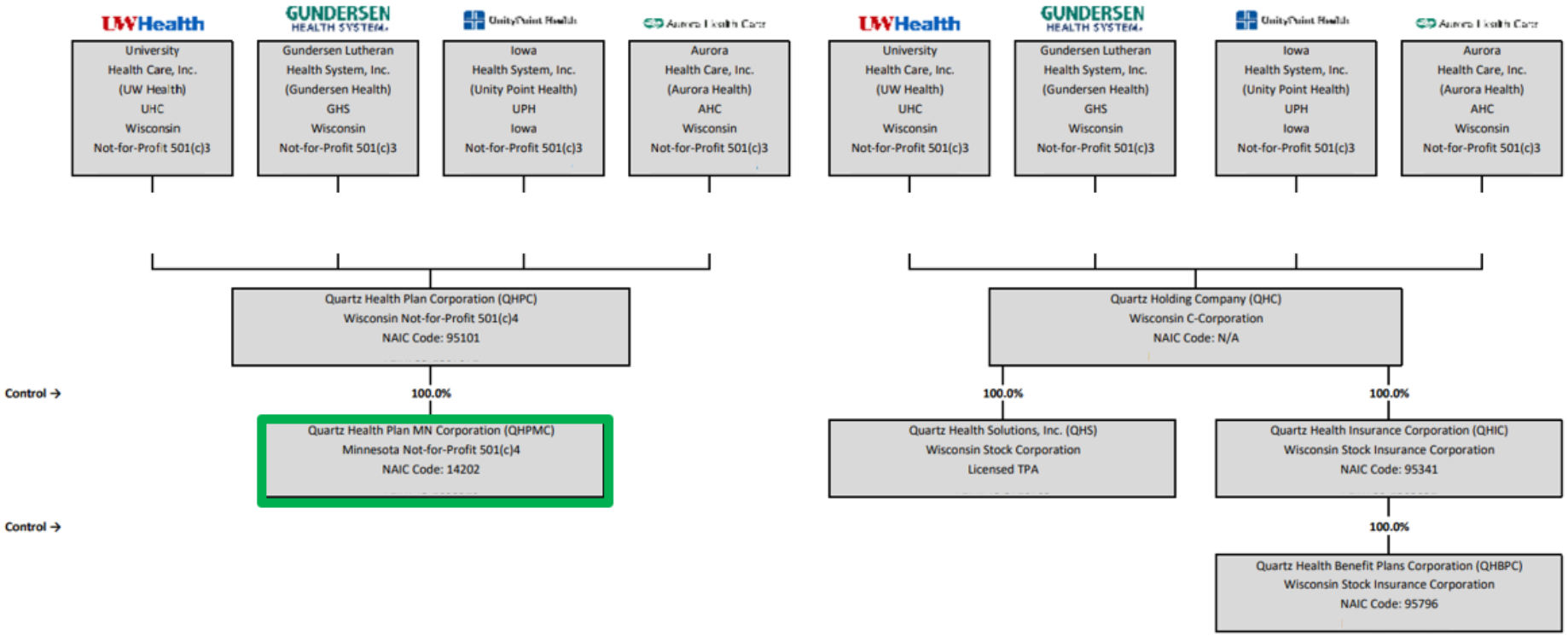
PreferredOne Community Health Plan[69]



Source: PreferredOne Community Health Plan organizational chart as of December 31, 2021. NAIC Health Annual Statement for the Year Ended December 31, 2021 of the Condition and Affairs of the PreferredOne Community Health Plan [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={0970D543-FE6E-4E55-BEE0-0568EA7E88F0}

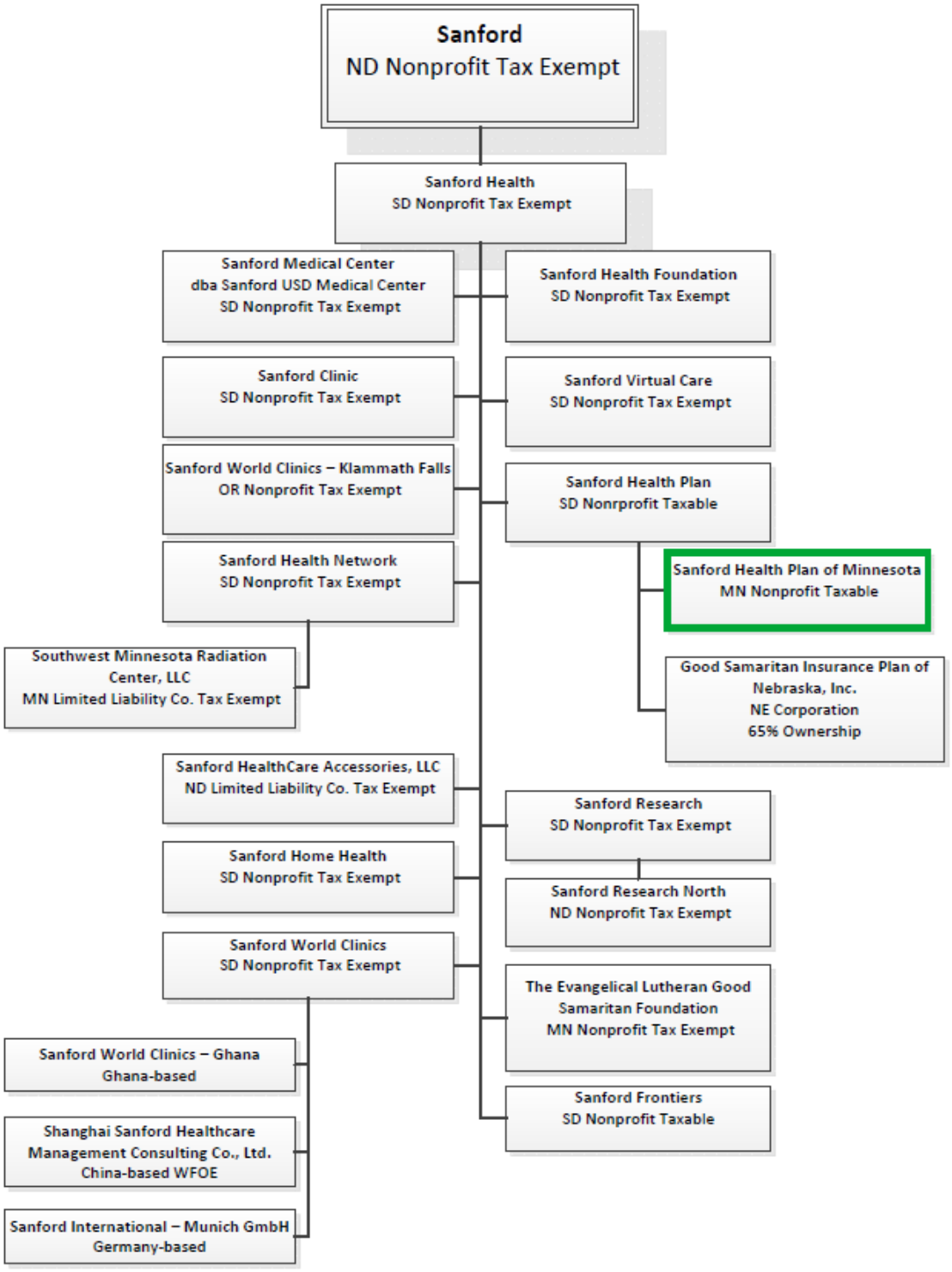
[69] PreferredOne Community Health Plan (PCHP) exited the commercial market in December 2021.

Quartz Health Plan MN Corporation



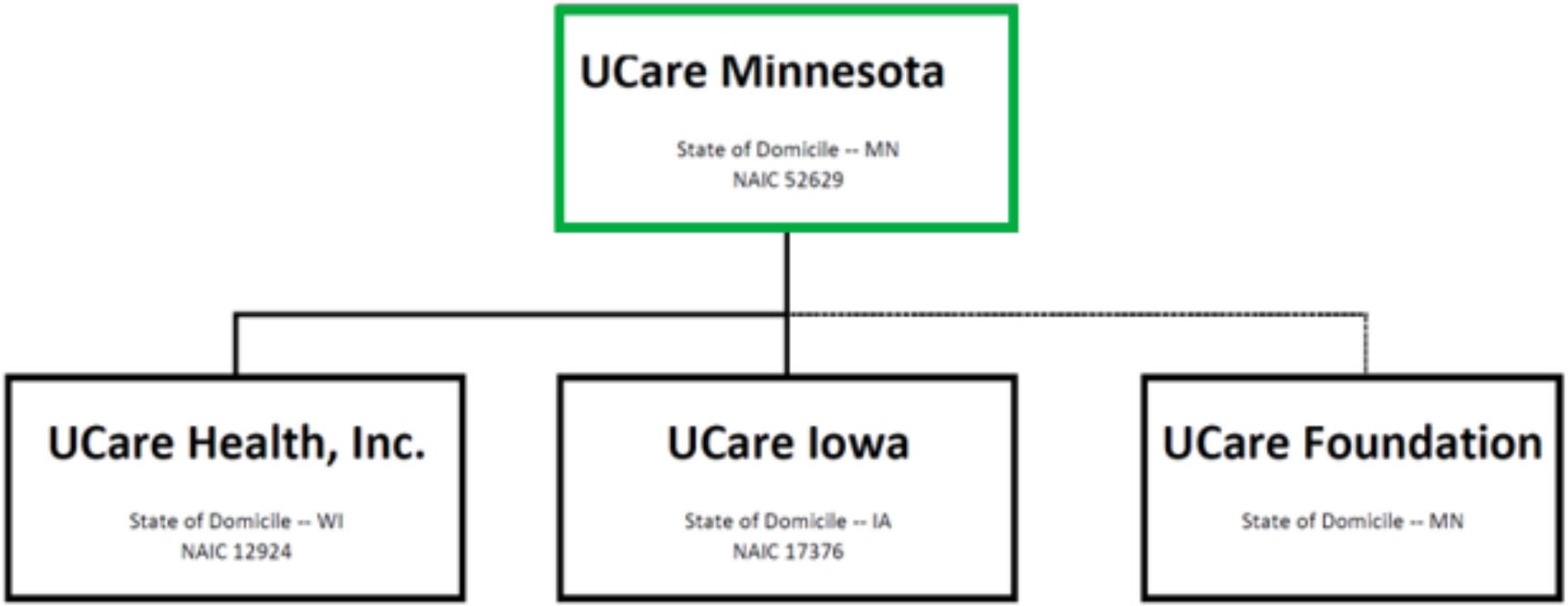
Source: [NAIC Health Annual Statement for the Year Ended December 31, 2022 of the Condition and Affairs of the Quartz Health Plan MN Corporation [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={5B83FA91-554B-4849-9AC7-6942C0BC01F9}]

Sanford Health Plan of Minnesota



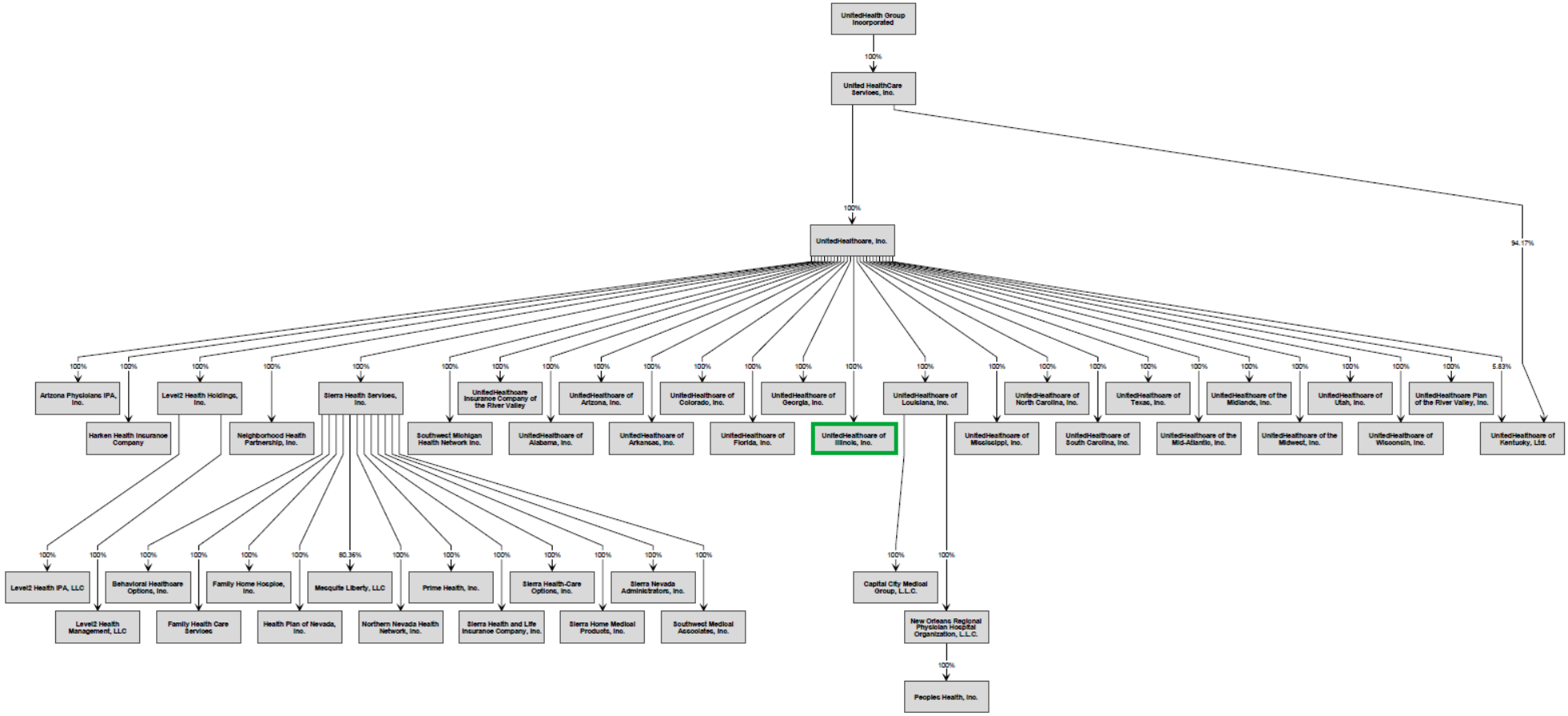
Source: Sanford organizational chart as of December 31, 2023; provided on January 19, 2024.

UCare Minnesota



Source: NAIC Health Annual Statement for the Year Ended December 31, 2022 of the Condition and Affairs of the UCare Minnesota [PDF] www.cards.commerce.state.mn.us/security/search.do?documentId={9B0AA21E-5C27-443D-AB2D-4F0E6FE63376}

United Healthcare of Illinois, Inc.



Source: truncated organizational chart provided by United Healthcare of Illinois, Inc. as of January 22, 2024; provided on January 22, 2024.

Appendix D: Health Care Entity Transactions

The Attorney General's Office has authority to take action to enjoin a transaction involving at least one health care entity from being executed if it does not comply with the public interest and other requirements of Minnesota Statutes, section 145D.01. Unlike Minnesota Statutes, section 317A.811, giving authority for the Attorney General to regulate nonprofits, only when a transfer of "all or substantially all" of an entity's assets are involved, a broader variety of transactions are included in Minnesota Statutes, section 145D.01. Wholesale merger or exchange and creation of a new health care entity trigger the provision. In addition, several other conditions may qualify including a lower 40% threshold which may be measured by 40% of total assets of an entity, 40% of shares of an entity, 40% change of membership, etc. The provisions apply to not only Minnesota-domiciled entities, but any health care entity licensed or operating in Minnesota. A "transaction" may include a series of transactions which occur within a five-year period that reach the 40% threshold when combined. Charitable Health Maintenance Organizations (HMOs) may be subject to both the Minnesota Statutes, section 317A.811 and Minnesota Statutes, section 145D.01 provisions.

While notice requirements under Minnesota Statutes, section 317A.811 focus on the financials of the entities and the preservation of charitable assets, Minnesota Statutes, section 145D.01 notice requirements include further disclosures about the potential market impacts of the transaction, including geographic service areas impacted, plans for the impacted workforce, and competitive impacts. The notice and waiting period under Minnesota Statutes, section 145D.01 are also longer, at 60 days with a potential 90-day extension. The longer notice period allows more time to review and to better account for the complexity of health care transactions and assess the impact of the transaction on public health, access to affordable and quality health care, health care costs, and other potential public interest impacts named in the law. This review timeline is also longer in order to facilitate opportunities for public input through public listening sessions, which are explicitly required in the law.

The provisions of Minnesota Statutes, section 145D.01 are an important tool to monitor the types of transactions that do not occur all at once, but rather involve a transformation of an entity or partnership over time. Many types of corporate structuring described above may be completed in a series of smaller transactions, with only a final transaction of "substantially all" assets resulting in a Minnesota Statutes, section 317A.811 notification (and even then, only for charitable organizations). However, because the provision is primarily meant to monitor and evaluate transactions involving health care entities, many transactions that occur completely outside of a structure involving health care entities, such as between insurance companies and HMOs, will not be subject to Minnesota Statutes, section 145D.01.

The Attorney General's powers are not limited to situations in which they receive notice under Minnesota Statutes, chapter 317A or Minnesota Statutes, chapter 145D. However, the notice provisions are important not only for awareness, but for the office to be able to intervene at an early phase if a transaction may not be in the public interest. If a nonprofit disposes of assets in such a way that notice is not required, the office may never learn about the transaction or may learn about it much later.

Sitting alongside Minnesota Statutes, section 145D.01, new requirements in Minnesota Statutes, section 145D.02 establish a requirement for reporting of certain transactions only to the Minnesota Department of Health (MDH) involving smaller health care entities, where at least one entity, or the entity resulting from the transaction, has annual revenue between $10 million and $80 million.[70] For these transactions, notice is required at least 30 days before the proposed completion date of the transaction, though aside from providing notice, MDH does not have authority to take action to stop the transaction from taking place. The reporting of these transactions provides sightlines into health care provider and systems consolidation in the marketplace.

[70] Information on the Minnesota Department of Health's reporting requirements can be found here: https://www.health.state.mn.us/data/mrktoversight/notices.html

Appendix E: HMO Study Public Input

The Minnesota Department of Health (MDH) requested information from the public about Health Maintenance Organization (HMO) nonprofit to for-profit conversions. Information was gathered through a Request for Information (RFI). The RFI included questions about the value and behavior of HMOs, limitations or conditions that could be put on conversions, what information and input the public should have about potential conversions, and which nonprofit HMO assets may have come from public funds. The actual RFI questions are below; it was not necessary for the public to provide a response to all questions.

Request for Information (RFI)

Value and Behavior of Nonprofit HMOs

1. What value does nonprofit status of an HMO bring and is it important? Why or why not?
2. In what ways do nonprofit HMOs act or function differently than for-profit HMO's?
3. Are there standards of community value or benefit that HMOs (nonprofit or for-profit) should be held to? If so, what should they be?
4. Should for-profit HMOs be regulated differently than nonprofits? In what ways? (Examples: Tax structure, community benefit requirements, licensing fees, etc.)
5. Should state regulatory policies incent or support HMOs to be/stay nonprofit?

Conversion Limitations or Conditions

6. Should any conditions be placed on nonprofit to for-profit conversions? (Examples: charitable asset limits, funding dedicated to a specific purpose, etc.)
7. Are there any situations or conditions under which a conversion should not be allowed?

Transparency and Public Input

8. Should enrollees of the HMO, or the public, be notified about a potential conversion? If so, at what point?
9. What information should the HMO be required to provide to the public or to enrollees about a potential conversion?
10. Should the public, or enrollees, be allowed to provide input into the potential conversion? If so, what should that process look like?
11. What kinds of post-conversion information should be monitored?
12. What post-conversion information should be public?

Public Benefit Assets of HMOs

13. What assets of an HMO should be considered as public benefit? Why?
14. Who should make the determination on what assets are for public benefit?
15. How should assets of a nonprofit HMO be managed during or after a transfer (conversion) to for-profit status?
16. Should there be restrictions placed on the use of public benefit assets during or after a transfer (conversion) to a for-profit HMO?

General

17. What else is it important for MDH to know or consider, as we make recommendations on conversion of HMOs?
18. Do you have any other comments?