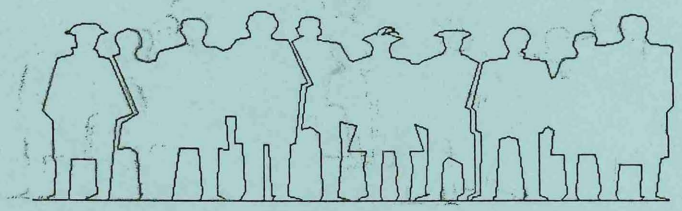
GOVERNOR'S COMMISSION ON HEALTH PLAN REGULATORY REFORM



Resource Materials
January - December, 1988

STATE OF MINNESOTA

GOVERNOR'S COMMISSION ON HEALTH PLAN REGULATORY REFORM

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Commission's
Origin and Charge

GOVERNOR'S COMMISSION ON HEALTH PLAN REGULATORY REFORM

Charge to the Commission

Minnesota's health care marketplace has changed greatly in recent years, with rapid growth of HMOs, development of "preferred provider" insurance, and increased incentives for health care providers to control costs. These and other changes have raised questions about whether the state's health plan company regulations have kept pace with the marketplace.

Ideally, health plan company regulations should afford consumers all necessary protections, but should not unnecessarily impede price and quality-based competition. Concerns about consumer protections arise as health plan companies assume new kinds of responsibilities, such as insurer involvement in managing health care delivery, and HMO involvement in insurance. Concerns about equity are raised by differences in the regulatory treatment of different types of health plan companies, insofar as those differences may place certain types of companies at a competitive advantage or disadvantage.

In light of these concerns, and to assist development of a regulatory structure for the 1990's, the Governor's Commission on Health Plan Regulatory Reform is charged:

(1) To evaluate state regulations governing health plans and health plan companies, in light of current conditions and trends in the health care marketplace, and the goals of consumer protection and equitable competition.

(2) To report to the Governor and the Legislature by January 1, 1989 with recommendations for improvements in state regulations concerning health insurers, non-profit health service plan corporations, health maintenance organizations, and other types of health plan companies.

This act is effective the day following its final enactment.

Approved June 2, 1987

CHAPTER 370—H.F.No. 1112

An act relating to human services; creating client advisory committees; defining the term "vendor of medical care" for medical assistance, authorizing the commissioner to examine records, providing for a study for a Minnesota institute of health; creating a commission on health plan regulatory reform; regulating public assistance liens; appropriating money; amending Minnesota Statutes 1986, sections 62A.046; 176.191, subdivision 4; 214.06, subdivision 1; 256B.02, subdivision 7, and by adding a subdivision; 256B.042, subdivisions 2, 3, and by adding subdivisions; 256B.064, subdivision 1c; 256B.27, subdivisions 3 and 4; 256B.37, subdivisions 1, 2, and by adding subdivisions; 256D.03, by adding a subdivision; 259.40, subdivisions 1, 2, and 3; 268.121; 473.405, subdivision 13; 514.69; proposing coding for new law in Minnesota Statutes, chapters 252 and 256.

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

ARTICLE 1

Section 1. Minnesota Statutes 1986, section 214.06, subdivision 1, is amended to read:

Subdivision 1. Notwithstanding any law to the contrary, the commissioner of health as authorized by section 214.13, all health-related licensing boards and all non-health-related licensing boards shall by rule, with the approval of the commissioner of finance, adjust any fee which the commissioner of health or the board is empowered to assess a sufficient amount so that the total fees collected by each board will as closely as possible equal anticipated expenditures during the fiscal biennium, as provided in section 16A.128. For members of an occupation registered after July 1, 1984 by the commissioner of health under the provisions of section 214.13, the fee established must include an amount necessary to recover, over a five-year period, the commissioner's direct expenditures for adoption of the rules providing for registration of members of the occupation. All fees received shall be deposited in the state treasury. Fees received by health-related licensing boards must be credited to the special revenue fund. Any balance remaining in the special revenue fund at the end of each fiscal year, after payment of health-related licensing board expenses including salaries, attorney general fees, and indirect costs, must be credited to the public health fund.

Sec. 2. [252.33] **CLIENT ADVISORY COMMITTEES.**

Subdivision 1. **DEFINITION.** For purposes of this section, the following terms have the meanings given:

tive parents or subsequent guardian or conservator at any time. When the commissioner determines that a child is eligible for adoption assistance under Title IV-E of the Social Security Act, United States Code, title 42, sections 670 to 676, the commissioner shall modify the subsidy agreement in order to obtain the funds under that act.

Sec. 10. **FEASIBILITY STUDY.**

The director of the state planning agency in cooperation with the commissioner of health may study the feasibility of a Minnesota institute for health research. Among the factors to be considered in this study are: clinical and community resources now existing in the state, methodology for the development of a health research institute, and components toward which an institute would direct its resources. No state funds may be expended for this purpose. The director of the state planning agency is authorized to accept and expend nonstate funds for this purpose and shall report to the legislature by January 1, 1989, on any study undertaken.

Sec. 11. **COMMISSION ON HEALTH PLAN REGULATORY REFORM.**

Subdivision 1. **PURPOSE.** The legislature finds that the present rapid development of new health plan products and arrangements may result in a situation in which consumer protection and equitable competition may be inadvertently impaired by statutes or rules adopted to address previously existing market conditions. The legislature further finds that it is desirable that existing regulatory requirements for health plans be reviewed in the light of recent and potential future changes in the types of health plans available to purchasers.

Subd. 2. **CREATION AND MEMBERSHIP.** The governor shall create a commission on health plan regulatory reform for the purpose of reviewing and making recommendations for any necessary improvements in state policy relating to the regulation of health insurers, nonprofit health service plans, health maintenance organizations, preferred provider organizations, and other arrangements that insure or finance the provision of health services.

The commission membership shall be as follows:

(1) the director of the state planning agency, or the director's designee, who shall chair the commission;

(2) two members from the senate of the state of Minnesota, one from the majority party and one from the minority party;

(3) two members from the house of representatives of the state of Minnesota, one from the majority party and one from the minority party;

(4) the commissioner of commerce, or the commissioner's designee;

(5) the commissioner of health, or the commissioner's designee;

(6) two members representing a health maintenance organization;

(7) one member representing a nonprofit health service plan;

(8) one member representing a health plan that is not a health maintenance organization or a nonprofit health service plan;

(9) one public employer;

(10) two private employers, one of whom self-insures for health benefits and one of whom offers health benefits to employees but does not bear risk;

(11) one member representing organized labor; and

(12) two natural persons who are consumers.

Subd. 3. **REPORT.** The commission shall perform the review specified in subdivision 2 and report to the governor and the legislature by January 1, 1989.

Subd. 4. **APPROPRIATION.** $25,000 is appropriated from the general fund to the commissioner of health for the purposes of this section. This appropriation is available only to the extent that it is matched on a dollar for dollar basis by contributions from the private sector. Pursuant to interagency agreement, the commissioner shall transfer appropriate portions of this amount to the state planning agency and the commerce department to support the staffing of the commission.

Sec. 12. **APPROPRIATION.**

$70,000 is appropriated from the general fund to the commissioner of jobs and training for developing client advisory committees under section 2.

$300,000 is appropriated to the commissioner of human services from federal reimbursement received as a result of the title IV-E foster care program to increase federal financial participation, to be distributed in fiscal year 1988 to counties that received Indian relief payments in fiscal year 1986 under section 245.76. The reimbursement must be allocated to the counties in the same proportion as the distribution of Indian relief payments in fiscal year 1986 under section 245.76.

Sec. 13. **EFFECTIVE DATE.**

Section 1 is effective June 30, 1987.

Commissioners

Governor's Commission on Health Plan Regulatory Reform
January - December 1988
Commission Members

Representing	Appointee
Director of State Planning Agency	Lani Kawamura, Chair
Minnesota Senate	Senator Linda Berglin
	Senator Howard A. Knutson
Minnesota House of Representatives	Representative David B. Gruenes
	Representative Ann Wynia
Commissioner of Commerce	Michael A. Hatch
Commissioner of Health	Sister Mary Madonna Ashton
Health Maintenance Organizations	George C. Halvorson Group Health
	Jan K. Malcolm MedCenters Health Plan
Nonprofit Health Service Plans (HSP)	Lois Wattman Blue Cross and Blue Shield of MN
Preferred Provider Organizations	Richard Frey, M.D. ???
Health Plans other than HMO or HSP	John G. Turner Northwestern National Life
Public Employers	Robert Cooley Department of Employee Relations
Insured Private Employers	John Reiling HealthEast
Self-Insured Private Employers	Lawrence Schwanke Bemis Company
Organized Labor	Dan W. Gustafson AFL-CIO
Consumers	Carl Carlson Metropolitan Senior Federation
	Kip Sullivan Minnesota COACT

GOVERNOR'S COMMISSION ON HEALTH PLAN REGULATORY REFORM

Mandated Health Care Benefits in Minnesota

- *Are mandates a necessary regulatory action to assure adequate health coverage, or will consumer demand achieve acceptable results?*
- *If Minnesota elects to continue mandating a specific level of care, what type and level of care should be required to be included in health policies?*
- *Should Minnesota establish a process for evaluating the social and financial implications of current and proposed mandates?*
- *Do mandated benefit laws inhibit small employers from providing health coverage?*
- *Should the regulatory playing field be leveled with respect to mandates so that all health plans are subject to the same mandates?*
- *Should individual and group policies be subject to the same mandates?*
- *Should the state retain qualified plan standards?*

Introduction

Mandated benefits may be defined as specific health benefit coverage required by a state to be included in health benefit policies issued or renewed in the state. Although the federal government has recently enacted certain health benefit mandates, the regulation of the content of health benefit plans through mandated benefit laws has traditionally been performed by the states.

State legislatures have used mandates to require coverage for specific diseases, expand coverage for the services of health professionals previously excluded from insurance coverage and prevent gaps in coverage due to a change in family or employment relationships. Mandated benefit laws increase the availability of health services to the public without directly increasing the consumer's tax burden. This off-budget ability to achieve social goals and increase health benefits is widely viewed as one of the most attractive features of mandated benefit laws.

The movement to mandate specific health benefits began in the 1960's. According to figures supplied by the Blue Cross and Blue Shield Association, state legislatures had enacted approximately 30 separate mandates by 1970. By the end of 1986, the number of total mandates enacted by all fifty states plus the District of Columbia had reached 645.

This rise in the number of mandates has resulted in increased concern on the part of employers, insurers and government as to the relationship between mandates and the rising costs of health care. In 1986, fewer mandates were enacted by state legislatures than at any time since 1972. In addition, nine states now require some type of cost-benefit

analysis prior to the enactment of new or expanded mandates.

Mandated benefit laws differ in their purpose and scope. There are essentially four categories of mandated benefits in Minnesota. Minnesota mandates coverage of specific diseases (e.g., TMJ, PKU, DES-related conditions, chemical dependency), the direct payment of specific providers (e.g., chiropractors, podiatrists), the coverage of specific classes of dependents (e.g.,newborns, adopted children, handicapped children) and continuation and conversion rights upon loss of coverage.

The current debate over mandated benefits has generally focused on disease and provider mandates. It is this category of mandates that many critics claim results in uncontrolled increases in health care costs. Dependent coverage mandates have not generated a great deal of controversy, in part because the number and scope of such mandates are inherently limited. Continuation and conversion mandates have often been criticized. However, the enactment of the federal continuation requirements (COBRA) has limited a state's ability to substantially revise or mend these types of mandates. As a result, this analysis will focus primarily on disease and provider mandates. Dependent coverage and continuation issues will be discussed in a later policy paper.

Summary of Minnesota's Mandated Benefits Program

Minnesota has been quite prolific in its use of mandated benefits; over 30 mandates are currently "on the books." These mandates are contained in four separate chapters in Minnesota Statutes. (Chapters 62A, 62C, 62D and 62E). Chapters 62A, 62C and 62D correspond to the different statutory schemes regulating insurance companies, health service plans and health maintenance organizations. Chapter 62E sets forth the requirements of a "qualified plan" and establishes the Minnesota Comprehensive Health Association.

Insurance companies, health service plans and HMOs are not subject to the same mandates. In general, HMOs are subject to more mandates than insurers and health service plans. An HMO is the only health plan required to provide "comprehensive health maintenance services." These services include emergency care, inpatient hospital care, physician care and preventive care. In addition, HMOs are more limited than other health plan companies in their ability to limit access to certain services through the use of copayments and deductibles.

In contrast, health service plans and insurers are required to reimburse a variety of ancillary providers which an HMO may elect not to cover. For example, insurers and health service plans are required to provide reimbursement for the care provided by podiatrists and chiropractors, a requirement not applicable to HMOs. While HMOs are not required to cover the services of particular types of providers, HMOs must cover all medically necessary services.

Mandates may also differ between health plan companies with respect to the same disease or treatment. For example, all health plan companies are required to provide a minimum level ofinpatient chemical dependency coverage. With respect to outpatient chemical dependency coverage, only health service plans and insurers are required to cover 130 hours of outpatient treatment per year. HMOs are permitted to limit coverage for outpatient chemical dependency and thereby provide less than 130 hours of coverage. With respect to mental health treatment, only HMOs are required to provide a minimum level of inpatient coverage; insurers and

health service plans have no similar requirement.

The current mandate structure also distinguishes between group and individual policies. In general, fewer mandates apply to individual policies. For example, maternity benefits, chemical dependency and outpatient mental health are mandated for group policies only. In addition, some health benefits are mandated for inclusion in the individual policies of only one type of health plan. Insurance companies must include chiropractic benefits in their individual policies; health service plans are required to include chiropractic benefits in their group plans only.

Minnesota health insurers are also subject to "qualified plan" requirements. These requirements are not mandated for inclusion in every policy; insurers are simply required to offer a qualified plan to buyers who satisfy the insurer's underwriting criteria. A large share of insurers' health policies are qualified plans.

A qualified plan must cover a specific range of services including hospital and physician services, prescription drugs, certain home health care, laboratory tests and well baby care. Out-of-pocket expenses and lifetime benefits are capped. Alternative benefits may be provided if they are actuarially equivalent. Insurance policies are certified by the Department of Commerce as #1, #2 or #3 qualified plan or as a non-qualified plan. A #3 qualified plan provides for the least amount of cost sharing between the plan and the enrollee. A HMO policy is statutorily considered a #3 qualified plan. Medicare supplement different scale. For Medicare policies, the highest rating is 1+, followed by 1, 2 or 3.

The qualified plan requirements create a standard against which consumers may measure their health coverage. The actuarial equivalence rules provide for variations between plans. As aresult, the qualified plan requirements do not establish a pro forma policy, but merely create a normative standard against which actual policies may be evaluated.

Arguments For and Against Mandated Benefits

Treatment and provider mandates have been the subject of the greatest degree of analysis concerning the effects of mandated benefits. Critics of provider mandates maintain that such mandates often reflect the needs of special interest provider groups, as opposed to the demonstrated demands of consumers. Several studies have suggested that a newly mandated provider's costs and charges will increase after insurance coverage is mandated. In addition, insurers generally experience an increase in total claims since the new service constitutes an additional, as opposed to a substituted benefit.

Opponents of mandates further argue that mandates eliminate the ability of employers, employees and insurers to tailor a benefits policy to suit their specific needs. Mandates are also criticized for creating a hidden or indirect subsidy for specific treatments and benefits. Critics of mandates also maintain that mandates function as regressive taxing mechanisms whereby low and high income individuals are forced to bear an equal increase in premium cost resulting from mandated services.

Small businesses, in particular, have argued that they are adversely affected by mandates. In general, small businesses maintain that the profit margin of a small business is narrow. Small businesses therefore claim that they are less able to absorb increased premium costs. As a

result, small employers who may wish to offer a minimum health insurance package may elect to offer no health insurance at all.

A decision by a small employer to offer no insurance may result in a large employer "subsidizing" a small employer through the dependent coverage offered by the large employer. Individual employees of small employers who do not offer health insurance may have no option other than individual coverage. Individual coverage is generally more expensive than group coverage and these employees must therefore bear this increased cost. Finally, many individual employees of small employers may elect to completely forego insurance if they cannot afford individual coverage.

Some consumers and regulatory analysts have argued that mandates create an incentive for employers to self-insure, thereby removing a benefit plan from the purview of mandated benefit laws. As a result, mandated benefit laws may actually have the effect of limiting consumer access to certain benefits and decreasing a state's ability to legislate a specific benefit level. In addition, insurers maintain that an employer's decision to self-insure reduces the insurers' risk pool and results in more expensive insurance coverage for those remaining in the insurance marketplace. Finally, insurers argue that the self-insurance trend, with its absence of mandated benefits, creates broad competitive inequities since insurers are not equally free to tailor a benefit plan to satisfy the specific needs of large group purchasers.

Proponents of mandated benefit laws maintain that mandates assure access to needed services and providers and protect consumers against gaps in coverage. Provider mandates are argued to be essential to counter past discrimination against certain ancillary providers, such as chiropractors. Certain treatment mandates are deemed necessary to counteract the unwillingness of many individuals to elect coverage and seek treatment for specific conditions (e.g. mental health). Finally, mandates may alleviate the financial hardship which may be associated with certain treatments by reducing the financial burden on the consumer.

Proponents of mandates also argue that mandated benefit laws may correct certain adverse selection problems by "forcing" both good and bad risks to purchase coverage. Proponents of mandates note that increases in costs reported by insurers after a mandate is enacted may only reflect a shift in the locus of final payment from the individual to the insurer and not a net increase in costs. Proponents argue that insurers' calculations of cost increases do not effectively take into account the costs to society of "sick" people who go untreated because a service is not mandated. In addition, proponents of mandates maintain that an insurer's increase utilization and cost after a mandate can not be proven to result solely from the mandate. Costs may have risen due to an independent increase in demand and an independent increase in the cost of a service. Finally, proponents maintain that it is good public policy for the state to establish an "approved" level of minimum health benefits.

Policy Options

The following paragraphs set forth a number of policy options. Although these options are not mutually exclusive, they may be divided into three major categories. The first category of options is premised on the theory that the marketplace can best determine appropriate benefit levels--current mandates should therefore be repealed or sunsetted. The second category is based on the establishment through mandates of a minimum benefit level. Current mandates which are inconsistent with a minimum level would be repealed or sunsetted. The third category is premised on the retention of the current level of mandates. Current mandated benefit laws could be amended to provide for a mandate evaluation process, clarify cost controls and correct differences in mandated benefit laws between types of health plans and between group and individual contracts.

The Commission may also wish to combine some of these options. For example, specific mandates may be repealed, others may be clarified and mandate differences between health plan companies may be resolved on a limited rather than global basis.

I. Marketplace Determines Benefit Levels.

A. Repeal all or a portion of mandated benefit laws and let the market determine benefit levels.

This option has the advantage of allowing individuals, employers and groups greater freedom of choice in purchasing and designing benefit plans. Fewer mandated benefits may lower premium costs. Some small employers who presently do not offer health insurance may elect to do so if they are able to select a less rich benefit package with a correspondingly lower premium.

The disadvantages of this option are that some individuals and groups may not be able to obtain coverage for certain conditions currently covered. The premium cost of obtaining coverage for certain conditions may actually increase if the number of individuals purchasing coverage for a specific condition decreases. The implementation of any repeal would need to be carefully designed to allow consumers to elect a new benefit plan without loss of coverage for preexisting conditions covered due to current mandates.

Under current law the Minnesota Comprehensive Health Association (MCHA) provides health insurance to persons who cannot obtain insurance through the marketplace. State law provides that MCHA must offer a #1 or #2 qualified plan, a medicare supplement plan and a HMO plan if HMO coverage is available in the area of the state where the enrollee resides. If current mandates and qualified plan requirements are repealed,
the Commission may wish to consider whether the level of benefits offered by MCHA should be statutorily prescribed or determined by the marketplace.

B. Sunset some or all mandated benefit laws and let the marketplace determine benefit levels.

This option has essentially the same advantages and disadvantages as Option A. Sunsetting may allow consumers and insurers to plan for the termination of a mandate. However, other states, most notably Arizona, have found that if a mandate is sunsetted after the next scheduled legislative session, provider groups will marshall all resources to repeal the sunset before it takes effect.

II. Mandate a Minimum Level Benefit Plan.

C. Legislatively determine a "core" minimum benefits package and repeal or sunset all mandates inconsistent with the minimum level or "core" benefits package.

This option has the advantage of retaining a foundation or "core" level of mandated benefits and a state approved benefits package. The primary disadvantage is arguably the difficulty of defining essential minimum benefits. The Kennedy Minimum Access to Health Care for All Workers Act may provide some basic criteria from which to work. It should be noted that if the Kennedy bill were to become law as it is currently drafted, it may preempt the majority of state mandated benefit laws pursuant to the Employee Retirement Income Security Act (ERISA).

III. Amend and Revise Current Mandated Benefit Laws to Correct Perceived Deficiencies.

D. Establish a mandate evalution process to formally evaluate the costs and benefits of proposed mandates.

In 1983 the National Association of Insurance Commissioners (NAIC) developed specific criteria by which to evaluate the social and financial impact of proposed mandates. One year later, inspired by the NAIC criteria, the State of Washington became the first state to enact legislation requiring the systematic review of the financial and social costs associated with a mandated benefits proposal. Similar legislation was introduced in 1985 in the Minnesota Senate but failed to pass.

As of 1988, at least seven states have established a formal process to evaluate proposed mandates. States have modeled their legislation after the Washington statute. The evaluation is conducted primarily by the legislative committee before whom the proposal is introduced. The committee relies on information and analysis provided by proponents and opponents of the mandate.

The social and financial impact of a proposed mandate are assessed using the following criteria:

1. The extent to which the treatment is utilized by a significant portion of the population;
2. The extent to which insurance coverage is currently generally available;
3. The extent to which the lack of coverage results in persons avoiding necessary health care;
4. The extent to which the lack of coverage results in unreasonable financial hardship;
5. The level of public demand for the service;
6. The level of public demand for insurance coverage;
7. The level of interest of collective bargaining agents in privately negotiating for inclusion of the coverage in group contracts;
8. The extent to which the coverage will increase or decrease the cost of the treatment;
9. The extent to which the coverage will increase the appropriate use of the service;
10. The extent to which the mandated treatment will be a substitute for a more expensive treatment;
11. The expected increase or decrease in the administrative costs of insurers and the premiums associated with the mandate;
12. The impact of the mandate on the total cost of health care.

States which have adopted a mandate evaluation process have required the proponent of the mandate to prepare the initial report analyzing the above criteria. A few states have also asked that a state agency comment on the proponent's report or have established an expert panel to provide a separate and independent analysis of the expected impact of the mandate. Washington amended its statute last year to provide that the state health coordinating council oversee the development of the social and financial impact report.

Minnesota has previously adopted an analogous process for the evaluation of applications of human services occupations for state licensing and credentialing. This function is the responsibility of the Commissioner of the Minnesota Department of Health. The evaluation process includes an analysis of the cost-effectiveness and economic impact of the regulation of the particular occupation, as well as the impact on the public of allowing the particular profession to provide services without regulatory oversight.

One advantage of a mandate evaluation statute is that an evaluation process contributes an objective analysis to the political and emotional debate which frequently surrounds a mandate proposal. Several states, particularly Hawaii, have reported a decrease in proposed mandates since adoption of an evaluation process. Nebraska reports that no mandates have been introduced since the evaluation process was enacted. Several mandates introduced after passage of the Pennsylvania statute have failed to pass.

Proponents of an evaluation process argue that fewer mandates may forestall increases in insurance premiums and overall health care costs. The enactment of fewer mandates is also consistent with the Minnesota policy of competition in the health care marketplace.

One disadvantage of an evaluation process may be the additional layer of process and the additional expense to state government associated with the process. A partial solution may be to require proponents of provider mandates to pay a "filing fee" or to otherwise subsidize the cost of the evaluation process. An evaluation process also may result in the arguments for and against a particular mandate being made several times. Every state which has enacted an evaluation process provides that the report of the proponent or the expert panel be submitted to the appropriate legislative committee for consideration. The debate is then frequently conducted for a second time before the legislative committee.

E. To the extent that certain mandates are retained, benefit laws may be amended to permit limitations on coverage levels, to require minimum levels of coverage only and to clarify other options available to insurers to control costs and utilization.

Current laws are unclear with respect to the ability of health plan companies to control costs and utilization. Specific mandates may be reviewed to determine if specific minimum levels of coverage should be specified and if dollar caps on certain benefits are appropriate. It may be useful to clarify the extent to which insurers may use copayments, deductibles, lifetime maximums, prior authorization and other cost and ultilization control methods with respect to mandated benefits.

F. To the extent that certain mandates are retained, mandated benefit laws may be recodified in a single chapter of Minnesota Statutes which will set forth all mandated benefits, the health plan companies to which they apply, allowable caps and utilization control measures and a mandate evaluation process for expanding or adding mandates.

Minnesota's mandated benefit "program" is highly fragmented. The benefits mandated are not part of a coherent or cohesive program and do not share a common purpose, sponsor or legislative history. As a result it is difficult for legislators, insurers and consumers to grasp the scope and purpose of many mandates. The advantage of recodification is the creation of a readily accessible body of law which addresses mandated health benefits.

G. To the extent that certain mandates are retained, mandated benefit laws may be revised to apply in an equal manner, as appropriate, to all types of health plan companies.

Several recent reports have identified the "level playing field" issue as a significant issue for regulatory reform. The advantages of equalizing the application of mandated benefit laws include the elimination of obstacles to a competitive market created

by the dissimilar regulatory schemes applicable to different health plan companies and the reduction of the adverse selection problems resulting from dissimilar mandates. It should be noted that the statutory requirement that HMOs provide "comprehensive" care is unique among health plan companies. As a result, if the Commission elects to "level the playing field" with respect to mandates, this unique characteristic of HMO coverage may require reevaluation. The Commission may also wish to consider the advisability of preserving certain distinctions between health plan companies.

H. To the extent that certain mandates are retained, mandated benefit laws may be revised to provide for the same level of coverage for individual and group contracts.

In general, group contracts are subject to a greater number of mandates than individual contracts. This places individuals at a disadvantage in the marketplace. One advantage of requiring the same mandates for individuals as for groups is that self-employed persons and others who seek individual contracts will be able to obtain the same level of care. On the other hand, if the number of mandates are numerous and result in increased expenses to the insured, the individual may be unable to afford a policy.

I. To the extent that certain mandated benefit laws are retained, mandates may be amended to require that benefits be offered to employers and individuals on a "made available" basis.

The qualified plan standards reflect a "made available" approach to mandates. Insurers are not required to offer a qualified plan, but merely to offer those products to individuals and groups upon request. The advantages of a "made available" approach are similar to the advantages discussed with respect to the repeal and sunsetting of mandates. If benefit levels are not mandated, the marketplace is free to determine benefit levels and purchasers and sellers are free to negotiate the contents of a health policy. While preserving this freedom to determine benefit levels, the "made available" approach preserves the existence of a state approved minimum benefits package.

Marketplace pressures are frequently thought to be sufficient to require insurers to offer a demanded service to a large group purchaser. As a result, the "made available" approach may be more useful in the individual market. One disadvantage of this approach in the individual market may be adverse selection. Individuals will likely purchase certain benefits only if they anticipate needing those services. As a result, the actuarial risk for certain conditions and treatments may be less evenly distributed among both good and bad risks.

The lack of perfect information is an acknowledged flaw in the health care marketplace. The "made available" approach requires that consumers have sufficient information concerning the options available.

J. Legislation may be enacted to improve the accuracy, clarity and availability of information to consumers.

A textbook requirement of a competitive marketplace is the availability of "perfect information." Without good information, the consumer cannot adequately select a health care product. The Commission may wish to consider establishing a consumer rating methodology whereby health plans are rated on a quantitative sliding scale. The scale could reflect a number of attributes including level of care, delivery mechanisms, cost sharing devices and access restrictions and highlight particular exclusions. A state regulatory agency would perform the rating.

One advantage of this methodology will be an increase in information to consumers. If mandates and/or qualified plans are repealed or sunsetted, the availability of accurate information will be especially important. If a mandated benefit structure is maintained, consumers will nevertheless benefit from increased information. The disadvantages of such a system include an increased burden to health plan companies to provide information to regulatory agencies and the addition of another form of regulatory evaluation of health plan products.

Summary

A variety of policy options are available to address the strengths and weaknesses of Minnesota's current mandated benefits structure. Any option chosen should be consistent with overall policy concerning the role of government in determining the type and range of health care services available to Minnesota's residents and state policy supporting competition as a means of promoting efficiency and controlling costs in the health care market.

Table 1.

MANDATED HEALTH PLAN BENEFITS IN MINNESOTA

I. Covered Treatments and Levels of Service

	Ins.	HMO	HSPC
a. Preventive health care w/o copayments[1]		X	
b. Emergency services (medically necessary in service area)		X	
c. Prescription drugs		X	
d. In-patient hospital care[2]		X	
e. In-patient physican care[3]		X	
f. Out-patient health services[4]		X	
g. In-patient mental & emotional conditions (=>30 days/year)[5]		X	
h. Out-patient mental health care (w limits & copay)[G]	X	X	X
i. Temporomandibular joint disorder (TMJ)	X	X	X
j. Craniomandibular disorder	X	X	X
k. DES related conditions (diethylstilbestrol)	X	X	X
l. Reconstructive surgery (under certain circumstances)	X	X	X
m. Scalp hair protheses for alopecia areata (<=$350/yr.)	X	X	X
n. Dietary treatment of phenylketonuria	X	X	X
p. Maternity benefits[G]	X	X	X
q. Residential facility care for emotionally disturbed children[G]	X	X	X
r. In-patient chemical dependency care[5, GH]	X	X	X

1. "Preventive health care" means: health education, health supervision, immunization, and early disease detection. Incl.; well-baby care and prenatal care. (MR. 4685.0100 Subp. 5, Item E., & 4685.08 Subp. 4.)

2. "In-patient hospital care" means: necessary hospital services affording residential treatment to patients. Incld.; room and board, drugs and medicine, dressings, nursing care, X-rays, lab examines, and other usual and customary hospital services. (MR. 4685.0100 Subp. 4, Item B.) Group coverage policies may limit hospital stays to 365 days, "per period of confinement." Individual coverage can be limited to 90 days per period of confinement.

3. "In-patient physician care" means: health services performed, prescribed or supervised by physicians in a hospital. Incld.; diagnostic and therapeutic care. (MR. 4865.0100 Subp. 4, Item C.)

4. "Out-patient health services" means: ambulatory care, incld.; health supervision, preventive, diagnostic and therapeutic services. (MR. 4685.0100 Subp. 4, Item D.)

5. Included as part of "in-patient hospital care," HMOs must also provide a second opinion from a non-affiliated provider if treatment for MH or CD is deemed unnecessary by the HMO. (MS. 62D.103, MR. 4685.0700 Subp. 3 Item N-4)

G. These mandates apply to only group policies not individual policies.

GH. Applies to group insurance and HSPC policies and all HMO policies.

MANDATED HEALTH PLAN BENEFITS IN MINNESOTA

II. Non-Physician Provider Access

	Ins.	HMO	HSPC
a. Chiropractor	X		X
b. Dentist, Podiatrist	X		X
c. Government Institutions	X	X	X
d. Government Operated Facilities	X		X
e. Registered Nurse	X		X
f. Optometrist	X		X
g. Osteopath, Optometrist, Chiropractor, Registered Nurse	X		X
h. Outpatient Surgical	X		X

Table 2.

QUALIFIED PLAN REQUIREMENTS IN MINNESOTA

I. Minimum Benefits of a Number Three Qualified Plan

Minnesota Statutes (M.S.) 62E.06 outlines the requirements for a qualified plan. For a number three plan benefits must be equal to "at least 80 percent of the cost of covered services in excess of an annual deductable which does not exceed $150 per person." The statute also establishes an annual limitation on out-of-pocket expenses at $3,000 per person, and a maximum lifetime benefit of not less than $250,000. Specific coverages to be included are:

a. hospitial services

b. professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental, which are rendered by a physician or at the physician's direction

c. drugs requiring a physcians prescription

d. services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under Medicare

e. services of a home health agency if qualified under Medicare

f. use of radium or other radioactive materials

g. oxygen

h. anesthetics

i. prostheses other than dental (incld. hair from alopecia areata)

j. rental or purchase of (as appropriate) of durable medical equipment other than eyeglasses and hearing aids

k. diagnostic x-rays and laboratory tests

m. oral surgery (with limitations; see M.S. 62E.05, Subd. 1 item 12)

n. services of a physical therapist

p. ambulance service (with limitations; M.S. 62E.05, subd.1 item 14)

q. services of an occupational therapist

II. Number Two Qualified Plan

A plan of health coverage is deemed a number two qualified plan when it meets the coverages above, "except that the deductible shall not exceed $500 per person."

III. Number Three Qualified Plan

Same as one and two above, "except that the deductible shall not exceed $1,000 per person."

Statute & Rule Index

GOVERNOR'S COMMISSION ON HEALTH PLAN REGULATORY REFORM

List of Statutes and Rules Concerning Health Plan Companies

* * * * *

This is a non-exhaustive list of the Minnesota Statutes and Rules affecting health plan companies, including insurers, non-profit health service plan corporations (HSPCs), health maintenance organizations (HMOs), third-party administrators (TPAs), and group self-insurers. The list is intended to aid Commission members in becoming familiar with and making references to health plan company regulations.

The list appears in two different forms. The first lists each chapter of the statutes and rules **in numeric sequence.** The second lists the chapters according to their **primary topics.** For each chapter, the listing contains the (A) number, (B) title, and (C) primary topics covered. In order to enhance the list's usefulness, the titles listed are sometimes more descriptive than the titles which appear in the statutes or rules themselves. The designation of primary topics (see below) should not be taken to mean that the statute or rule addresses that topic(s) only.

PART I. LIST BY NUMERIC SEQUENCE

MINNESOTA STATUTES

NUMBER	TITLE	PRIMARY TOPICS
Ch. 60A	Department of Commerce; Insurance	FI, IN, TA
Ch. 60B	Insurers Rehabilitation and Liquidation	FI
Ch. 60D	Insurance Holding Company Systems	FI, IN
Ch. 61A	Life Insurance Generally	FI, IN
Ch. 61B	Life and Health Guaranty Association	FI
Ch. 62A	Accident and Health Insurance	CA, CC, MB, PF, RP, UM

(continued)

AQ = access to care, quality of care
CA = claims administration
CC = coverage continuation and conversion
FI = financial integrity
IN = establishment, governance
MB = mandated benefits, "qualified plans"
PF = policy filing, format, and wording
PR = provider relationships
RP = rates and premiums
TA = tax and assessment status
UM = underwriting and marketing

NUMBER	TITLE	PRIMARY TOPICS
Ch. 62C	Nonprofit Health Service Plan Corporations (HSPCs)	CA, CC, FI, IN, PF, PR, TA, UM
Ch. 62D	Health Maintenance Organizations (HMOs)	AQ, CA, CC, FI, IN, MB, PF, PR, RP, TA, UM
Ch. 62E	Qualified Plan Standards; Minnesota Comprehensive Health Association (MCHA)	AQ, MB, TA, UM
Ch. 62H	Joint Self-Insurance Employee Health Plans	FI, IN, TA
Ch. 64B	Fraternal Benefit Societies	FI, IN, PF, TA
Ch. 66A	Mutual Companies (excluding Life Insurance Cos.)	FI, IN
Ch. 71A	Reciprocals or Interinsurance Exchange	FI, IN, TA
Ch. 72A	Regulation of Trade Practices	CA, PF, PR, RP, UM
Ch. 72C	Readability of Insurance Policies	PF
	MINNESOTA RULES	
Ch. 2605	Filing Fees; Insurance	PF
Ch. 2700	Insurance Policies, Practices	PF, UM
Ch. 2710	Annual Audits	FI
Ch. 2715	Domestic Stock Companies	FI, IN
Ch. 2720	Insurance Holding Company Systems	FI, IN
Ch. 2725	Insurance Continuing Education	UM
Ch. 2730	HMO Agents and Unreasonable Expenses	FI, IN, UM
Ch. 2735	Sexual Discrimination	MB, UM

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NUMBER	TITLE	PRIMARY TOPICS
Ch. 2740	Qualified Plan Standards; Minnesota Comprehensive Health Association (MCHA)	AQ, CC, MB, PF, TA, UM
Ch. 2742	Coordination of Benefits	CA
Ch. 2755	Group Insurance Coverage Replacement	CC, UM
Ch. 2765	Employee Joint Self-Insurance	FI, IN
Ch. 2767	Self-Insurance or Third-Party Administrators	FI, IN
Ch. 2785	Political Subdivision Self-Insurance Pools	FI, IN
Ch. 2790	Insurance Marketing Standards	PF, UM
Ch. 2795	Insurance Agents	UM
Ch. 4685	Health Maintenance Organizations	AQ, CA, CC, FI, IN, MB, PF, PR, UM

PART II. LIST BY PRIMARY TOPIC

Access to Care and Quality of Care

Ch. 62D	Health Maintenance Organizations (HMOs)
Ch. 62E	Qualified Plan Standards, MN Comprehensive Health Association
Ch. 2740	Qualified Plan Standards, MN Comprehensive Health Association
Ch. 4685	Health Maintenance Organizations (HMOs)

Claims Administration

Ch. 62A	Accident and Health Insurance
Ch. 62C	Non-Profit Health Service Plan Corporations (HSPCs)
Ch. 62D	Health Maintenance Organizations (HMOs)
Ch. 72A	Regulation of Trade Practices
Ch. 2742	Coordination of Benefits
Ch. 4685	Health Maintenance Organizations (HMOs)

(continued)

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Coverage Extension, Continuation and Conversion

Ch. 62A	Accident and Health Insurance
Ch. 62C	Non-Profit Health Service Plan Corporations (HSPCs)
Ch. 62D	Health Maintenance Organizations (HMOs)
Ch. 2740	Qualified Plan Standards, MN Comprehensive Health Association
Ch. 2755	Group Insurance Coverage Replacement
Ch. 4685	Health Maintenance Organizations (HMOs)

Financial Integrity

Ch. 60A	Department of Commerce, Insurance
Ch. 60B	Insurers Rehabilitation and Liquidation
Ch. 60D	Insurance Holding Company Systems
Ch. 61A	Life Insurance Generally
Ch. 61B	Life and Health Guaranty Association
Ch. 62C	Non-Profit Health Service Plan Corporations (HSPCs)
Ch. 62D	Health Maintenance Organizations (HMOs)
Ch. 62H	Joint Self-Insurance Employee Health Plans
Ch. 64B	Fraternal Benefit Societies
Ch. 66A	Mutual Companies (excluding Life Insurance Companies)
Ch. 71A	Reciprocals or Interinsurance Exchange
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Ch. 2715	Domestic Stock Companies
Ch. 2720	Insurance Holding Company Systems
Ch. 2730	HMO Agents and Unreasonable Expenses
Ch. 2765	Employee Joint Self-Insurance
Ch. 2767	Self-Insurance or Third-Party Administrators
Ch. 2785	Political Subdivision Self-Insurance Pools
Ch. 4685	Health Maintenance Organizations (HMOs)

Incorporation, Establishment, and Governance

Ch. 60A	Department of Commerce, Insurance
Ch. 60D	Insurance Holding Company Systems
Ch. 61A	Life Insurance Generally
Ch. 62C	Non-Profit Health Service Plan Corporations (HSPCs)
Ch. 62D	Health Maintenance Organizations (HMOs)
Ch. 62H	Joint Self-Insurance Employee Health Plans
Ch. 64B	Fraternal Benefit Societies
Ch. 66A	Mutual Companies (excluding Life Insurance Companies)
Ch. 71A	Reciprocals or Interinsurance Exchange
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Ch. 2720	Insurance Holding Company Systems
Ch. 2730	HMO Agents and Unreasonable Expenses
Ch. 2765	Employee Joint Self-Insurance
Ch. 2767	Self-Insurance or Third-Party Administrators
Ch. 2785	Political Subdivision Self-Insurance Pools
Ch. 4685	Health Maintenance Organizations (HMOs)

Mandated Benefits and "Qualified Plan" Standards

Ch. 62A	Accident and Health Insurance
Ch. 62D	Health Maintenance Organizations (HMOs)
Ch. 62E	Qualified Plan Standards, MN Comprehensive Health Association
Ch. 2735	Sexual Discrimination
Ch. 2740	Qualified Plan Standards, MN Comprehensive Health Association
Ch. 4685	Health Maintenance Organizations (HMOs)

Policy Filing, Format, and Wording

Ch. 62A	Accident and Health Insurance
Ch. 62C	Non-Profit Health Service Plan Corporations (HSPCs)
Ch. 62D	Health Maintenance Organizations (HMOs)
Ch. 64B	Fraternal Benefit Societies
Ch. 72A	Regulation of Trade Practices
Ch. 72C	Readability of Insurance Policies
Ch. 2605	Filing Fees; Insurance
Ch. 2700	Insurance Policies, Practices
Ch. 2740	Qualified Plan Standards, MN Comprehensive Health Association
Ch. 2790	Insurance Marketing Standards
Ch. 4685	Health Maintenance Organizations (HMOs)

Provider Relationships

Ch. 62C	Non-Profit Health Service Plan Corporations (HSPCs)
Ch. 62D	Health Maintenance Organizations (HMOs)
Ch. 72A	Regulation of Trade Practices
Ch. 4685	Health Maintenance Organizations (HMOs)

Rates and Premiums

Ch. 62A	Accident and Health Insurance
Ch. 62D	Health Maintenance Organizations (HMOs)
Ch. 72A	Regulation of Trade Practices
Ch. 4685	Health Maintenance Organizations (HMOs)

Tax and Assessment Status

Ch. 60A	Department of Commerce, Insurance
Ch. 62C	Non-Profit Health Service Plan Corporations (HSPCs)
Ch. 62D	Health Maintenance Organizations (HMOs)
Ch. 62E	Qualified Plan Standards, MN Comprehensive Health Association
Ch. 62H	Joint Self-Insurance Employee Health Plans
Ch. 64B	Fraternal Benefit Societies
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Underwriting and Marketing

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Ch. 2735	Sexual Discrimination
Ch. 2740	Qualified Plan Standards, MN Comprehensive Health Association
Ch. 2755	Group Insurance Coverage Replacement
Ch. 2790	Insurance Marketing Standards
Ch. 2795	Insurance Agents
Ch. 4685	Health Maintenance Organizations (HMOs)

Background Papers

REGULATORY ISSUES FOR HEALTH PLAN COMPANIES

1. **PREMIUM RATE REVIEW**
   - Should rate review be solely to evaluate excessive rates or should the adequacy of rates also be reviewed?
   - Should reviews be performed routinely or only in the event of financial integrity problems?
   - Should HMOs be subjected to rate review?
   - Should rate review be eliminated?

2. **MANDATED BENEFITS: INEQUITIES**
   - How does the broad HMO mandate to provide "comprehensive health maintenance services," compare with mandates on insurers and HSPCs?
   - Are provider mandates equitable? Are provider mandates necessary to assure access and quality?
   - Do qualified plan standards serve a useful role?
   - Are mandates a necessary regulatory action to assure adequate health care coverage, or will consumer demand achieve the same results?

3. **MANDATED BENEFITS: GOVERNMENTAL PROCESS/ COST-BENEFIT REVIEW**
   - Should the State evaluate the cost effectiveness and/or medical necessity of some or all current mandates?
   - Currently nine other states employ some form of cost/benefit evaluation for new benefit mandates. Should Minnesota adopt a formal cost benefit review process for future mandates?
   - Mandates vs. free market: does the existence of mandates prevent some companies (especially smaller employers) from providing employees at least minimal health coverage, as opposed to no coverage at all?

4. **PROFIT/ NON-PROFIT: TAX EQUITY AND MARKETPLACE JUSTIFICATION**
   - Financial stability, consumer protection and quality health care delivery: what are the implications of profit vs. non-profit ownership?
   - Should insurance companies be required to give consumers and providers a voice in corporate governance similar to state requirements for HMOs and HSPCs?
   - Should non-profit health plan companies be exempt from state taxes?
   - Would for-profit HMOs and HSPCs improve the financial strength of Minnesota's health plan markets?

5. **CONSUMER ACCESS TO HEALTH CARE AND/OR PLAN COVERAGE**
   - Do regulations requiring HMOs to offer group open enrollment result in some consumers (e.g., small groups) being denied access to HMO plans?
   - Should the State regulate the administrative requirements of health plans, in order to avoid health plan companies adopting administrative procedures which delay or deny access to some health services?

6. **QUALITY OF CARE**
   - Should insurers & HSPCs be required to provide for consumer representation in corporate governance and consumer complaint forums similar to those prescribed for HMOs?
   - Should the State attempt to determine when financial incentives for over- or under-service are resulting in lower standards of quality care?

7. **CATEGORIZATION OF HEALTH PLAN COMPANIES IN STATE REGULATION**
   - Should insurers and HSPCs be allowed to engage in direct provider contracting, similar to HMO/provider relationships?
   - Current health plan regulation is based upon company type, but is an institution-based system reasonable as the plans and services provided become increasingly similar? Might access to care and managed care, or other functional categorization lend uniformity to the statutes for all health plan companies?

8. **THE MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION (MCHA)**
   - Self-insurers pay neither state tax nor contributions to the Minnesota Comprehensive Health Association (MCHA). As increasing numbers of Minnesota employers turn to self-insurance for health plan benefits what will be the fate of the MCHA risk pool? Should MCHA financing be spread more broadly than just the state regulated health plan business?
   - Which groups should MCHA serve - the uninsurable? the under-insured? the uninsured?
   - Are current eligibility standards appropriate and fair?
   - What conditions should provide presumptive eligibility?
   - Is the six month waiting period now required for all new MCHA enrollees justified in the event of contract cancellations and what are the alternatives?
   - Could immediate enrollment in the MCHA risk pool reduce the need for expensive conversion policies?

9. **PPA PLANS**
   - The health plans market has seen the development of companies which arrange preferred provider arrangements for insurers and self-insured employers. How should PPA companies be regulated?
   - How should "in-panel" and "out-of-panel" benefits be structured?
   - What consumer protection issues are raised by PPAs?
   - What competitive equity concerns need to be addressed?

10. **EXPERIMENTAL MEDICAL TECHNOLOGY**
   - As medical technology changes, how should health plan companies provide coverage for procedures newly accepted as "standard" medical practice? How should costliness of these procedures be accounted for?
   - What role should state regulations play in determining when procedures are no longer "experimental," when disputes between enrollees and health plan companies arise?
   - Does the State need a process for making decisions concerning experimental medical technology?

11. **POLICY FORMAT, CONTENT AND APPROVAL**
   - Currently regulations governing the appearance and content of consumer health plan contracts are not uniform. Would consumers be better able to discern plan differences if all contract requirements were similar?

12. **PREPAID DENTAL PLANS**
   - Currently little state regulation exists for the oversight of dental health plans. Should the State extend geographic certification and other requirements of medical HMOs to prepaid dental plans?
   - Do such plans offered by large employers in Greater Minnesota carry anti-trust implications?

13. **PROVIDER DISPUTE ARBITRATION**
    - With the prevalence of provider contracting in health care markets, should the State establish arbitration guidelines to handle contract disputes? Should the members of arbitration panels be specified?

14. **FINANCIAL INTEGRITY ***
    - Were actions of the 1988 legislature with respect to HMO financial solvency adequate? Too restrictive?
    - Are existing requirements imposed on HSPCs and insurers adequate? Too restrictive?
    - Are financial requirements imposed on the various health plan companies equitable?
    - What are the appropriate financial requirements for PPA plans?

15. **CONTINUATION, CONVERSION, AND NON-CANCELLATION ***
    - Were actions of the 1988 legislature to provide replacement coverage for individual policy holders adequate? Too restrictive?
    - Are requirements for group continuation and conversion policies for HMOs, insurers or HSPCs adequate? Too restrictive?
    - Should continuation and conversion requirements be imposed on PPAs?
    - Are current continuation, conversion and cancellation regulations for health plan companies equitable?

16. **ADMINISTRATION OF HEALTH PLAN REGULATION**
    - Is the current division of labor between Health and Commerce appropriate for current market conditions? If not, how should it be different?

* These issues will be addressed by legislative bills sponsored by the Minnesota Department of Health during the 1988 session.

HEALTH TERMS GLOSSARY

BC\BS (Blue Cross\Blue Shield): Largest of the nonprofit health service plan corporations. The "Blues" historically dominated third-party reimbursement in many areas of the U.S. because of their ability to offer reduced rates through negotiated discounts with health care providers.

Capitation: A health care provider reimbursement method where, regardless of service utilization, health plan companies make fixed payments to providers on a periodic basis (e.g., monthly) per health plan enrollee.

Contract of Coverage/Policy: A document establishing the rights of health plan enrollees to health services and/or reimbursement for the cost of the services.

ERISA (Employee Retirement Income Security Act of 1974): ERISA was enacted primarily to effect pension reform. However, ERISA also contains broad provisions to protect employee benefit plans from state regulations, which could vary across the country. Because of ERISA, self insured employers are exempt from state regulations.

HMO (Health Maintenance Organization): For a prepaid, established fee (capitation), HMOs provide comprehensive health care services to enrollees. In Minnesota, HMOs hold the largest share of the health plans market, representing about 45 percent of all health insurance in 1986.

Health Plan: The entire network of contracts and arrangements associated with a particular insurance policy, contract of coverage, or comparable document.

Health Plan Company: An organization in the business of insuring, financing, and/or arranging health services on behalf of enrollees.

Health Screening/Risk Assessment: An evaluation of health related characteristics of an individual or group, to determine the potential financial risk to a health plan company.

HSPC (Non-profit Health Service Plan Corporation): Like HMOs HSPCs are engaged exclusively in the business of health coverage. HSPCs contract directly with providers and health care facilities to establish the level of charges the HSPC will pay for services rendered to its insureds. BC/BS and Delta Dental are the two most prominent HSPCs in Minnesota.

Hold Harmless Clause: A contract clause providing that in the event of insolvency, providers will not take recourse against health plan company enrollees for unpaid bills.

Indemnity Insurance: A type of insurance plan coverage where reimbursement is paid on a fee-for-service basis.

MET (Multiple Employer Trust): A mechanism allowing small employees in the same industry or related industries to provide group insurance to their employees under a trust agreement.

PPA (Preferred Provider Arrangement): A form of "health plan" based upon a contractual agreement between a providers and a third party payer. Typically, health plan enrollees receive services at a negotiated, discounted fee, in return for prompt payment and guaranteed patient volumes from the insurance company or self-insured employer.

PPO (Preferred Provider Organization): A group of providers who agree to participate in a PPA under the contractual agreements established.

Provider: An institution, organization, or person that furnishes health services directly to consumers.

QA (Quality Assurance): The use of on-going performance measures and peer review to maintain health services at an optimal level of efficiency and effectiveness.

Reinsurance/Stop-Loss Insurance: An insurance mechanism used by health plan companies and self-insured employees to reduce their exposure to catastrophic loss. Under the terms of a reinsurance agreement, claims exceeding a specified level, would be paid by the re-insurer.

UR (Utilization Review): Cost control tools used by health plan companies to evaluate health care on the basis of appropriateness, necessity and quality. UR can include hospital pre-admission certification, concurrent review with discharge planning, retrospective review and other factors.

Information Source: THE HEALTH INSURANCE ANSWER BOOK, Charles E. Vadakin II, and Zelda Lipton, Institute for Management, 1986.

GOVERNOR'S COMMISSION OF HEALTH PLAN REGULATORY REFORM

Background Paper #1: Overview of Health Plan Company Regulation and Public Policy Concerns

* * * * *

A. INTRODUCTION TO THE BACKGROUND PAPERS

This is the first of several background papers for the Governor's Commission on Health Plan Regulatory Reform. This paper begins with a discussion of some key terms, including **health plan**, **health plan company**, and **contract of coverage**. Paper #1 describes the four major categories of health plan companies: insurers, "Blues" plans, HMOs, and self-insurers, and highlights the history of health plan companies. The paper concludes with a brief overview of the scope of state regulations and current public policy concerns.

Additional papers will examine the following specific areas of regulation and public policy concerns in greater detail: regulation of health plan companies' corporate structure and financial integrity; regulations concerning coverage, rates, and trade practices; and regulations pertaining to access to care and quality of care.

B. THE MEANING OF "HEALTH PLAN"

The complexities of the health plan regulation field have given rise to a special vocabulary which, in most cases, helps to cut through the complexity. Recently, however, changes in the health plan field have often outpaced the rate of vocabulary evolution. For this reason, these background papers begin in the same way that regulations begin, with a few key definitions.

It is especially important for a commission on health plan regulatory reform to have common understanding of the term **health plan**. In current usage, "health plan" can mean a variety of things, including:

1. **Organizations** in the business of insuring, financing, and/or arranging health services on behalf of enrollees (for example, "MedCenters Health Plan").

2. A particular **policy** of insurance, **contract** of coverage, or comparable document that establishes enrollees' rights to receive health services and/or be reimbursed for the cost of services (for example, "My health plan states that coverage begins after enrollees pay the first $100").

3. The **entire network of contracts** and arrangements associated with a particular insurance policy, contract of coverage, or comparable document (for example, "Many doctors and hospitals belong to the Aware Gold health plan").

To avoid confusion, we will use a different term to designate each of these three meanings. For the first meaning, organizations in the business of

financing or arranging health services, we will use the term **health plan companies**. For the second meaning, insurance policies or contracts of coverage, we will use the term **contract of coverage**. We will only use the term **health plan** for the last meaning, the entire network of contracts and arrangements associated with a contract of coverage. Using these definitions, someone could:

- purchase a contract of coverage . . .
- for the Aware Gold health plan . . .
- offered by the Blue Cross and Blue Shield of Minnesota health plan company.

It is important to maintain distinctions between health plans, contracts of coverage, and health plan companies, because these distinctions are important for regulation. In general, regulations concerning the business of insuring, financing, and/or arranging health services on behalf of enrollees make health plan companies responsible for compliance. Because regulations concern the activities of health plan companies, including but not limited to activities concerning contracts of coverage and health plans, the commission's charge could, strictly speaking, be described as health plan company regulatory reform.

C. REGULATORY CATEGORIES OF HEALTH PLAN COMPANIES

Most health plan companies are required to be incorporated under the laws of their state or country of domicile. In addition, most health plan companies must be licensed or authorized by the state of Minnesota to engage in the business of insuring, financing, and/or arranging health services on behalf of enrollees as a particular type of health plan company. (Certain types of self-insured entities are not subject to state oversight, as we discuss in part C4 below.) Regulators consider health plan companies to be of different types if they are licensed or authorized under different statutes.

In Minnesota, there are four major types of regulated health plan companies: (1) insurance companies, (2) health maintenance organizations (HMOs), (3) non-profit health service plan corporations (HSPCs), and (4) self-insurers. The self-insurance category requires a two-part discussion: (4A) companies that provide self-insurance administration, often called third-party administrators (TPAs), and (4B) the actual self-insuring entity or entities. Within each of the four major categories there are several subcategories with different statutory provisions.

1. **Insurance Companies**. In terms of the number of companies, the most prominent type of health plan company in Minnesota is the commercial insurance company. Approximately 400 insurance companies write at least some health insurance coverage in Minnesota, and over 400 more are licensed to do so. In total, insurance companies represented about 38 percent of all "insured" business* in the state in 1986. The largest 30 companies accounted for over one-half of this total. The three insurance companies with the largest Minnesota premium volume are Bankers Life, Prudential, and Mutual of Omaha.

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*"Insured" business includes coverage issued through all types of insurance companies, health maintenance organizations, and non-profit health service plan corporations. It excludes coverage provided by "self-insured" entities.

Insurance companies may be organized in several different ways with slightly different requirements. The major categories and authorizing statutes are as follows:

A. stock companies (Minnesota Statutes 60A)
B. mutual companies (M.S. 61A -- for mutual life insurance companies, the type of mutual company most likely to write health insurance)
C. fraternal benefit societies (M.S. 64B)
D. reciprocals or interinsurance exchanges (M.S. 71A)

Stock and mutual companies are the most common forms of insurance company, and are the most significant for health insurance. The major difference between these two types is that stock companies are owned by their shareholders, while mutual companies are owned by their policyholders. Under certain conditions, insurers may qualify as "combination" stock and mutual companies (M.S. 61A.33 - 61A.36).

A relatively small amount of health insurance is written through fraternal benefit societies and through reciprocals or interinsurance exchanges (henceforth simply "fraternals" and "reciprocals"). These types of health plan companies have their own special histories and public policy origins. Fraternal benefit societies were established to serve the needs of specific religious and/or ethnic communities. Reciprocals commonly serve trade associations or large businesses with common interests.

All health insurance companies must receive a license from the Commissioner of Commerce with specific authorization to issue policies "to insure against loss or damage by the sickness, bodily injury or death by accident of the assured or dependents" (M.S. 60A.06, subd. 1, clause 5a). Over 85 percent of all health insurance in Minnesota is written by insurers licensed primarily as "life and health" companies. Most of the remainder is written through insurers licensed primarily as "property/casualty" companies. Property/casualty companies write only group health insurance coverage, usually as a supplement to other coverage.

Regulators' vocabulary has recently grown with the addition of the terms "PPA" and "PPO" (used interchangably), which stand for **preferred provider arrangement** or **organization.** PPAs are a type of health plan offered by insurers, or in some cases by HSPCs or self-insurers. Like HMO health plans, preferred provider health plans encourage enrollees to use providers that participate in the plan. As we discuss in subsequent papers, the distinctions between HMO and PPA health plans are becoming less clear, which poses regulatory problems. For the purposes of this paper, however, it is important to understand that preferred provider health plans are <u>offered</u> by health plan companies, but are not actual health plan <u>companies</u> themselves. For this reason, the term preferred provider <u>organization</u> is misleading, and PPA or preferred provider health plan should be used instead.

2. <u>Health Maintenance Organizations</u> (HMOs). Although far fewer in number than insurance companies, HMOs account for the largest market share of any type of health plan company. Unlike insurance companies, HMOs are engaged exclusively in the health care coverage business. There are currently 13 authorized HMOs in Minnesota. In 1986, HMOs represented about 45 percent of all insured business in Minnesota. The second, third, fourth, fifth, and seventh largest health plan companies in Minnesota (in terms of total premiums) are HMOs.

All HMOs must receive a certificate of authority from the Commissioner of Health (M.S. 62D.04). In addition, HMOs may become "federally certified" by applying to the U.S. Department of Health and Human Services and meeting their requirements. Federal certification permits HMOs to participate in federal programs such as Medicare, and to come under federal laws such as the "dual option" mandate, which requires employers to offer an HMO to their employees under certain circumstances. Accordingly, an HMO must be:

A. state certified (M.S. 62D.04) --- and may also be
B. federally certified

3. **Non-Profit Health Service Plan Corporations** (HSPCs). HSPCs are still fewer in number, there being only 5, but they represented about 17 percent of all insured business in the state in 1986. Like HMOs, HSPCs are engaged exclusively in the health care coverage business, although they may have subsidiaries and affiliates engaged in other businesses.

By far the most prominent HSPC is Blue Cross and Blue Shield of Minnesota, which accounts for more insured business than any other single health plan company: $312.7 million in 1986, slightly more than Physicians Health Plan, the largest HMO. Delta Dental Plan of Minnesota is also a large, well-known HSPC.

HSPCs must receive a certificate of authority from the Commissioner of Commerce (M.S. 62C.08). Like insurance companies, HSPCs may be organized either as:

A. stock companies (M.S. 62C.09, subds. 1 and 3), or
B. mutual companies (M.S. 62C.09, subds. 1 and 3)

In addition to the stock or mutual designation, HSPCs also come under somewhat different requirements if they opt to limit themselves to:

C. dental or vision care services only (M.S. 62C.09, subd. 3)

4. **Self-Insurance**. The fourth major type of health plan company actually consists of two types of companies, usually with a contractual relationship between them: (4A) companies that provide self-insurance administration, often called third-party administrators (TPAs), and (4B) the actual self-insuring entity or entities. The self-insuring entity retains primary financial responsibility for the contracts of coverage (the "insurance risk"), while the TPA performs some or all of the administrative functions associated with the coverage.

4A. **Self-Insurance Administrators** or **Third-Party Administrators** (TPAs). Third-party administration services may be provided by any of the three major types of health plan companies discussed earlier, namely:

A. insurance companies (M.S. 60A.23, subd. 8)
B. non-profit health service plan corporations (M.S. 60A.23, subd. 8)
C. health maintenance organizations (M.S. 60A.23, subd. 8, and 62D.04, subd. 1, clause f2)

No additional license or certification is required for these types of companies to provide TPA services. A TPA may also be a separate corporation, in which

case it must be licensed by the Department of Commerce as a:

D. self-insurance plan administration company (M.S. 60A.23, subd. 8, clause 3)

Finally, a self-insurer may administer its self-insurance program internally using its own staff:

E. in-house administration by the self-insurer

No license is required in this case. As we discuss in part 4B, federal law prohibits direct state regulation of self-insurance activities, including in-house administration.

4B. **The Self-Insuring Entities**. Any type of TPA may be paired with any type of self-insurer. There are six different types of self-insurer organizations:

A. individual private-sector employers
B. individual public-sector employers (M.S. 471.616 and 471.617)
C. Taft-Hartley union trusts
D. multiple-employer welfare associations (MEWAs)
E. joint self-insurance employee health plans (M.S. 62H)
F. pools of public-sector employers (M.S. 471.616 and 471.617)

The first two (A and B) are "individual" self-insurers, usually business corporations or governmental entities. The remaining four (C through F) are self-insurance "groups" or "pools," made up of two or more corporations or governmental units. Unlike individual self-insurance, group self-insurance requires the creation of a new legal entity: the pool or trust. Most group self-insurance regulation concerns the characteristics and activities of the pool or trust.

As discussed in more detail later in this paper, the federal Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from directly regulating employee benefit programs, including health benefits. States are authorized to regulate the activities of health plan companies and TPAs, but ERISA specifically prohibits states from "deeming" employers to be health plan companies. In effect, this means that states cannot directly regulate the activities of self-insured employers. The only exceptions to this prohibition are for political subdivisions of the state (cities, counties, etc.), and some types of group self-insurance entities.

Individual self-insurers are an important part of the health plan company landscape in Minnesota. It is difficult to measure the overall volume of self-insured health care coverage, because most of it is outside the scope of state reporting requirements. Estimation is also complicated by the fact that the state does not require insurers, HSPCs, or HMOs handling self-insured business to report their volume of self-insured claims. However, on the basis of the 1985 Minnesota Employer Survey,* we estimate that self-insurance covers approximately 25 percent of all Minnesotans with private health care coverage.

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*Conducted jointly by the Minnesota Department of Health and the Division of Health Services Research and Policy, School of Public Health, University of Minnesota.

(This excludes people with coverage administered directly by government agencies.) Most self-insured business is accounted for by individually self-insured private companies. The remaining 75 percent of the state's citizens not served by government programs are "insured" by insurers, HSPCs, or HMOs.

Private, individual self-insurers are not regulated at all. Public, individual self-insurers are subject to some state requirements regarding bid solicition and reserve establishment, but are otherwise exempt from most state health plan company regulations.

ERISA also prohibits states from regulating some categories of group self-insurers. These include Taft-Hartley trusts and multiple-employer welfare associations (MEWAs). Taft-Hartley trusts are health benefit trust funds established pursuant to a collective bargaining agreement, and operated under the control of an association of employers and/or unions. Such trusts have historically been established in industries where single unions represent employees who work for many different employers, and/or where employees may shift frequently among employers (e.g., the construction industry).

MEWAs, by contrast, are associations of similar employers, usually in the same industry, for the purposes of pooling employee benefit costs. (MEWAs need have no union connection.) The federal government established MEWA definitions and standards in the early 1980s to assist states in cracking down on financially unstable multiple employer trusts (METs). In theory, trusts meeting the MEWA standards were to be outside state jurisdiction, but trusts failing the MEWA standards would be subject to state regulation and sanctions. Unfortunately, the MEWA standards are not very clear and the U.S. Department of Labor is not very active in evaluating trusts according to MEWA standards. This has led to continued confusion about the extent of state authority.

In part to remedy this confusion, Minnesota passed a statute in 1983 (M.S. 62H) to regulate trusts that do not meet the MEWA standards. Group self-insurance pools subject to M.S. 62H are called "joint self-insurance employee health plans." Two such entities have been in existence since the effective date of the statute, consisting primarily of small and medium-sized employers not in the same industry. To the extent that group self-insurers are subject to state regulation, it is handled by the Department of Commerce.

M.S. 62H applies to group self-insurance pools of private companies. Similar regulations apply to group self-insurance pools of public entities (M.S. 471.617). Several such pools exist in Minnesota, although the largest and oldest pools were exempted from all state insurance laws by a "grandfather" clause passed in 1983 (M.S. 62H.08).

D. THE HISTORY OF HEALTH PLAN COMPANIES*

The only extensive private health plans before the 1930s offered direct services, usually to employees in large industries and/or remote areas. Many obstacles existed to the development of private health insurance, including high acquisition and collection costs, the difficulty of controlling abuse and "adverse selection" (disproportionate enrollment of the sick), and the opposi-

*Part D is based largely on The Social Transformation of American Medicine, by Paul Starr (New York, 1982).

tion of established health care providers. However, the rising costs of hospital care during the 1920s, especially for middle-class families, and the attendant difficulties for hospitals in collecting bills, created conditions more favorable to the development of insurance.

The first efforts in this direction were by several hospitals in Texas, which began to offer guaranteed services in return for an annual "subscription" fee. However, single-hospital plans proved to be financially unstable, and gradually gave way to more broadly based community-wide plans, which permitted enrollees to use any hospital in a given community. A plan of this kind was created in St. Paul in 1932. By 1937, over 800,000 people nationwide had enrolled in such hospital insurance plans, and the American Hospital Association began to actively promote such plans under the name of Blue Cross.

Around 1940, most states passed special enabling acts for such "hospital service plans," as they were then called (in Minnesota, 1941, originally M.S. 309.10 - 309.17). In most states, including Minnesota, these acts provided that the organizations would be non-profit, controlled by the member hospitals, and under the supervision of the state insurance commissioner. Hospital service plans were the forerunners of the current non-profit health service plan corporations.

Despite fears about adverse selection and abuse, the success of the Blue Cross companies encouraged some commercial insurers to also offer hospital insurance beginning in 1934. By 1940, commercial insurers had about 3.7 million subscribers for hospital insurance, while Blue Cross companies had over 6 million. As provider-controlled organizations, Blue Cross companies were specifically authorized to extend coverage in the form of service benefits, which guarantee payment for services directly to health care providers (often the entire bill). Service benefits usually entail explicit agreements between providers and health plan companies. By contrast, commercial insurers in most states were restricted to indemnity benefits, which reimburse enrollees for medical expenses (usually not the entire bill). This difference, in addition to non-profit status, constituted one of the primary original differences between commercial insurers and HSPCs.

Initially, both Blue Cross plans and commercial insurers covered only hospital care, but commercial insurers gradually began to add coverage for medical services as well. The American Medical Association became concerned about commercial insurers' growing role in health care financing. Blue Cross companies, which could legally provide only hospital coverage, also became concerned about losing business because commercial insurers' could offer broader coverage. These concerns gave rise to the formation of Blue Shield companies, similar to Blue Cross, but physician controlled and for the purpose of covering physicians' services.

The Minnesota enabling act for Blue Shield plans was passed in 1945 (M.S. 159). It authorized creation of "voluntary nonprofit medical service plan corporations," in order "to make possible a wider and more timely availability of medical care, thereby advancing the public health and the science and art of medicine in this state." The Blue Cross and Blue Shield statutes were consolidated in 1971 as M.S. 62C (Laws 1971, ch. 568). By 1945, Blue Cross had more than 19 million subscribers nationwide, commercial insurers had about 8 million, and the fledgling Blue Shield companies had about 2 million.

The number of people with health care coverage continued to grow rapidly during the late 1940s and 1950s. By 1953, approximately 63 percent of all

Americans had hospital coverage, split almost evenly between Blue Cross companies and commercial insurers. Coverage for physicians' services remained significantly less common, with commerical insurers retaining an advantage over Blue Shield companies. Commercial insurers' success was largely attributable to their increasing emphasis on employment group business, particularly by life insurers, and on their practice of experience rating---giving a lower price on healthy, low-risk workers. By contrast, Blue Cross and Blue Shield companies practiced community rating, whereby all subscribers received the same, community-average rate. Because experience rating allowed commercial insurers to offer a lower rate for low-risk groups, competitive pressures eventually forced Blue Cross and Blue Shield to offer experience rating as well.

HMOs, a third type of health plan company, began to emerge in the 1940s and 1950s, although the term "HMO" was not coined until the early 1970s. Unlike the Blues and commercial insurers, HMOs (to use the modern term):

- offer direct services as distinct from indemnity or service benefits;
- place providers at financial risk for at least part of the cost of health services; and
- restrict enrollees' access to health care providers affiliated with the HMO.

In these respects, HMOs were like the original subscriptions offered by single hospitals in the early 1930s. Because of vigorous opposition by established health care providers to the "corporate practice of medicine," HMOs were originally successful only in circumstances where they had their own hospitals or other independent resources. Early examples of success include Group Health Cooperative of Puget Sound, Kaiser-Permanente in California, the Health Insurance Plan (HIP) of New York, and the Group Health Association of Washington, D.C. By the mid-1950s, both Kaiser-Permanente and HIP had approximately 500,000 enrollees, but these cases were the exception rather than the rule.

HMOs got their big boost in 1971 when, as an alternative to pressures for national health insurance, President Nixon announced "a new national health care strategy" based on HMOs. HMO advocates argued that, by rewarding health care providers for maintaining health rather than treating sickness, the health care system would become more efficient and accessible. In pursuit of this goal, government aided HMO development by:

- providing grants and loans;
- requiring employers to offer employees the option of HMOs under certain circumstances (the "dual option" mandate), and
- establishing separate regulatory authority for HMOs, preempting certain state laws hostile to HMO development.

Minnesota passed its HMO enabling act in 1973 (M.S. 62D). By 1979, nationwide HMO enrollment was 7.9 million, or 4 percent of the population. This growth has accelerated rapidly in the 1980s, caused in part by continuing employer and government concerns about rising costs. In Minnesota, over one-quarter of the population is now enrolled in HMOs.

Self-insurance also experienced explosive growth in the 1970s and 1980s. As stated earlier, we estimate that of all Minnesotans with private health care coverage, 25 percent are now in self-insured plans. Vendors of self-insurance management services stress that self-insurance allows employers:

- to avoid the high overhead costs of large insurers;

- to retain control of their health benefits cash, and the associated investment earnings; and
- to be assured that they will not be penalized for the high costs of other employers---in this sense, self-insurance might be considered the most extreme possible form of experience rating.

Self-insurance was originally common only among large employers and union trusts. But through the use of "stop-loss" insurance to limit the risk for extraordinary incidents, self-insurance has become more practical and appealing for small and medium-sized employers.

Like HMOs, self-insurance benefitted significantly from a change in federal policy in the early 1970s, specifically, passage of ERISA, as discussed earlier. Although ERISA was concerned mainly with pension reform, it has had the unintended effect of changing the health care financing landscape. One particular ERISA provision, with convoluted language that has given rise to abundant litigation, has the effect of preempting state regulation of employee benefit plans, including self-insured health benefits. States can regulate the business of self-insurance plan administration, but they cannot directly regulate most private-sector self-insurers or their internal financial and administrative arrangements.

Because the federal government has not moved to regulate self-insurers, a function performed primarily by the states for all other health plan companies, they are substantially unregulated. This regulatory vacuum increases the advantages of self-insurance for employers, because it allows them to avoid costs associated with regulation such as premium taxes and state-mandated benefits.

E. CURRENT AREAS OF REGULATION

The regulations affecting health plans and health plan companies are extensive and complex, and would require a much larger paper to describe even in summary. Other background papers will assist commission members to become familiar with some of the most important features of Minnesota's regulatory structure, with special attention to differences in the treatment of different types of plans and plan companies.

It may be useful for commission members to think of regulations according their public policy purposes. These purposes, like the regulations themselves, do not lend themselves to simple, mutually exclusive categories. Nevertheless, with this disclaimer in mind, we suggest (at least as a starting point or basis for discussion) that all health plan and plan company regulations may be considered to serve one or more of the following purposes:

1. Sound organizational structure.
2. Financial integrity.
3. Fair rates and trade practices.
4. Adequate and continuous coverage.
5. Access to care and quality of care.
6. Competition.

Subsequent papers will address these regulatory purposes. Each of these six purposes is served by a variety of regulations. Taking each in turn, the purpose of ensuring a **sound organizational structure** is served by regulations that prescribe how a health plan company may be organized, who may benefit

from its operations, and who may have a role in its operations. This includes (but is not limited to) regulations concerning:

- What business forms a health plan company can take (e.g., partnership, business corporation, not-for-profit corporation).
- The composition of the governing board.
- The role of subscribers or enrollees in policy making.
- The retention of experienced and competent staff.
- For-profit vs. non-profit status, and the disposition of assets.
- Limitations on the delegation of responsibility.
- Limitations on the companies' relationships with health care providers.

The purpose of **financial integrity** is served by regulations that seek to prevent insolvency, and to protect consumers against the loss of coverage or services in the event that insolvency occurs. This includes (but is not limited to) regulations concerning:

- Capital, surplus, and liquidity.
- Accounting, reserving, and reporting.
- Permitted investments and reinsurance.
- External financial guarantees, including special segregated deposits.
- Health care provider risk sharing, including "hold harmless" agreements.
- State inspections and investigations.
- Insolvency guaranty funds, and procedures for managing insolvency and rehabilitation.

The goal of **fair rates and trade practices** is served by regulations that require adherence to principles of fairness in marketing and underwriting (i.e., criteria for accepting enrollees). This includes (but is not limited to) regulations concerning:

- Licensure and sales practices of agents.
- Use of accurate marketing materials, including advertising.
- Use of clear language in contracts of coverage, including prominent display of significant coverage limitations.
- Use of actuarially sound, socially acceptable, and non-discriminatry underwriting categories.
- Minimum acceptable "loss ratios" (the amount of benefits paid relative to premiums collected) for specific types of coverage.

The purpose of **adequate and continuous coverage** is served by regulations requiring that contracts of coverage include important coverages and enrollee protections, and that plan companies handle claims fairly and expeditiously. This includes (but is not limited to) regulations concerning:

- Coverage for specific services and protections: so-called "mandated benefits."
- The scope and amount of permissible cost sharing.
- Benefit-level criteria for certification as a "qualified plan."
- State approval of contracts of coverage before they can be marketed.
- Standards for terminating coverage.
- Enrollee rights to continue group coverage and/or convert to individual coverage upon losing group membership, discontinuance of provider participation, or plan company insolvency.

- Coordination of benefits among different health plan companies, and prompt and equitable settlement of claims.
- Arrangements with health care providers for continous service in the event of insolvency or contract termination.

The purpose of **access to care and quality of care** is served by regulations that seek to ensure that people in need of coverage can obtain it, that health plan companies do not limit enrollees' access to covered services unreasonably, and that the quality of care is protected. This includes (but is not limited to) the following types of regulations, most of which presently apply only to HMOs:

- Periodic open enrollment periods, and restrictions on the use of health screening in underwriting.
- Subsidized high risk pool coverage (Minnesota Comprehensive Health Association, or MCHA), for people with health conditions that prevent them from obtaining coverage on their own.
- Minimum arrangements with providers to be certified to serve a particular area, and arrangements for providing or paying for care outside the authorized service area.
- Permitted procedures for restricting enrollees' ability to obtain "in-panel" services or reimbursement, and minimum level of coverage for "out-of-panel" providers.
- Internal procedures for handling complaints and grievances.
- State inspections and investigations regarding access to care and quality of care.
- Internal quality assurance plan, committee, protocols, evaluation procedures, and feedback/correction procedures.
- Enrollee education, preventive care, and self-care programs.
- Procedures for handling medical records.
- Affiliated provider standards and education.

Last but not least, the purpose of promoting **competition** in the health care market is served by regulations that seek to promote a market structure conducive to competition, and the availability of competition-enhancing information to buyers of health plans and health care. While some competition-enhancing information and assistance programs would not be considered "regulation," they would include (but are not limited to) regulations concerning:

- Anti-trust issues, including price fixing, mergers that result in excessive market concentration, and other unreasonable restraints of trade.
- The promotion of alternative health plans (e.g., dual option mandate for offering HMOs).
- Reporting of information that, once made public, may assist buyers or otherwise strengthen competition.

F. MAJOR PUBLIC POLICY CONCERNS

The rapid changes occurring in the health care marketplace have given rise to a variety of public policy concerns regarding health plan and health plan company regulation. Specifically, concerns have been raised about (1) the adequacy of regulation, and (2) the equity of regulation. Questions have also been raised about the division of regulatory responsibility within state govern-

ment.* Subsequent papers will discuss in detail the key features of Minnesota's regulations as they affect these concerns.

Health plan companies other than HMOs, such as insurers and HSPCs, are becoming increasingly involved in activities formerly associated only with HMOs. These include:

1. direct arrangements with health care providers for the purposes of sharing risk, attracting customers, and/or influencing the costs of health care delivery; and
2. restrictions on enrollees' coverage if they do not obtain services from affiliated health care providers.

Thus far, insurers and HSPCs have not sought to provide services directly, as some HMOs do. But some insurer and HSPC-sponsored health plans, such as preferred provider arrangements (PPAs), have tested the boundaries between HMO and non-HMO products.

HMOs, for their part, are also becoming more involved in activities that were formerly the sole province of insurers, including fee-for-service coverage for providers not affiliated with the HMO. So-called "wraparound" or "combination" plans that offer coverage both inside and outside an HMO's panel of providers are becoming increasingly popular. HMOs received expanded authority in this area in 1987 (subject to the adoption of rules by the Department of Health, M.S. 62D.05. subd. 6).

These changes in plan companies' scope of activities raise questions about the adequacy of consumer protection regulation. For example, insurers' and HSPCs' increasing involvement in questions of health care appropriateness or efficiency may require new regulations. HMOs are subject to some regulations to ensure that the quality of care is not compromised by efforts to improve efficiency, but insurers and HSPCs are not. Conversely, insurers and HSPCs are subject to more stringent financial integrity regulations than HMOs, in part because HMOs' contracts with providers often reduces the HMOs' risk. As HMOs undertake more activities similar to insurance companies, it may be appropriate to strengthen their financial integrity requirements.

Concerns have also been raised about the equity of regulation, specifically, whether differences in the regulatory treatment of different types of plans and plan companies are appropriate. As we discuss in the remaining background papers, significant regulatory differences exist in the areas of: (1) financial integrity, (2) quality and continuity of care, (3) mandated benefits and contract provisions, (4) tax status, (5) provider contracting authority, (6) open enrollment periods, and other areas. Many of these differences affect the relative competitive standing of health plan companies.

As discussed earlier, each type of health plan company has unique historical origins, and associated public policy purposes that shaped the regulations governing it. The health care market of 1988 is much different than it was when the statutes authorizing each type of health plan company were first

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*The Department of Commerce has primary responsibility for most health plan company regulation, except for HMO regulation, which is the responsibility of the Department of Health. For public programs such as Medicaid, the Department of Human Services also has a limited regulatory role.

established. In light of this, it is appropriate to ask whether the different categories and regulations still make sense today. How do the differences affect competition between plan companies? Do the purposes served by the different categories outweigh potential competitive inequities? More fundamentally still, do the different categories of health plans and health plan companies still serve the public interest, or might the public be better served by new categories based on the new conditions in the marketplace? These questions and more may be considered by the commission in evaluating the need for regulatory reform.

BACKGROUND PAPER

CURRENT ISSUES AFFECTING HMOS

MINNESOTA DEPARTMENT OF HEALTH

HEALTH SYSTEMS DEVELOPMENT DIVISION

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INTRODUCTION

This paper is prepared as a brief overview for policymakers and others interested in current developments affecting health maintenance organizations (HMOs). This paper explores changes in relationships among HMOs, providers, and health plan purchasers, and to identify potential problem areas. For a more complete discussion of Minnesota's health care markets, see Minnesota Health Care Markets--1987 (hereafter cited as Markets '87). This report, to be released shortly, provides a detailed analysis of changes in the health care system, and an assessment of Minnesota health care markets' performance in the areas of cost containment, access to care, and quality of care.

BACKGROUND

Minnesota has experienced significant growth in HMO enrollment since the HMO Act was enacted in 1973. What began as an experiment in health care coverage now includes nearly half of the residents of the Twin Cities Metropolitan Area, and nearly one quarter of the state's population. In 1986, HMO enrollment grew 16%. 1987 enrollment figures for all HMOs are not yet available, but preliminary figures show that some plans grew as much as 13% and 23%. Minnesota is regarded as a national leader in the development of Os; many industry analyst look here to see what the next national trends will be.

It is helpful in discussing changes in health care financing and delivery to define certain key terms used in this paper, and to describe the basic relationships among key actors in the health care market.

An HMO is a health care financing and delivery system which, for a prepaid sum, provides all services necessary to maintain an enrollee in good health. The prepaid sum cannot be adjusted retroactively to reflect an enrollee's past consumption of health care services. Therefore, HMOs have strong incentives to deliver health care services efficiently.

HMOs reimburse participating health care providers, that is, providers with whom they have contracts, or who are employees of the plan. The participating provider does not bill the enrollee for services received, but is paid by the HMO. HMO enrollees, in turn, must receive their care from HMO participating providers in order to receive coverage. Care provided by nonparticipating providers is generally at the enrollee's expense. Two notable exceptions to this practice are out-of-area health care costs and authorized referrals.

In the traditional fee-for-service system, providers billed the enrollee, who was then reimbursed by the insurer. Providers charged what they thought were appropriate rates, and insurers paid claims if the service was covered in the contract. Only rarely did the insurer dispute the "medical necessity" of the service.

Other types of health plans combine fee-for-service reimbursement structures, but providers discount their rates to the health plan. A newer model of health plan is the preferred provider arrangement (PPA). In a PPA system, an enrollee is reimbursed at a higher rate for using a preferred provider than for using a non-preferred provider. The difference between a PPA and an HMO is that the majority of costs of using non-preferred providers is still covered; the enrollee is not as limited in choice of provider as with an HMO.

In an HMO system, the plan may share risk with participating providers for health care expenses through its provider contracts. Many HMO providers share this risk through "capitation" arrangements. That is, providers receive a fixed sum per member to treat the HMOs' members. The provider must then treat the HMO members he or she serves within the overall income from the HMO. In other cases, the provider shares the risk with the HMO through "holdback" or withholding arrangement. Under a holdback arrangement, a percentage of the providers' reimbursement is held back from periodic provider payments, and returned to the providers if the plan has a successful year, or is kept by the plan to balance its budget if necessary. Providers may also be salaried employees of the plan. As with any business, salary increases and job security are dependent upon the plan's success.

HMOs often receive significant price discounts from major providers such as hospitals, in return for directing its members to that facility. Such discounts are granted by the providers in the expectation that HMO patient volume will at least make up for the discount.

These contractual or employment relationships are intended to control health care costs by allowing providers to experience the cost of services they deliver. In a fee-for-service system where providers are paid after services are rendered, providers can increase their revenues by providing more services. Most analysts believe that fee-for-service reimbursement contributed substantially to health care inflation over the last several decades. The HMO concept was introduced as an alternative to the fee-for-service model, with cost containment as one of its major objectives.

In addition to cost containment, HMOs were expected to deliver care based on entirely different assumptions than traditional health insurance. Rather than paying for the treatment of diseases, HMOs would have incentives to emphasize preventive care. By avoiding the treatment costs associated with illness, the HMO would spend less out of its fixed pre-paid sum. This theory is reflected in the statutory prohibition against copayments or deductibles for preventive health services. Other copayments and deductibles are limited by Health department rules to 25% of the cost of the service provided.

Another significant difference between HMOs and other health plans is the responsibility imposed upon HMOs by state law to monitor quality of health care. When the HMO Act was passed by the Minnesota Legislature in 1973, concerns about the potential for underservice posed by economic arrangements placing providers at financial risk for over-utilization led to the imposition of requirements that HMOs maintain well thought-out and well-staffed quality assurance systems. Historically, insurers did not directly control the amount or kind of services provided to insureds. Therefore, quality assurance systems have not been imposed on non-HMO health plans.

While HMOs' relationships with providers differ from those of insurers, HMOs are like insurers on the other side of the marketplace, i.e., the market for health plan customers. In that market, they compete with other health plans such as fee-for-service plans, Blue Cross/Blue Shield plans, and preferred provider insurance plans. Another source of competition are the third party administrators which serve self insured employers. HMOs have traditionally served group purchasers, but have recently increased the number of individual policies they offer, mainly in the Medicare market.

Some group purchasers are in a position to directly negotiate the price and benefits of the health plans. Individuals and small groups, on the other hand, negotiate indirectly by switching plans if comparable benefits can be found at a lower cost. Self insured employers have the most flexibility relative to benefit plan design. These employers are not subject to state mandated or minimum benefits laws due to the federal (ERISA) law which pre-empts state regulation. They can therefore design a benefits package to suit their needs. On the cost side, self insured employers face costs of health services consumption directly through claims volume. While the skills and negotiating leverage of purchasers varies, the general rule of the market still holds--purchasers will try to keep their costs down.

Government has more recently looked to HMOs to hold down health care costs in public assistance programs. A Prepayment Demonstration Project involving three counties began in 1984, and in 1987, the Legislature authorized prepayment on a statewide basis. Similarly, the federal government since 1985 added HMOs as an option for Medicare recipients.

In both cases, state and federal laws set HMO reimbursements at a rate somewhat lower than projected fee-for-service costs. The expected cost savings to government are "up front;" the plans either accept the business at the quoted rates or decline to contract with the government. Recently, HMOs have declined to serve in the expanded Medicaid Prepayment Initiative, and have withdrawn from the Medicare program in several rural counties on the grounds that the government's rates are too low.

With this general overview in mind, one can focus on market changes which have taken place in the last two years.

RECENT EVENTS

Three competing pressures on HMOs have increased over the past few years. The first is that health care providers are increasingly demanding higher rates of reimbursement from third party payors of health care costs. The rate of inflation in health care services costs is significantly higher than the overall consumer price index. At the same time, employers are resisting what they perceive to be excessively high premium quotations from HMOs and other health insurers. A third force, which affects all third party payors, is increased sophistication in medical technology coupled with consumer demand for that technology. Finally, quality of care issues affect the HMO market.

Provider Relations. A perhaps inevitable series of negotiations and discussions are taking place between several HMOs and their contracted providers of care. In order to keep rates competitive, the HMOs have limited their reimbursements to participating providers. These providers, on the other hand, believe that their reimbursements have been inadequate in recent ars. The result in some cases has been well-publicized confrontations between HMOs and their participating providers.

A notable example of an HMO/provider dispute occurred between Physician's Health Plan and a group of dissatisfied providers (whose numbers reportedly reached 1,000). A group of concerned doctors had expressed displeasure with the plan's management; this displeasure resulted in a litigation. Their numbers increased when, in order to balance its budget, PHP announced that it would not be returning the providers' contingency reserve (a holdback arrangement.) Additional providers joined the ranks of the dissidents, ultimately forcing a restructuring of the plan's board of directors. Reimbursement issues and quality concerns were the principal reasons for the dispute.

The major clinic in Faribault announced its intention to terminate affiliations with PHP this fall, and more recently, four major Twin Cities clinics have announced their plan to terminate contracts with PHP, citing inadequate reimbursement. Major readjustments were necessary to ensure that enrollees health care needs would continue to be met.

MedCenters Health Plan was also involved in a dispute with its major provider group, the Park Nicollet Medical Center. Again, reimbursement issues were a factor. The Clinic wished to be able to contract with other plans, and some members of the MedCenters Board believed that to be in violation of the provider agreement. The dispute was settled in 1987 after MedCenters agreed to allow the Medical Center to contract with another health plan in limited ways. Another dispute, this one concerning reimbursement, was submitted to arbitration. Out of concern for the financial solvency of the HMO, the Minnesota Department of Health subsequently issued a cease and desist order to prevent the HMO from implementing the arbitrator's award. The matter is the subject of pending litigation.

Share Health Plan's arrangements with the Buffalo Medical Center and St. Cloud Clinic were terminated after a lengthy attempt to negotiate a reimbursement structure which was satisfactory to both the providers and the plan. The plan had altered its capitation agreement with the St. Cloud Clinic to a modified fee-for-service arrangement in November of 1986. However, the plan projected a loss of $1 million in 1987 and clearly, the plan could not continue with that arrangement. Providers, however, held firm, apparently willing to terminate their contracts with SHARE.

The negotiating strength of providers can be significant in Greater Minnesota, where a small city or town may be served by one or two dominant clinic groups. Alternative providers may not be located within a sufficiently close distance to permit substitution of those providers within the service area under state laws and rules. Thus, a failure on the part of an HMO to make arrangements

with the dominant clinic may result in the HMO's withdrawal from that service area. HMOs will naturally withdraw from a service area only as a last resort. This situation gives the dominant provider a strong hand in negotiating with the HMO.

Hospitals have also objected to HMO provider agreements. The Minnesota spital Association sought and obtained a directive from the Commerce Department which prevented one HMO from implementing a provider agreement it found unfavorable to its members. The Commerce Department found the contracts to be in violation of state law. The example is cited to show that HMOs' reimbursement negotiations with providers is by no means limited to physicians.

Only a few years ago, providers felt that the HMOs had the upper hand in the marketplace, and that to resist them would be to lose a significant portion of patients. Providers are clearly much more aggressive now, and these issues will take time to resolve.

Employer Relations. Employers are becoming increasingly resistant to premium increases. The State of Minnesota has a labor-management team which reviews bids from health plans. This past year, the labor-management team adopted a very tough approach to premium increases. Several plans were forced to trim requested increases.

In addition, the state sets its contribution at the level of the lowest plan's premium. State employees must make up the difference. Considerable evidence exists that employees have switched because of price or benefit differentials. Clearly, the pressure is on the plans to bid low in order to be selected, first by the state, and then by state employees.

Honeywell Corporation made a major shift in its health plan purchasing practices last year by only offering two preferred provider type plans to management employees. Several HMOs were dropped as a result of this change. As a self-insured employer, exempt from the minimum benefit and coverage requirements of state laws, Honeywell was free to negotiate extensive changes in copayments and deductibles.

This past fall, Hennepin County, a major public employer, dropped PHP, Share, and MedCenters in favor of Group Health, Metropolitan Health Plan, and a small preferred provider arrangement. Premium costs were cited as a factor in the county's decision. Approximately half of the county's employees elected one of the HMOs.

Health plan companies have for the last few years perceived the marketplace as highly price sensitive. Many plans believed that while they needed to increase premiums to cover anticipated expenditures, the market would not tolerate that level of increase. Business would quickly shift to the lower priced plan or plans. Their perception is reflected by the single digit increases in premiums for all types of health care plans during the years 1982-86, compared with higher rates of premium increases nationally. Minnesota consumers have benefited in terms of premium costs from this competition. (See, Markets '87, forthcoming).

Another highly price sensitive market is the Medicare market. Advertisements quoting prices for Medicare products are quite common, and HMOs compete fiercely for market share. HMO premiums were considerably lower than the prices of insurance plans, and HMo coverage is usually more comprehensive. Recent terminations of Medicare contracts in rural Minnesota are an indication that the rates were too low relative to the costs of serving the Medicare population in that area.

In addition to perceiving the market as unwilling to sustain large premium increases, many HMOs priced their products low in order to increase their market share. Indeed, the low-premium increase years are also those of rapid HMO enrollment growth. Some observers believe that the Medicare products were underpriced, given the utilization that could be expected from an elderly population.

This past year, some upward movement in premiums has taken place. During the previous four years, health plan premium increases averaged 5% for the State of Minnesota's benefits program (including HMO and other plans). In 1987, the average increases for health insurance plans were approximately 9% for individual contracts and 11% for family contracts. (These figures do not reflect the renegotiation of the state's contract with Blue Cross/Blue Shield of Minnesota). There was, however, quite a bit of variation across plans. ports from other employers indicate similar average premium increases (Markets '87, forthcoming).

Increases for particular groups varies widely, of course. Some major Twin Cities employers were quoted increases for insurance plans between 40% and 90%. Some of these rates were eventually withdrawn due to employer resistance.

Overall, HMO premiums have not increased as rapidly as insurance plans. Medical Benefits (January 31, 1987) cited expected rate increases of 20% for insurers, but noted that HMO premiums were expected to increase only 2% to 8%. An article in the Minneapolis Star-Tribune (January 21, 1988) compared HMO premium increases averaging 17% with ranges from 5% to 26.8%. Fee-for-service plan were expected to increase up to 30%. Blue Cross/Blue Shield increases were quoted at 15%.

Other evidence of the role of premiums in employers' decisions to offer health plans are presented in the Markets '87 report.

Advances in Medical Technology and Other Medical Issues. Another major force affecting HMOs and other third party payors is the rapid change in medical technology. Organ transplants are a primary example of an area of health benefits once routinely excluded as "experimental". However, transplants are increasingly becoming standard medical practice. Movement into the mainstream of practice does not necessarily mean that the procedure becomes inexpensive. On the contrary, transplants still cost hundreds of thousands of dollars. Depending upon contract language, a plan may be liable for an expensive procedure once that procedure becomes standard medical practice. Costs can greatly exceed projections even if the plan only experiences a few such cases.

Neonatal intensive care is another example of expensive health care. Today, low birthweight babies survive who may have died even a few years ago. The necessary care must be provided by HMOs to eligible dependents, and may run thousands of dollars per day. Again, a few cases may have a significant impact on the plan's overall financial performance, particularly in the smaller plans.

HMOs, which are required to provide all services necessary to maintain an enrollee in good health, have less latitude than insurers and other health plans in limiting coverage under state laws. Further, advertising to consumers which emphasizes broad coverage creates expectations on the part of those consumers that all health care needs will be covered.

As medical technology advances, consumers demand that technology when they feel they need those services. Denials of service are often widely publicized disputes between the plan and the enrollee. Advocacy groups for special needs populations such as the technology dependent frequently take their case to the media or even the legislature in an attempt to mandate additional benefits.

AIDS and AIDS-Related Complex (ARC) represent another significant area where third party payors can expect costs to increase. Medical technology may find a cure, a vaccine, or less expensive treatment modes in time, but such solutions are not yet in sight. Until then, third party payors can look forward to paying for hospitalizations, drug treatment, and possibly, home care services for these patients. Of one thing we can be certain: the numbers of HIV infected individuals will increase in the short run, as will the associated health care costs.

Unlike insurers, HMOs may not impose lifetime maximums on benefits provided to any enrollee. Thus, HMOs' financial performance is more threatened by the addition of mandates for expensive care, or by changes in standard medical practice which make expensive procedures the "norm".

Quality of Care. The quality of health care provided by HMOs has been challenged since the beginning by those who favor fee-for-service arrangements. There has been much discussion about hospital discharges occurring too early, before patients have fully recovered. Some physicians feel that the financial incentives to withhold needed services is too strong, and that patients are being underserved to the patients' detriment.

The HMOs dispute the notion that their incentive systems do more than encourage physicians to be more efficient in their use of health care services. HMO representatives note that any choice between enhanced income and the patient's needs is an ethical one for the physician, who is note "forced" to practice in a particular style by the HMO.

One of the difficulties in the debate is the absence of systematic data on how patient outcomes are affected by the delivery of care. Many discussions about quality of care simply take the fee-for-service standard of health service delivery as the norm. One cannot assume, however, that more health care services leads to better health care. For example, medical experts generally agree that U. S. cesarean section rates are too high (American Journal of

Public Health, August 1987). A recent California survey shows that patients of private insurers had a significantly higher cesarean section rate than HMO patients. (See American Journal of Public Health, January, 1988).

Three of Minnesota's HMOs have contributed significantly to the development of such standards over the past two years. Working with the Minnesota Department of Health, they refined and tested a quality assurance tool which focuses on preventable inpatient admissions. When a preventable admission is detected, review of the patient's chart is initiated to determine the quality of the ambulatory care provided prior to the admission. This work has received national acclamation, and serves as a positive model for voluntary quality assurance improvements.

The assessment of quality of care delivered by the various health care financing mechanisms is a difficult one. Until the medical community develops quality standards based upon objective evidence of patient outcomes, we must temper the discussion by reminding ourselves that all reimbursement systems contain incentives of one kind or the other, and the lack of quality assurance mechanisms by insurers does not necessarily mean that fee-for-service doctors do not provide quality care, any more than the existence of quality assurance mechanisms in HMOs means that quality is always assured.

DISCUSSION

The market HMOs face today is dramatically different than it was ten years ago. The health plans market has experienced several years of relatively intense price competition. More recently, providers who contract with HMOs have resisted traditional HMO reimbursement rates and mechanisms, in some cases opting not to do business with particular HMOs. Consumer demands for medical care services continue to increase, in part because consumers have been largely insulated from the costs of those services by third party payment. There is an increasing tendency to believe that "insurance" should cover all medical needs. The cost of health care services the HMOs pay for have continued to increase. At the same time, premium increases necessary to finance the costs of increased benefits and more costly care are strongly resisted by purchasers.

Price competition on the one hand, and increased costs and expectations on the other, have resulted in poor financial performance for the HMO industry over the past two years. In addition to market pressures, HMOs experienced a significant unbudgeted cost increase when the 1987 Legislature included them in the Minnesota Comprehensive Health Association. Assessments to support this insurance pool for uninsurable individuals ranged from $1 million to $2 million for the four largest HMOs.

HMOs and state policymakers are understandably concerned about the current state of the HMO industry. However, these concerns must be understood in the larger context of concerns about the entire health care industry.

While Minnesota's health care markets have held premium increases and health care expenditures lower than national averages, health care costs continue to increase well in excess of the general rate of inflation. In 1987, health

care costs increased 7.7%, while the Consumer Price Index increased only 1.1%. Health care's share of the Gross National Product continues to climb; in 1970, the share was 6.1%, but in 1985, reached 10.6%. Physician charges continued to increase; physicians' median individual profits increased 10% in 1986 (Medical Benefits, October 15, 1987).

While inpatient utilization has decreased, many analysts suspect that outpatient services, which are more difficult to control, have increased. Drugs costs, which HMOs must cover, have also increased sharply. Two examples are AZT, used in the treatment of AIDS, and Mevacor, which is used to reduce serum cholesterol. AZT averages $100 per patient per month. Mevacor averages $65 per patient per month. Utilization of both of these drugs is expected to increase. Policymakers, health plan companies, and purchasers continue to search for ways to control health care costs.

The AIDS epidemic and the aging population of Minnesota and the United States will alone increase the demand, and the price, of health care services. HMOs, which must provide comprehensive health care services, and may not impose dollar maxima on individual enrollees, will feel these cost increases more than insurers who can limit benefits and have more flexibility to impose copayments and deductibles.

The State of Minnesota has adopted a policy of fostering competition in order to discipline health care costs. In a competitive approach, government does not try to protect firms from the marketplace. If individual firms make poor business decisions, they must suffer the discipline of the market. Similarly, if the marketplace is no longer interested in the product or service produced by an industry, it is not the role of government to maintain that industry, unless the industry supplies a basic human need, like health care.

Low surpluses on the part of health plan companies could be one indication of efficiency and strong competition. Even overall losses might be necessary if the market contained too many actors. Elimination of weak actors, and consolidation of others may be a necessary part of competition.

A competitive approach does not mean that government has no role in the HMO market, or in the broader health care market, however. Unlike many goods and services produced in the marketplace, health care is essential to life. Poor health impairs an individual's ability to hold a job, function well in school, or engage in most of life's activities. Because health care is so important, competition will be limited if necessary to ensure that access to health care is not disrupted.

Competition may detract from other, equally important public policy objectives. Health care for those without means to pay is a clear example. In the typical market, those who cannot pay do not obtain the good or service produced. In contrast, our society has traditionally expected that health care providers will provide care to those in need without regard to whether the patient can pay. Some question whether an ethic of charity and compassion can be maintained in a competitive environment. Balancing our multiple objectives for health care is the challenge that state policymakers, the industry, and the public must confront.

One important limit to competition is inherent in the reason insurance policies exist. Consumers purchase health insurance, or any other insurance, to protect themselves from financial risk. Therefore, states have traditionally regulated insurance to ensure that the plan providing protection to the consumer is able to meet its obligations. Insurance coverage does little good if it is not available when it is needed. In health health care coverage, particularly HMOs, continued access to care, rather than financial stability per se is the objective.

Reserves, net worth, and other financial requirements place limits to competition in that they impose barriers to entry into the marketplace. Only those firms which can meet financial requirements are allowed to operate. Both the size of plans, and the number of plans will be directly affected by financial integrity requirements imposed to protect consumers.

Strengthening of requirements for HMO financial integrity are clearly needed at this time. The financial standards which were appropriate for a developing industry, struggling to compete with fee-for-service plans are not appropriate for an industry which claims as enrollees nearly half of the metropolitan area population, nearly a quarter of the state's population, and which operates in nearly every county in the State of Minnesota. The failure of a mature HMO would cause significant disruption in service for enrollees. Therefore, the Minnesota Department of Health will be introducing legislation to address this issue in the 1988 Legislative Session.

In addition to considering issues of financial integrity, policy makers and the public at large need to re-examine their demands on HMOs and other third party payors of health care costs. We cannot continue to expect both more costly services, broader coverage, unlimited access to health care providers and low premiums.

In many respects, HMOs have been crucibles for these competing pressures. Consumers expect an HMO to provide comprehensive coverage with minimal or no copayments or deductibles, to provide whatever service the consumer thinks he or she needs, and to allow the consumer access to the provider of choice, while at the same time containing health care costs. In addition, the state imposes an organizational responsibility on HMOs to assure quality, while other health plans are permitted to pass that responsibility to the provider.

Issues relating to mandated benefits need special scrutiny. As we require HMOs and insurers to assume more responsibility for financing more services, particularly expensive ones, the costs of premiums will increase. Increased premiums drive employers to self insure, in order to avoid the expensive mandates. Equity in mandated benefits must also be equitably applied to all payors.

Equity of regulatory burdens is clearly an important issue. As other health plans mimic the features of HMOs, important regulatory questions are raised. If these plans can market nearly identical products, but without the same regulatory burdens, HMOs are at a competitive disadvantage. As important, inequitable regulation raises concerns about gaps in consumer protection. The issue of relative regulatory burdens will be addressed by the newly created Governor's Commission on Health Plan Regulatory Reform.

Competition and cost containment are not the only public policy objectives in the area of health care. Access to health care is equally important. Insurance plays an important role in that access. Research has shown that persons with insurance visit the doctor an average of 3.5 times per year, compared with 1.5 for those without insurance. (See, Minnesota Department of Health, The Challenge of Providing Financial Access to Health Care in Minnesota). Maintaining acces to affordable comprehensive health care coverage is a public health concern.

Quality of health care is another important public policy goal. HMOs, other health plans, regulators, medical and public health experts must work together to to develop valid systems for quality assurance. Access to health care must continue to be access to health care of acceptable quality.

As discussion of the current financial situation of the HMO industry continues, policymakers, the public, and the industry itself must bear in mind the numerous objectives we all have for the health care system. These objectives often conflict with one another, and when the do, we must make hard choices. No one will be completely satisfied with every choice made in every situation. Since we cannot satisfy all of our objectives all of the time, we must instead make our choices on an informed and rational basis. The Minnesota Department of Health is prepared to exercise the leadership needed to facilitate that discussion.

Minutes

GOVERNOR'S COMMISSION ON HEALTH PLAN REGULATORY REFORM
MEETING SCHEDULE

MEETINGS BEGIN AT 1:00 pm. 4/22/88

Mtg #		Agenda to Begin Issue Discussion
		I. *What should health plan companies be required to offer consumers?*
# 5:	April 22	A. Mandated Benefits
# 6:	May 13	B. Limits on Risk Selection
		II. What must health plan companies do to assure that they have the resources to deliver an acceptable health plan?
# 7:	June 3	A. Financial Integrity
Week of June 6		Public testimony*
Week of June 13		Public testimony*
#8:	June 24	B. Delivery System Capacity, Continuity and Restrictions
		III. Besides competitive forces, what methods or mechanisms will guarantee health plan company accountability to consumers?
#9:	July 15	A-B. Quality Reviews and Corporate Governance & Consumer Complaint Procedures
#10:	Aug. 5	C. Categorization of Health Plan Companies in State Laws
#11:	Aug. 26	D. Price/Cost Reviews
#12:	Sept. 16	E. Differentiation in Benefits/Pricing Based on Consumer Accountability
		IV. What health plan coverage options should the State make available to those left-out by the private market?
#13:	Oct. 7	A. Minnesota Comprehensive Health Association (MCHA)
		V. Other Regulatory Concerns
#14:	Oct. 28	A. Profit Status, Taxes and Administration of Regulations
#15:	Nov. 18	**Draft Report**
#16:	Dec. 9	**Adopt Final Report**
#17:	Dec. 30	(if necessary)

* Meetings for public testimony will cover an entire morning or afternoon.

COMMISSION ON HEALTH PLAN REGULATORY REFORM

4/22/88

WORKPLAN FRAMEWORK

I. What should health plan companies be required to offer consumers?

A. Benefit Mandates (4/22)

Mandated Benefits
- Are mandates a necessary regulatory action to assure adequate health care coverage, or will consumer demand achieve acceptable results?
- Should the State establish a mandatory process to evaluate the cost effectiveness and economic impact of proposed mandates before they are introduced for legislative consideration?
- Should the State evaluate the cost effectiveness and economic impact of current benefits?
- Does the existence of mandates prevent some companies (especially small employers) from providing employees at least minimal health coverage, as opposed to no coverage at all?

Qualified Plan Requirements
- Do qualified plan standards serve a useful role?

B. Limits on Risk Selection (5/13)

Extension, Conversion and Replacement Requirements
- Were actions of the 1988 legislature to provide replacement coverage for individual policy holders adequate? Inadequate? Too restrictive?
- Are requirements for group continuation and conversion policies for HMOs, insurers or HSPCs adequate? Inadequate? Too restrictive? How much authority does the State have in-light of federal regulation?
- Should continuation and conversion requirements be imposed on PPAs?
- Are current continuation, conversion and cancellation regulations for health plan companies equitable?

Open Enrollment and Underwriting
- Should HMOs be allowed to place dollar limits on liabilities as as insurers are allowed to?
- Should all types of health plan companies be required to offer "open-enrollment" as HMOs are now required to do, or should open-enrollment be eliminated altogether?

II. What must health plan companies do to assure society that they have the resources to deliver an acceptable health plan as defined in I. above?

A. Financial Integrity of Health Plan Companies (6/3)

Financial Integrity Regulations (Within limitations - ERISA overview)
- Start-up capital requirements. Adequate?
- Reserve requirements. Adequate?

A. Financial Integrity for Health Plan Companies (cont.)

Insolvency Protections
- What if any provisions are needed to better protect enrollees, in the event of health plan comapany insolvency? Guaranty Fund participation? How should HMO's unpaid bills from out-of-panel providers be handled?
- Should all managed care health plans be required to have hold-harmless provisions in their contracts with providers (e.g. PPAs)? Are hold-harmless provisions necessary for HMOs in-light of insolvency protection laws passed by the 1988 legislature?

B. Delivery System Capacity, Continuity, and Restrictions on Access (6/24)

Delivery System Capacity
- Should non-HMO managed care plans be certified for geographic market areas, to assure adequate in-panel system capacity?

PPA and HMO/Wrap-Around Plans
- Should the State regulate the manner in which health plan companies structure in-panel/ out-of-panel benefits for hybrid products of managed care and insurance?

Consumer Access Requirements
- Should the State regulate or disallow administrative requirements imposed upon enrollees by health plans, which may unduly delay or deny access to health care services? (e.g., Gatekeeper models)
- Should regulatory limits be established for provider reimbursement arrangements which may jeopardize the delivery of quality health care? (e.g., provider capitation arrangements)

III. Besides competitive market forces, what methods or mechanisms will guarantee health plan company accountability to consumers?

A. Quality Reviews and Corporate Governance (7/15)

Quality Assurance Systems and Studies Requirements
- HMOs are subject to certain quality of care regulations. Should these requirements be examined? Are they adequate? Inadequate? Should these requirements be extended to other health plan companies, especially those restricting access to providers?

Consumer/Provider Boardroom Representation
- Should insurers and HSPCs be required to provide for consumer representation in corporate governance like those required of HMOs? Should this requirement continue to apply to HMOs?

B. Consumer Complaint and Arbitration Procedures (7/15)
- Should insurers and HSPCs be required to provide consumer complaint forums similar to those prescribed for HMOs? Should these requirements continue to apply to HMOs?

C. Health Plan Regulation (8/5)

Categories of Health Plan Companies

- At what point do traditional health insurance plans and self-insured health plans become managed care plans in terms of: a) administrative requirements, b) provider risk sharing and contracting, and c) consumer access limitations?
- The current regulatory scheme is based upon company type, but as the product attributes of the various companies become increasingly similar, might another system of categorization lend uniformity and coherence to statutes governing health plan companies? Can regulatory lines be drawn such that different health plan products can be organized and offer through one corporation?

D. Price/Cost Reviews (8/26)

Premium Rate Review

- Are premium rate reviews necessary, or do market forces prevent excessive profit taking? Should rate regulation be considered for all types of health plan companies?
- Should rates be reviewed to prevent inadequate or "low-ball" rate practices. Are regulations adequate?

Health Plan Provider Contract Disputes

- The 1988 legislature established new authority for the State to order mediation in major disputes between HMOs and providers under contract. Are these regulations appropriate? Should this mechanism be extended to all managed care plans?

Coverage for Extraordinary Costs

- Should the State establish a special dispute resolution mechanism for experimental medical technology issues?
- Should government play a role in resolving disputes between health plan companies and enrollees regarding questions of medical necessity, and the distinction between medical and educational/social services?

E. Differentiation in Benefits/Pricing Based Upon Consumer Accountability (9/16)

Consumer Education and Responsibility

- What role can the State play in educating consumers about healthy lifestyles and cost effective medical choices? Should managed care health plans be required to have a more active role in consumer education?
- How much latitude should health plan companies have in pricing products based upon consumers responsibility toward a healthy lifestyle?

IV. What health plan coverage options should the State make available to those left-out by the private market system?

A. MCHA (10/7)

The Minnesota Comprehensive Health Association (MCHA)
- Which groups should MCHA serve - the uninsurable? the under-insured? the uninsured?
- Are current eligibility standards appropriate and fair? What conditions should provide presumptive eligibility?
- How should MCHA be financed? Should the financing of MCHA be changed (to a payroll tax for all employers) to include the participation of self-insured companies?

V. Other Regulatory Considerations

A. Profit Status (10/28)

Not-for-Profit Status of HMOs and HSPCs
- Are there sufficient reasons to maintain this requirement?
- Are regulations sufficient to prohibit unreasonable reimbursement of providers under contract and/or for-profit management firms?

Corporate Taxes
- Should HMOs pay corporate income tax as do the Blues? What types of health plan companies should pay premium taxes?

B. Administration of Health Plan Company Regulation

Who Regulates Whom
- Is the current division of labor between Health and Commerce appropriate for current market conditions? If not, how should it be different?

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APR 18 1988
Health Systems Development Division
MN Department of Health

HEALTH PLAN REGULATORY REFORM COMMISSION
March 25, 1988
MINUTES

Members present: Deputy Commissioner Ditmore for Commissioner Kawamura, chair; Commissioner Ashton, Carl Carlson, Robert Cooley, Dr. Richard Frey, George Halvorson, Dick Gomsrud for Commissioner Hatch, Jan Malcolm, Lawrence Schwanke, John Turner, Lois Wattman, Kip Sullivan, Representative Gruenes, and John Reiling.

Jack Ditmore introduced himself and stated that he was sitting in for Lani Kawamura, chair, who was unable to attend the meeting.

Ditmore asked for a motion and a second to adopt the minutes of the March 11, meeting. There was no discussion or changes. They were adopted.

Ditmore stated that the transcripts that members received should be edited and returned before the next meeting, so that they could be made available for members on the April 22, meeting. If no edited version is sent back, it will be assumed that the statement is correct, and will be passed out as so.

Ditmore asked Robert Cooley to make a statement of his views of the issues of this commission. (A complete transcript of his remarks is being prepared.)

Ditmore asked Kent Peterson, Director of Alternative Delivery Systems, Minnesota Department of Health to give an overview of the Health Department's regulation of HMOs.

Peterson explained that the department regulates HMOs through Chapter 62D of Minnesota Statutes. Their review is based on four elements: availability, accessibility, appropriateness, and acceptability. Under availability, they review the enrollee contracts, the provider structure and composition, the HMO corporation, their financial solvency, and the clearness of information for enrollees. In determining accessibility, they examine the geographic service area, emergency coverage, reasonable appointment scheduling including capacity and approval mechanisms, and hours of operation including the pre-authorization and referral process. In assessing appropriateness, they examine the quality assurance, physician certification, and ongoing peer review mechanisms. In determining acceptability, they look for consumer satisfaction through enrollee surveys and complaint systems.

Sister Ashton let all the members know that the Department of Health has now published the Minnesota Health Care Market--1987; it has interesting information as it relates to a competitive system and what is working and what is not working. It also has suggestions to what might make it more effective.

She will make copies of that available to the members of the commission.

Ditmore asked Richard Gomsrud, Agency Counsel for the Minnesota Commerce Department to give an overview of the Commerce Department's regulation of insurance companies and health plan service corporations (HSPCs).

Gomsrud stated that in reviewing a company that wishes to sell health insurance in Minnesota, they initially look at financial standards; asking whether the company has the ability to pay claimes. In many instances, companies that offer health insurance also offer life insurance. In those cases, the department would look at both kinds of insurance to assure that there is the financial integrity to pay claims in both areas. After determining financial solvency, the Department of Commerce reviews the product. The product is measured against statutory requirements. The department has four main chapters of Minnesota law which must be applied. Disputes on policy approval are handled through a hearing before an administrative law judge. Gomsrud indicated that the area of greatest activity for the department is enforcement. Items the department is involved in are arguments over access to treatment. With insurers and employers more involved in cost containment activities, consumers find themselves needing to turn to government for assistance. The department is involved in complaints about misrepresentation and insurance agents conduct.

Ditmore asked Mark Berndt to characterize the major regulatory differences between insurance and HMO health plan companies.

Mark Berndt distributed some papers to the members showing the differences between insurance and HMO health plan companies. He gave an overview of the approximate market share of Minnesota's health plan coverage, the health care industry, taxes and assessments, financial integrity requirements, and access and quality regulation. There were several areas needing modification, and Ditmore asked Mark to make the change and give the new information to the commission.

Ditmore introduced Alan Baumgarten, Office of the Legislative Auditor to present findings from the Auditor's recent study of health plan regulation.

Baumgarten stated that they were asked to do the study last May. Before they did the study they asked three questions. 1) Has state regulation of health plans kept up with changes in the marketplace? 2) What role, if any, should the state play in regulating self-insured health plans? and 3) How have the Departments of Health and Commerce carried out their regulatory duties? He stated that the enrollment in self-insured plans has grown in recent years. He gave a comparison of various health plans and showed how they have become very similar. He talked

about mandated benefits, and stated that health service plans sometimes replace mandated benefits with others that are "acturially equivalent."

Baumgarten showed examples of nonprofit organizations owning or operating for profit corporations. He said that HMOs have gotten around the nonprofit requirement through these kinds of companies. There was some discussion about this with commission members.

Baumgarten said that the state law is not effective in achieving what the legislature had as a goal--mainly, trying to influence how medicine was practiced, and how health care was delivered. Commission members said that they did not understand that. Baumgarten stated that the image of an HMO in 1973 was that of integration of health care provision and health care financing. A more typical model in Minnesota today is that of three tiers. You have providers, who are contracting with an HMO, and the third tier is that of a management corporation. So, rather than achieving integration of health care financing and health care delivery that was sought, we have divided it in more ways than was originally seen.

The conclusion that the Auditor reached is that 1) the differential regulations impair competition; 2) that some of the regulations have the effect of skewing business decisions; 3) having the multiple layers of these corporations in order to work around these regulations is inefficient; 4) as these corporations get more complex, it becomes harder for the state to oversee and regulate their functions; and 5) that an unlevel playing field creates an incentive for plans to get into self-insured adminstration and for them to steer employers to self-insurance plans.

The recommendations they have are that: 1) the consumer should better understand the coverage that they have; and 2) that the state create a body of managed health care plan regulation.

Baumgarten talked about solvency briefly. He said that only four HMOs had the deposit required by Minnesota Statute. Two of those four companies were the ones that are now being liquidated. He talked about the role of state agencies. The two recommendations they have regarding who should regulate HMOs are: 1) the legislature should transfer most regulatory responsibilties for HMOs to the Department of Commerce; and 2) the Department of Health should assume responsibility for quality assurance activities for all managed health care plans.

Baumgarten introduced Kathy Vanderwall. She talked about the survey they conducted. They sent the survey to employers of small, medium, and large companies. She spent some time going over the results of the survey.

There was discussion about the study. Commission members wanted to know what the reasons were behind companies going to self-insurance plans.

Ditmore thanked Alan and Kathy for there presentation to the commission.

Ditmore asked Commissioner Ashton if she wanted to distribute her written comments on the LAC report to the commission. She said that she wanted to wait with her comments until later.

Ditmore stated the next meeting date would be April 22, 1988. A Parking passes will be sent to commission members. A map is attached noting parking area and State Office Building.

Ditmore adjourned the meeting at 3:30.

*** Next Meeting ***

April 22, 1988, 1:00 - 4:00 PM
Room 5, State Office Building

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Health Systems Development Division
MN Department of Health

HEALTH PLAN REGULATORY REFORM COMMISSION
March 11, 1988
MINUTES

Members present: Commissioner Kawamura, chair; Commissioner Ashton, Carl Carlson, Dave Lutes for Robert Cooley, Dr. Richard Frey, Kathy Young for George Halvorson, Dick Gomsrud for Commissioner Hatch, Shiela Leatherman for Jan Malcolm, Lawrence Schwanke, Larry Frederickson for John Turner, Lois Wattman, Kip Sullivan, and Representative Gruenes.

Lani Kawamura, chair, opened the meeting by introducing herself and welcoming the commission members.

Kawamura asked for a motion and a second to adopt the minutes of the February 19, meeting. There was no discussion or changes. They were adopted.

Kawamura asked Kip Sullivan and Representative Gruenes to make statements of their views of the issues of this commission. (A complete transcript of their remarks is being prepared.)

Kawamura asked that the commission members to begin work on the plan for the commission's work over the next seven or eight months. She mentioned the issues that were handed out at the February 19 meeting and that Mark Berndt, Kathy Burek, and she had made another smaller list of those issues.

Kawamura asked Mark Berndt to review the one-page list. Under mandated benefits, Berndt stated that there has been questions as to how benefits are working to reduce health care costs. Under managed care plan regulation, Berndt stated that the list looks at the concerns of how quality care is being affected by managed care, and if the state should play any role in how companies administer their policies. Under consumer access to health plan coverage, Berndt stated that this issue concerns the fairness of coverage between HMOs and Insurance Companies regarding risk selection. Under regulating financial integrity, Berndt stated that there are some broad questions regarding this issue. Under level playing field, it really deals with specific inequities and administrative requirements regarding various health plans.

Kawamura asked Kathy Burek whether there were any key issues that were on the first list that were not on the second list. Burek stated that the general categories covered the issues very well. She said that the only issue that wasn't included was the notion of a cost benefit process for reviewing mandated benefits proposed. Provider dispute resolution also did not get picked up on the second list.

Kawamura said that the list that Mark put together was pulled from what the commission members said in their statements. The

statements have been sent to each presenter and will be distributed once they are sent back with any needed changes.

Kawamura then opened it up for discussion. There was some questions concerning a list of priorities for the commission to follow during the upcoming meetings.

Kawamura asked Kip Sullivan to start a discussion concerning guidelines for the commission to follow. Sullivan stated that he feels that efficiency is the guiding question. He said that he didn't think it was efficient for health plan companies to go belly-up every few years, and also nonprofit centers shipping money off to Colorado to subsidize some startup company through the parent company. Lois Wattman stated that she feels the guiding question is whether health care is a right to everyone. The other members seemed to agree with either Wattman or Sullivan.

Because of the disagreement as to what the guiding question for the commission should be, Kawamura asked that a voluntary, three or four person, Ad Hoc Committee be set up to report back to the commission, on the April 22 meeting, on the strategies the committee might use to determine the workplan. Kip Sullivan, Carl Carlson, Larry Schwanke, and Jan Malcolm volunteered to serve on the Ad Hoc committee. Kawamura stated that the commission will work on and adopt the workplan on April 22.

Kawamura stated that the Allan Baumgarten, Legislative Auditor, will make his presentation at the March 25 meeting.

Lois Wattman stated that it would be her preference, once the commission begins its work, to have three to four hour meetings instead of two hour meetings. There would be more time to work on the volume of things that need to be done.

Kawamura stated that one of the things she wants the Ad Hoc committee to look into is if it is necessary to have a committee structure, or if this could be decided as the need arises.

Mark Berndt stated that he would appreciate the name of alternates being sent to him as soon as possible. He also stated that on the tentative schedule the commission is planning to have some industry experts come in and have a panel session. Please give Mark suggestions for a panel member or any specific questions this panel should address. Also, if you have any background materials for the commission, Mark set up a small depository in the Legislative Reference Library. There was some discussion on a time table to secure these experts for the panel, because of their busy schedules. Mark stated that the panel would be sometime in May.

Kawamura adjourned the meeting at 3:00.

HEALTH PLAN REGULATORY REFORM COMMISSION
February 19, 1988
MINUTES

Members present: Commissioner Kawamura, chair; Dan McInerney for Commissioner Ashton, Carl Carlson, Robert Cooley, Dr. Richard Frey, George Halvorson, Commissioner Hatch, Senator Howard Knutson, Jan Malcolm, John Reiling, Lawrence Schwanke, John Turner, Lois Wattman, and Representative Ann Wynia.

Lani Kawamura, chair, opened the meeting by introducing herself and welcoming the commission members.

Kawamura asked for a motion and a second to adopt the minutes of the January 29, meeting. There was no discussion or changes. They were adopted.

Kawamura asked for discussion and questions regarding the charge of the commission. There was a question of how well the market works among the various companies. Would the state set up a yardstick insurance plan of its own to operate in certain areas? Kawamura asked the two staff people who drafted the charge for their response. Marianne Miller stated that the charge is very broad to address issues of regulation among health plan companies.

Carl Carlson asked what the companies are doing to come up with coverage for low income persons. Kawamura asked Representative Wynia to give her opinion on health care for low income persons. Wynia stated that the focus of the legislation was whether or not there needed to be a more uniform regulatory structure for all of the health insurance products. She said that the issue in regard to the problem of the uninsured was not the primary focus in establishing the commission. She said that the issues about the cost of the product is certainly related to the availability and the ability of people to purchase it, but they really were focusing, more specifically, on some regulatory issues than they were to a much bigger issue in our society; and that is the availability of health care.

Kawamura asked Representative Wynia if the charge gets at the fundamental concern about information and understanding on the part of the consumers. Representative Wynia stated that she is in general agreement with the charge.

There was some discussion regarding the commission being unable to separate the issues in the charge from the availability of services to the underinsured. Kawamura stated that the commission could discuss further those issues. Representative Wynia stated that the focus was not a commission to try to advise how to insure the ten percent of the population that don't have health insurance, but to look more at regulatory

issues and particularly as to how different types of health plans all relate to one another and how our regulations relate to each other. The charge was adopted on a voice vote.

Kawamura stated that each member of the commission was being asked to make a statement of their views of the issues of this commission. She then called on George Halvorson, Ann Wynia, Michael Hatch, John Turner, Dr. Richard Frey, Carl Carlson, and Lawrence Schwanke. (A complete transcript of members remarks is being prepared.)

Kawamura said that the presentations have been extremely helpful in educating her about the issues and educating commission members about the variety of positions represented on the commission. She stated that one of the things that struck her about the presentations is that each one of the people heard from have all dealt very articulately with the larger picture of health care. Kawamura asked the commission members to constantly remind themselves of the larger picture.

Kawamura stated that the staff of the commission is making transcripts of each presentation so that the commission would have them to use as references.

A handout, prepared by staff, was given to the commission members on potential issues for the workplan. Kawamura asked commission members to look at the issues and determine if they are within the charge of the commission and are the issues the commission wishes to address.

Carl Carlson stated that California is doing something very similar to what this commission is doing. Kawamura stated that maybe the commission should take a look at that and bring back some information for the next meeting.

Kathy Burek stated that the list handed out was not to be used as a strict guideline, but to be used as a help list. Burek also stated that the commission has about 14 meetings shown on the tentative meeting schedule, but the last 3 or 4 should be necessary to finalize reports and recommendations so that gives the commission about ten or eleven meetings to deal with issues.

Kawamura handed out a meeting schedule of dates. She stated that except for the next couple of meetings, we are going to try to get a regular place in the State Office Building. However, the next two meetings are during the session and it will be difficult to schedule meetings here. She also asked the commission members to mark the April 8, 1988 meeting as tentative. She said that this date is, hopefully, the last date of the session and some of our members may not be able to attend that day. The meeting date may change but someone will let you know as soon as they can. She also said that maps and parking information will also be provided for those meetings.

Kawamura asked the commission members to designate an alternate person to sit in when they cannot attend meetings.

Kawamura said that at the next meeting we will hear from the last four or five members and prioritize the issues and develop the workplan for the remainder of the year.

Kawamura adjourned the meeting at 3:00.

*** Next Meeting ***

March 11, 1988, 1:00 - 3:00 PM
Hennepin County Government Center
Grand Jury Room
20th Floor
Use "C" Tower Elevators

HEALTH PLAN REGULATORY REFORM COMMISSION
January 29, 1988
MINUTES

Members present: Commissioner Kawamura, chair; Commissioner Ashton, Senator Linda Berglin, Carl Carlson, Robert Cooley, Dr. Richard Frey, Richard Gomsrud, Represenative David Gruenes, George Halvorson, Senator Howard Knutson, Jan Malcolm, John Reiling, Lawrence Schwanke, John Turner, and Lois Wattman

Lani Kawamura, chair, opened the meeting by introducing herself and welcoming the commission members.

Kawamura introduced Senator Linda Berglin, one of the authors of the legislation creating the commission. Berglin stated that she thought the commission had an important role to play. She reviewed the reasons HMOs were established in Minnesota law and the early expectations for creating a more competitive environment for health care. She noted that some of these expectations have been met. She suggested that as Minnesota examines regulations of health plans, it keep in mind changes that are occuring in the industry, both in Minnesota and nationally. (A complete transcript of Berglin's remarks is being prepared.)

Kawamura asked Kathy Burek (Director, Health Systems Development Section, MN Department of Health) to read the charge. Burek stated that the charge of this commission is to look at the regulations and laws that govern health plan companies as currently in statute, to look at what's going on in the marketplace now, to look to the future to see what might happen in the next ten to twenty years, and to recommend health plan regulations for the State of Minnesota for the next few years. The commission is to be designing a blue print for health plan regulations for the next decade.

Kawamura stated that this is a draft charge to the commission. She stated that she is going to ask for an adoption of the charge at the next meeting. There was some discussion of making sure that the charge was not defined to narrowly or to broadly so as not to prohibit the commission from exploring some of the issues.

Kawamura asked Commissioner Ashton to bring the commission up-to-date on the Department of Health's 1988 legislation related to health plan regulation.

Commissioner Ashton said that when the commission was first established it was the department's hope that all of the issues related to health plan regulation would be able to be addressed

by this commission, and that there would be no legislation needed in this coming session. Given the events of this past year, the Department of Health felt, at this point, that they could not wait for the work of the commission to take care of some emergency needs.

Commissioner Ashton gave a synopsis of what is included in the legislation. She said the two major areas of concern are the financial strength of the HMO's and the continuity of coverage issue. The legislation that the department is proposing is going to require that HMO's net worth requirements are increased using a formula that will be based on the size of the HMO and on the nature of the provider agreement. There are several measures proposed to better protect the consumers in the event of insolvency. The department is proposing that the people who carry individual contracts have the same protection that there now is for groups--that there will be a continuity of coverage for these people and that cancellation will require a greater notice period.

Kawamura asked Commissioner Ashton to keep the commission up-to-date during the upcoming meetings.

Kawamura asked John Klein (Senior Analyst, MN Department of Health) to walk the commission through his background paper related to terminology. Klein reviewed the terminology that is used in dealing with health plan company regulations. There was some discussion and several questions dealing with regulation that John answered. There was a suggestion that charts and graphs be used for some of the information given in the reports to the commission.

Kawamura stated that her intent is to have each commission member give his/her views during this or the next meeting. She then asked commission member Jan Malcolm to give her views to the commission. Malcolm noted that this commission was unique in the nation. Minnesota took a lead in endorsing a competitive model for health care. It is appropriate that we first take a deliberative look at how health care policy should be shaped in the next generation of evolution in the health care system. Malcolm reviewed the history of HMOs, the current environment, and the challenges that exist for health plans. (A transcript of Ms. Malcolm's comments is being prepared.)

Kawamura then asked Lois Wattman to give her views to the commission. Wattman stated that reasons for creating the commission should not be viewed as a failure of competition, but rather the success of the model. The model may need to be adjusted from time to time, but we must be careful not to swing so far back in the regulatory mode that will not allow for the same positive results we have seen in the last decade. (A complete transcript of Ms. Wattman's comments is being prepared.)

Kawamura stated that the next meeting would be held February 19 from 1:00 to 3:00 p.m., in Room 5 of the State Office Building.

A discussion on future meetings was held. The group decided to have Friday afternoon meetings. A schedule of future meetings will be presented the next meeting.

Kawamura asked that if commission members need to send an alternate, that it always be the same person, and that he/she have voting rights. An alternate to Friday afternoon meetings during the legislative session will be explored.

Kawamura thanked everyone for helping to get the commission off to a good start, and the meeting was adjourned at 3:15 p.m.

GOVERNOR'S COMMISSION ON HEALTH PLAN REGULATORY REFORM

Access Mandates in Minnesota

*What is the appropriate role of the state in mandating continuation coverage in light of recently enacted federal laws requiring employers to offer continuation coverage?

*Should state continuation and conversion statutes be extended to products offered by preferred provider organizations (PPOs)?

*Does the 1988 legislation mandating the provision of replacement coverage for individual policyholders satisfactorily balance the needs of consumers and health plan companies?

Introduction

The majority of insured persons in the United States receive health insurance through an employment or family relationship. As a result, a change in employment or family relationships can result in a loss of health insurance coverage. In order to maintain uninterrupted health insurance coverage for persons undergoing such changes, the majority of states, including Minnesota, have enacted various statutes to continue health insurance after the employment or family relationship has been altered.

There are two types of statutes extending the availability of health insurance after a change in an employment or family relationship. "Continuation" laws provide that an individual experiencing a loss of coverage due to several statutorily prescribed changes in circumstance may, for a specified period of time, continue to receive benefits under a former employer's or spouse's health policy. Benefits received pursuant to such an arrangement are frequently described as "continuation coverage." Continuation enrollees are generally responsible for payment of the policy premium. The purpose of continuation statutes is to allow individuals who would otherwise be forced into the individual policy market to benefit from the lower rates paid by large group purchasers.

"Conversion" statutes provide that after continuation coverage is exhausted, the individual may apply for and receive an individual conversion policy without proof of insurability or a lapse in coverage. Benefits received pursuant to such an

arrangement are referred to as "conversion coverage." Conversion enrollees are also responsible for payment of the policy premium. The premiums for conversion coverage are higher than group rates paid by individuals receiving continuation coverage and generally higher that the premium for an individual policy. Conversion policy premiums are significantly higher due to the inability of health plan companies to screen for pre-exisiting conditions.

The primary purpose of conversion statutes is the prevention of loss of coverage when continuation coverage expires. Conversion enrollees are not required to show proof of insurability; coverage is therefore uninterrupted. If conversion coverage is not available to continuation enrollees and they are difficult to insure due to pre-existing health conditions, the only coverage available to the enrollee may be through the Minnesota Comprehensive Health Association (MCHA). MCHA generally applies a six month waiting period for pre-existing conditions. Other continuation enrollees who are able to obtain individual coverage from other health plan companies may also face a waiting period for pre-existing conditions. As a result, conversion coverage may fill a potential coverage gap resulting from pre-existing condition clauses.

In the case of health maintenance organizations (HMOs) only, out-of-area conversion coverage must be offered to HMO enrollees who leave the HMO's service area. If the enrollee received services through a group contract, the HMO must make arrangements with an insurer for conversion coverage. If the enrollee was the holder of an individual HMO policy, out-of-area coverage must only be provided if an arrangement with an insurer for such coverage can "reasonably be made." Finally, conversion coverage must be offered by a HMO if the HMO is forced to cancel coverage due to a loss of its provider network in a specific service area. Health service plans and insurers do not have state certified "service areas". Consequently, there are no similar "out-of-area" conversion requirements for these types of health plan companies.

The 1988 Legislature also recently enacted a third category of "extension" coverage denominated "replacement coverage." Health maintenance organizations, health service plan companies and insurers are required to offer replacement coverage to individual policy holders who lose their coverage for reasons other than a failure to pay a premium, copayment or health care charge, relocation from the HMO's "service area," or the insurer's and health service plan company's area of service, or a materially false application. This new type of coverage was enacted to address recent situations where health plan companies elected to discontinue a particular "book of business" or product line.

The continuation, conversion and replacement statutes apply to HMOs, health service plans and insurers; these requirements do not apply to PPOs or self-insured arrangments. A variety of different types of PPOs have evolved in recent years, including physician-sponsored, broker-sponsored, insurer-sponsored and employer-sponsored PPOs. Since PPOs are not extensively regulated in Minnesota, access mandates have not been extended to PPOs. Self-insured arrangements are exempt from the state continuation requirements under ERISA.

In April 1986, Congress took the unprecedented step of enacting federal continuation requirements. These requirements are the federal government's first regulation of the substantive content of employee welfare benefit plans and are codified in ERISA, the federal tax code and the federal Public Health Service Act. Because these requirements were enacted into law as part of the Consolidated Omnibus Reconcilation Act of 1985, they are commonly referred to as the "COBRA" requirements. In contrast to state access mandates, COBRA directly regulates employers, as opposed to health plan companies. As a result, self-insured plans are also subject to COBRA's requirements.

Overview of State and Federal Access Mandates

Federal Mandates

COBRA mandates that employers offer continuation coverage to employees, spouses and dependent children of employees who lose their health care coverage due to the occurrence of one of five "qualifying events." The qualifying events are: 1) the death of the employee; 2) the termination of the employee's employment (other than for gross misconduct) or a reduction of the employee's hours; 3) the divorce or legal separation of the employee from the employee's spouse; 4) the employee's entitlement to Medicare; or 5) loss of dependent status under the terms of the plan. Employer bankruptcy is a qualifying event for retirees only.

The mandated coverage must be identical to the coverage provided under the plan to similarly situated "active" employees and must continue for 36 months, except in the case of a reduction in hours or termination of employment, in which case coverage need only be offered for a maximum of 18 months. Special coverage periods apply to retirees who lose coverage because a former employer files for bankruptcy. Coverage may be terminated prior to the 18 or 36 month maximum if the enrollee becomes covered under another group health plan, fails to pay a premium, becomes eligible for Medicare or if the employer ceases to offer any health care coverage.

The continuation enrollee may be required to pay for the

extended coverage. The premium, however, may not exceed 102% of the cost to the plan for coverage of similarly situated active employees. The additional 2% is intended to compensate employers for the costs associated with COBRA compliance. Premiums may be payable in monthly installments.

COBRA contains extensive administrative requirements. Employers or plan administrators are required to send a number of notices to enrollees and their dependents, both before and at the time that a qualifying event occurs. Employers may also be required to calculate premium costs and must maintain accurate and complete records concerning their current and former employees and their dependents.

The administrative burdens imposed on employers and their plan administrators have been the subject of considerable complaint. In general, employers complain that the costs of COBRA compliance far exceed the administrative fees which an employer may collect to offset these costs. For example, Burlington Industries recently reported that over the first year COBRA compliance cost Burlington $150,000; only $7,500 in administrative fees was collected. Employers who experience seasonal fluctuation in their employment forces and who use students and part-time employees have experienced particularly high administrative costs. Numerous employers have threatened to cease offering health benefits altogether, rather than bear the increased administrative costs.

Many employers view these administrative burdens as particularly onerous in light of the penalties for noncompliance. A failure to provide continuation coverage, whether intentional or negligent, will result in a denial of the federal income tax deduction for health care expenses incurred by the employer. In addition, highly compensated employees who participate in a plan which fails to comply with COBRA will not be permitted to exclude from their income the amount contributed by the employer on their behalf. Finally, the Department of Labor may impose an administratve penalty of up to $100 per day per plan participant for failure to provide the required notices.

COBRA's enactment fills a prior regulatory "gap" since it applies to self-insured employers as well as to employers purchasing an insured plan. However, COBRA does not apply to small employers, defined as an employer with less than 20 employees on a typical business day, church plans and the federal government. As a result, state regulation may continue to be necessary to require that continuation coverage be available to employees of these exempted groups. In addition, COBRA does not mandate that conversion coverage be offered when continuation coverage expires. COBRA merely requires that if an employer's health plan contains a conversion option, this option

must also be offered to continuation enrollees. Consequently, state regulation requiring the inclusion of a conversion option in an insured product may still be required to assure the availability of conversion coverage in the insured market.

COBRA does not completely preempt state access mandates. Proposed IRS regulations indicate that state and federal continuation periods will be deemed to run concurrently. Thus, state laws requiring continuation coverage will not extend the COBRA coverage periods beyond the prescribed 18 or 36 month periods.

State Continuation and Conversion Mandates

A. Continuation Coverage

Prior to COBRA's enactment, state access mandates provided that health plan companies must offer continuation coverage upon the occurrence of certain circumstances, including termination or lay-off from employment, a "break in the marital relationship" and the death of an insured spouse. Minnesota Statutes, sections 62A.17, 62A.21, 62C.162, 62D.101. Special provisions also prohibited group policies from restricting or terminating benefits "solely on account of absence caused by total disability" and prohibited individual and group policies from terminating coverage when a dependent reached the age of majority if the dependent was physically or mentally impaired and not capable of self-sustaining employment. Minnesota Statutes, sections 62A.146, 62A.14, 62C.14, subd.5.

After COBRA's passage, Minnesota amended its continuation statutes in an attempt to conform them with COBRA. These amendments were enacted prior to the issuance by the Internal Revenue Service of COBRA's administrative regulations. As a result, a number of state continuation laws are arguably in conflict with COBRA's provisions and are in need of further clarification. In addition, state law requires additional coverage in some circumstances. For example, state law requires that a surviving spouse be offered continuation coverage until covered by another plan or until coverage would have terminated had the employee lived. In contrast, COBRA limits continuation coverage to 36 months and lists additional events which will result in termination prior to the 36 month maximum. Under state law a surviving spouse has 90 days to make a premium payment; COBRA requires payment in 30 days. If an employee is laid-off, state law requires that the requisite notice be provided in 10 days; COBRA requires that notice be provided within 14 days.

COBRA's regulations indicate that states may impose additional requirements. However, to the extent that states

impose additional regulatory constraints on insured products, competitive inequities may result between the insured and self-insured markets. Arguably, if a self-insured plan is only required to provide continuation coverage to a surviving spouse for 36 months and an insured plan must provide coverage for a longer period, the insured plan suffers from a competitive disadvantage.

B. Conversion Coverage

Minnesota law currently mandates that all health plan companies offer conversion coverage in both individual and group policies to a spouse and dependents who would otherwise lose coverage due to a "break in a marital relationship." Minnesota Statutes, sections 62A.21, 62C.142, 62D.101. Conversion coverage is also available after continuation coverage has lapsed due to a termination from employment or reduction in hours. Minnesota Statutes, section 62A.17. There are no specific state statutes which provide for conversion coverage in the event of other COBRA "qualifying events" such as loss of dependent status or eligibility of the insured for Medicare. However, chapter 62E contains a "catchall" conversion provision which provides for conversion coverage if the individual "leaves the group, regardless of the reason for leaving the group." Minnesota Statute, section 62E.16.

This catchall provision was amended in 1988 to provide that if an HMO is required to cancel coverage due to a loss of providers in a service area, the HMO must arrange for other HMO or indemnity coverage without additional underwriting restrictions.

The 1988 Legislature also enacted special "out-of-area" conversion rights for individual HMO enrollees only. If an individual HMO policyholder leaves the HMO service area but remains a state resident, the HMO must offer the enrollee an number one, two or three qualified plan if an arrangment with an insurer "can reasonably be made." Minn. Stat. 62D.104. This out-of-area conversion coverage must be offered without evidence of insurabiity or interruption of coverage. If the HMO cannot made arrangements for conversion coverage, the HMO must provide the individual enrollees with a list of available health plans in the enrollee's area.

This new out-of-area conversion coverage is similar to conversion rights previously accorded group enrollees of HMOs. In the case of a group HMO enrollee, the HMO is required to offer enrollees a number one, two or three qualified plan without evidence of insurability or interruption of coverage. This obligation is not "qualified" by the ability of the HMO to make "reasonable" arrangements with an insurer. Neither of these out-of-area conversion provisions apply to health service plan

companies or insurers since these types of companies do not have state certified service areas.

It is interesting to note that the coverage available through MCHA fulfills a function similar to the purpose of conversion coverage, namely the provision of coverage to persons otherwise difficult to insure. In some cases, conversion coverage may be more expensive than MCHA coverage. As a result, persons electing conversion coverage may have a less expensive alternative available through MCHA. MCHA, however, will normally impose a six month waiting period for pre-existing conditions. Since conversion coverage must be made available without regard to pre-existing conditions, there is no waiting period when electing conversion coverage.

C. Replacement Coverage

In 1988 the Minnesota legislature enacted a new form of continuation coverage referred to as replacement coverage. The legislature was concerned about the termination of individual Medicare contracts by several health plan companies during 1987 and concluded that an additional type of continuation coverage was required "so that no other consumers face a threat to their health care coverage."

The replacement provisions provide that if an insurer, health service plan company or HMO terminates an individual policy for a reason other than failure to pay required charges, relocation from the service area, or submission of a false application, the health plan company must provide replacement coverage equivalent to a number 2 or number 3 qualified plan. If the policy is a Medicare policy, coverage must be equal to a Medicare supplement two plan and must cover Part A and Part B deductibles. The statute places limits on the amount which may be charged for such coverage and establishes a policy review process for HMOs. The review process is designed to evaluate whether the replacement coverage offered satisfies the statutory criteria. The statute does not specify a review process for health service plan companies and insurers.

The statute creates a number of strong incentives to provide adequate replacement coverage. If replacement coverage is not provided, the enrollees may enter MCHA with a waiver of pre-existing conditions. However, the health plan company terminating the enrollee must cover all costs associated with those pre-existing conditions for six months and must pay an additional special assessment to MCHA.

POLICY OPTIONS

1. Amend state continuation statutes to conform with COBRA and eliminate state continuation requirements imposed on group contracts which exceed COBRA's mandates.

The advantage of this option is the reduction of competitive inequities between insured and self-insured products. The disadvantage is that some classes of individuals such as surviving spouses, may experience a reduction in their continuation coverage.

To the extent that the federal government has indicated a desire to enact extensive regulation in this area, the Commission may wish to consider recommending that the state allow federal legislation to "level the playing field" with respect to the access mandates. COBRA has leveled the playing field in two separate ways. First, COBRA's requirements apply equally to both the insured and self-insured market. Second, COBRA's requirements apply equally to all types of health plan companies.

2. Continue to mandate continuation coverage for small groups exempted from COBRA's requirements.

Since small employers are exempted from COBRA, the Commission may wish to continue to mandate inclusion of continuation coverage in small group contracts. The continuation required for these small groups may be identical to COBRA or the continuation requirements may differ for small groups. It should be noted that continuation mandates for small groups will apply only to insured products. Small employers who choose to self-insure, either individually or through multiple employer trusts, will continue to be exempt from state access mandates.

3. Continue to mandate the inclusion of continuation coverage in individual policies in certain limited circumstances.

Since COBRA does not apply to individual policies, the Commission may wish to consider continuing to mandate continuation coverage in individual contracts in limited circumstances. Those circumstances may include loss of coverage under an individual policy due to a change in the marital relationship, due to the death of the primary insured, the Medicare eligibility of the insured or the loss of dependent status. Since continuation requirements affecting individual contracts need not comply with COBRA, state requirements in this area may differ from COBRA's

requirements.

4. Amend state conversion statutes.

The Commission has three options with respect to conversion statutes. First, the Commission may elect to retain all current conversion requirements. Second, the Commission may decide that conversion options should be extended to certain "qualifying events" which currently do not require conversion coverage after continuation coverage has ceased. Third, the Commission may wish to consider repealing conversion requirements.

a. Retain and Extend Current Conversion Requirements.

Since COBRA does not require that health policies contain conversion options, the Commission may wish to retain provisions requiring insured plans to offer conversion options. COBRA established the "qualifying events" requiring continuation coverage. Some of those qualifying events, such as loss of dependent status and Medicare eligibility, are not currently the subject of state statutes requiring conversion. As a result, the Commission may also wish to extend the offer of conversion coverage to individuals experiencing one of those events.

b. Repeal Conversion Requirements.

The Commission may also wish to evaluate the necessity of continuing to mandate any conversion coverage when MCHA coverage is available for the difficult to insure. The feasibility of this option may depend on other decisions the Commission may undertake in upcoming months with respect to the administration of MCHA, continued application of a six month waiting period in MCHA contracts, and the method of funding MCHA expenses.

Any decision to repeal or limit conversion options may impact MCHA's enrollment since the availability of conversion coverage may limit the pool of individuals seeking coverage from MCHA. The existence of conversion coverage may arguably keep certain bad risks out of the MCHA pool and in the private insurance market. The amendment or repeal of conversion statutes is tied to the Commission's ultimate decision concerning the role which Minnesota's high risk pool should play in providing insurance coverage to those residents who are poor

insurance risks.

Currently, some poor risks may choose conversion coverage and some individuals may end up in MCHA's pool. In many cases, conversion coverage may be more expensive than the MCHA premium. Although conversion coverage is very expensive, insurers may nevertheless lose money on their conversion policies due to the heavy utilization of expensive services. As a result, individual insurers may be cross-subsidizing their conversion business. MCHA's assessment process essentially requires insurers, health service plan companies and HMOs to cross-subsidize these poor risks on a more global basis. The elimination of conversion would likely result in increased MCHA enrollment and the transfer of current subsidization from an individual company level to MCHA's contributing members as a group.

It should be noted that the self-insurance market makes no contribution to MCHA's expenses and is not required under state law to offer conversion coverage. As a result, it is possible that the insured companies, through their MCHA contributions, are currently subsidizing some of the bad risks within the self-insurance market. Any expansion of conversion requirements will likely increase the competitive advantage currently enjoyed by the self-insurers who are not required to offer conversion and are not required to contribute to MCHA's high risk pool. Likewise, a decision to repeal conversion requirements and arguably expand MCHA's pool of potential enrollees may also unequally impact insurers since the self-insurers have no current obligation to contribute to MCHA.

5. Continue to mandate additional coverage for specific classes of disabled or handicapped adults.

Minnesota statutes provide special protection for disabled employees and adult handicapped individuals who are unable to engage in self-sustaining employment. These mandates go beyond COBRA requirements since state laws extend continuation coverage in these special situations beyond the 18 or 36 months provided in COBRA. If the Commission concludes that these special mandates are appropriate, the Commission may wish to recommend that such access mandates be continued. It should be noted, however, that any mandate which requires coverage beyond COBRA periods potentially contributes to the unequal playing field between insured and self-insured products.

6. To the extent that certain access mandates are retained, access mandates may be recodified with other provider, treatment and dependent mandates in a single chapter of Minnesota statutes.

Access mandates are codified in several chapters, including chapters 62A, 62C, 62D and 62E. The Commission has tentatively agreed to recommend that the legislature recodify provider and treatment mandates in a single chapter of Minnesota statutes or that the Revisor of Statutes prepare an annual compilation of mandated benefit laws.

It may also be advisable to recodify the access mandates in the same chapter. Since the Department of Health and the Department of Commerce currently split the regulatory jurisdiction of health plan companies, each agency administers different continuation and conversion statutes. After COBRA's enactment, each agency amended its access mandates in different ways to comply with COBRA. The result is a confusing array of continuation and conversion statutes with widely varying language, restrictions and limitations.

7. To the extent that certain preferred provider organizations offer insured products and are therefore not exempt from state regulation under ERISA, access mandates may be equally applied to PPOs.

Minnesota has not yet formally adopted regulations addressing preferred provider organizations. PPOs vary widely in form, structure, payment mechanisms and benefit levels.

PPOs are generally incorporated entities offering a managed care product to employer groups. The term "preferred provider arrangement" (PPA) is also increasingly used to refer to product lines and reimbursement arrangements offered by insurers, HMOs and health service plan companies, as an alternative to open access arrangements.

Future Commission topics include the role of the state in regulating PPOs and PPAs. To the extent that a PPO offers a self-insured product to employers, that product will be exempt from state regulation under ERISA. However, the Commission may decide to regulate insured products of PPOs, as well as specific features of PPOs such as risk sharing arrangments with providers. For that reason, the Commission may wish to delay a final decision concerning whether access mandates should extend to PPOs.

Since COBRA regulates employers, COBRA's continuation requirements will apply to PPOs utilized by employers. As a result, the Commission may wish to conclude that the federal requirements are sufficient and that additional state regulation is not warranted. However, to the extent that the Commission determines that PPOs should be the subject of additional state regulation and that the competitive playing field should be leveled, the Commission may wish to impose the same access mandates on PPOs as are ultimately imposed on HMOs, insurers and health service plan companies.

8. Recommend Amendments to Recently Enacted Replacement Coverage Statutes

The replacement coverage statute applies in certain circumstances when a health plan company terminates an individual policy. The statute defines the level of replacement coverage which must be provided by HMOs and the premium which may be charged by HMO's for the coverage. The Department of Health reviews replacement coverage applications to determine if the coverage satisfies the statutory criteria. If the criteria are not satisfied, the individual enrollees are allowed to enter MCHA with a waiver of pre-existing conditions. The HMO must bear the costs of any such pre-existing conditions for six months and must pay a special assessment. This special assessment may be adjusted if the termination of coverage is due to a loss of providers and payment of the assessment may have an "adverse impact" on the health plan company.

Although health service plan companies and insurers are required to pay the same penalties as HMOs for neglecting to provide adequate replacement coverage, the statute does not establish a standard against which such replacement coverage must be measured and does not establish a review process for health service plan companies and insurers.

The Commission may wish to recommend that replacement coverage standards and a review process be established for health service plans and insurers. In addition, the Commission may wish to evaluate the penalty and assessment provisions. The purpose of these provisions is the creation of a strong incentive not to cancel out a particular product line without the provision of replacement coverage. On the other hand, the health plan company may have no choice but to terminate a product line which is incurring severe losses. After incurring large losses, the company may also be required to cover all pre-existing conditions and pay a special assessment as the price for terminating this line of business, if

replacement coverage cannot be located. The Commission may wish to consider if these provisions appropriately balance the needs of consumers and health plan companies in a competitive marketplace.

Summary

Until COBRA's enactment, continuation and conversion mandates were exclusively creatures of state law. Federal law now contains comprehensive continuation requirements, applicable to insured and self-insured products. Consequently, federal law has effectively "leveled the playing field" in certain areas.

Minnesota law contains additional requirements. Minnesota statutes contain special provisions for disabled workers, handicapped adults, individual policyholders and requires that conversion options be included in group policies. HMOs are subject to special out-of-area conversion obligations. Recent legislation requires special "replacement coverage" to be offered to individual policyholders who lose their coverage due to a decision by a health plan company to cancel a particular product line.

Since federal law has created a national standard of continuation coverage for almost all employer groups, the Commission may wish to focus on whether the additional coverages required by state law are required to adequately protect the consumer. The Commission may wish to evaluate any additional requirements in light of the effect of such requirements on the ability of insured plans to effectively compete with the growing self-insurance market.

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GOVERNOR'S COMMISSION ON HEALTH PLAN REGULATORY REFORM

RISK SELECTION: UNDERWRITING AND OPEN ENROLLMENT

- *Should HMOs be allowed to place dollar limits on liabilities as insurers are allowed to?*

- *Should all types of health plan companies be required to offer "open enrollment" as HMOs are now required to do, or should open-enrollment be eliminated altogether?*

Introduction

Underwriting describes various techniques insurers use to evaluate the risk of indemnifying an insured party against loss or damage. Thus, underwriting lies at the heart of the insurance concept as the elements which determine whether or not an applicant is an acceptable risk. Underwriting also determines the contract terms and premium rates sufficient to cover enrollees against the probability of incurring a loss. From a regulatory standpoint underwriting practices should maintain sufficient premium income to ensure financial solvency, yet avoid unfair discrimination against selected groups or individual consumers.

To provide health insurance coverage for a single individual, underwriters establish premium rates and contract terms based upon the age, gender and/or medical history of the applicant. Traditionally, group health insurance plans have been underwritten based upon the average utilization of services within the group. When a group history is not available, premiums are likely to be based upon the experiences in a similar group. Premiums derived by "experience rating" reflect <u>average</u> use of benefits among members of the group. Group members using fewer benefits than the average pay for those who use more than the average.

In 1973, when the federal government enacted legislation to allow the formation of health maintenance organizations (HMOs), it required HMOs seeking federal qualification to use "community rating." In other words, federally qualified HMOs must establish premium rates based upon the utilization of services within the entire HMO enrollment. "Community" can also be defined by class, using demographic characteristics of enrollees "such as age, sex, marital status, or occupation."[1] Federal laws also allow a modified definition of "community," permitting rate adjustments based upon enrollees' family size.

Both federal and state laws require HMO group coverage to be offered through annual open enrollment.

Open Enrollment & Underwriting

Minnesota laws do not require HMOs to community rate. Thus, non-federally qualified HMOs can experience rate as insurers do. But Minnesota does require that HMOs which have been in operation for more than two years to offer "open enrollment" to <u>group</u> enrollees:

> "an annual open enrollment period of at least 14 days during which it shall accept all otherwise eligible individuals in the order in which they apply for enrollment in a manner which does not discriminate on the basis of age, sex, race, health, or economic status."[2]

Under the terms of open enrollment HMOs cannot, in most instances, health screen individual members of a group for pre-existing medical conditions. By contrast, it is common among insurance carriers to "screen" high risk members of a group for pre-existing medical conditions. Health screening usually means that the existing condition is excluded from coverage for up to two years. Attachment A shows a typical group plan contract clause, exempting pre-existing conditions.

It is common, especially in large employer groups, for insurers to participate in open enrollment. However, in instances where more than one health plan is offered to a group, and an HMO is the only health plan company participating in open enrollment, the HMO may require "differential" copayments on services resulting from an enrollees' pre-existing condition.

HMOs are also allowed to screen individual group members in the sense that they may require applicants to answer questions pertaining to their medical history, but the HMO can use the information only to accept or reject the entire group.

Insurance companies are also better able to safeguard against high risks through deductibles, coinsurance and limits on lifetime benefits. For instance, a number 3 qualified plan may require a $150 annual deductible, 80% coinsurance (enrollee pays 20% of service costs, up to $3,000 per year), and limit the maximum lifetime benefit from the policy to $250,000. HMOs are prohibited from instituting lifetime payment limits or deductibles. HMOs may require co-payments on areas of coverage except health education and preventive care. (Preventive care may include an array of out-patient services.) HMOs are also allowed to place payment limits on emergency out-of-area services and some benefits covered under Medicare demonstration projects. A summary of benefit limitations for both HMOs and insurance plans is given in Attachment B.

The inability of HMOs to place an "upper limit" on the extent of their coverage may place an HMO at considerable risk. Advanced technology may now sustain life for persons with severe disabilities, where never before possible,at a very high cost. According to one analysis it typically costs several hundred thousand dollars or more per case to care for the technology dependent.[3] Becaus they are unable to place limits on technology dependent care, HMOs are particularly vulnerable to "adverse selection" during open enrollment. As a result HMOs may decline to offer coverage to some groups, and have in some cases withdrawn coverage from an employer groups to avoid an extensive liability.[4]

Adverse Selection

Many large employers offer multiple health plan options which allows employees a choice between traditional insurance plans and HMO plans. In many cases HMO plans were initially less expensive than insurance plans. Faced with a less expensive choice, large numbers of healthy enrollees bought HMO coverage. But, as time progressed, insurance carriers responded with even less expensive packages, attractive to healthy, low utilizers of care.

The phenomenon of switching health plans based upon expected utilization of services is known as "adverse-selection," "risk skimming," or "risk pool manipulation." Although adverse selection does not actually result in overall higher utilization of services, it does result in fewer premium dollars from a groups' low utilizers of care being available to

subsidize the cost of high utilizers of services.

Open enrollment makes it relatively easy for group members to switch health plans. Therefore, it has become an issue in the adverse selection debate. Yet, for large employee groups it is likely that insurance companies, as well as HMOs will participate in open-enrollment, either voluntarily or at the request of the employer. This reduces the risk of adverse selection against HMOs. Risk selection can also be influenced by the way in which benefit managers structure employee contributions in multiple option plans.

Open enrollment is more frequently cited as the reason small employee groups are often denied HMO options. Because HMOs cannot health screen and are restricted in their ability to limit major liabilities, small groups do not provide a risk pool large enough for HMOs to extend coverage. State laws do allow HMOs to apply for a waiver from open enrollment, but the HMO Unit at the Department of Health has received few requests for such waivers. HMOs can apply for the waiver under several circumstances, where open enrollment would:

> A. prevent a health plan from competing effectively with other health plans or with commercial insurers for the enrollment of new members or for the retention of current members;
>
> B. result in a health plan incurring unreasonably high expenses in relation to the value of the benefits or services it provides;
>
> C. jeopardize the availability or adequacy of a health plan's working capital and any required surpluses or reserves; or
>
> D. endanger the ability of a health plan to meet its current and future obligations to enrollees.[5]

In several instances HMOs have been able to effectively conduct health screening of individuals in small groups by establishing what are referred to as "collector groups." Collector groups are usually made-up of affiliated small businesses (usually less than fifty employees per location). Employees buy individual coverage, but submit payment through the affiliation's "remitting agent." Often such groups receive a discount from the plan and the remitting agent may also make contributions toward the cost of the HMO coverage. Examples of collector groups include the Hennepin County Bar Association and the Minnesota Automobile Dealers Association.

Group Plan Continuation Laws

As a related issue of open enrollment, it should be noted that there are laws governing health screening when an employer switches health plan companies, or the group plan is otherwise cancelled. Insurance companies are not allowed to health screen members of a group when one insurer replaces another, or an insurer replaces HMO group coverage:

> A person covered under group medical expense insurance, shall not be denied benefits to which the person is otherwise entitled solely because of a change in the insurance company writing the coverage or in the group contract applicable to the person.[6]

The laws governing a change of insurer also apply to health service plan corporations and HMOs.

Summary

Currently under Minnesota laws, health plans offered by insurance companies and health service plan corporations have greater latitude

than plans offered by HMOs, in shaping and limiting benefit packages. Although HMOs were created to offer "first dollar" care, increasing market pressures may warrant a re-examination of the consumer's role in managing health care decisions.

In particular the inability to "cap" dollar amounts on plan benefits, may threaten the already precarious financial situation of some HMOs. Advances in medical technology have created situations were patients may consume lifetimes of custodial care. Such cases illustrate the need to examine this issue so that both the health plan companies and the community are better served.

This report was prepared by Mark J. Berndt, Staff Analyst to the Commission.

1. An HMO Regulatory Primer, National Association of HMO Regulators, April 1988. pp. 3.24 Adapted from: Introduction to Health Economics: The U.S. Health Care Economy, and the Place of Prepaid Group Practice In It, Kaiser Permanente.

2. Minnesota Statutes 62D.10, Subd. 3.

3. Jeanne McGee, Ph.D., Reimbursement by Third Party Payors of Home Health Benefits For "Technology-Dependent Individuals. A study conducted for the Minnesota Legislature, under contract to the Minnesota Department of Health. February 1988. Executive Summary.

4. Ibid. pp. 9

5. Minnesota Rules. 4685.3200 Subd. 2

6. Minnesota Statutes 60A.082

POLICY OPTIONS

1. Maintain the current regulatory system, whereby HMOs are required to offer annual open enrollment and prohibited from implementing maximum benefit levels or deductibles.

The current regulatory system was established specifically to distinguish medical care offered by an HMO from that offered through an indemnity insurance plan. Significant changes in enrollment and underwriting guidelines may dissolve these distinctions. Many current "hot-buttons" may have alternative solutions to legislative action, such as: 1) Individual waiver requests from open enrollment for HMOs wishing to extend coverage to expected high risk groups. 2) Require HMOs to obtain appropriate levels of stop-loss insurance for out-patient care, to protect against excessive losses resulting from technology dependent disabilities.

2. Require all health plan companies in the state to offer group contracts through annual open enrollment.

This option would place all health plan companies at the same level of risk when underwriting group contracts. The disadvantage of this option is the possibility that small employer groups may have difficulty finding carriers when significant risks exist within the group.

3. Eliminate altogether the state HMO requirement for open enrollment, and allow HMOs to impose limited coverage exemptions for pre-existing conditions.

This option would enable HMOs to reduce their exposure to adverse selection when underwriting group policies. The disadvantage would be to limit or deny some group members of HMO coverage, although federally qualified HMOs would still be required to offer open enrollment. The federal requirements would also leave in-place the current issue of marketplace inequity.

3. Grant HMOs a blanket waiver of the open enrollment requirement for employee groups of less than 50 members.

This option would have a similar effect as #2 above, but may not require a legislative process. Because open enrollment may now deny HMO coverage toall members of small groups, this option would allow greater access to HMO coverage for both large and small groups.

5. Allow HMOs to establish maximum lifetime benefit limits.

Indemnity plans are already allowed to place limits on the extent of policy coverage, thus eliminating their exposure to unlimited liabilities as might be found in cases of prolonged technology dependence. Allowing HMOs to establish such limits would not only level the regulatory playing field, but would also reduce HMOs' exposure to financial risk and reduce the incidence of adverse selection. The down side of this option would be significant reductions in cost containment pressure. As stated in #1 above, reducing incentives to manage care might significantly dissolve intended HMO distinctions. It might also discriminate against HMOs which do not record coverage on a fee-for-service basis. HMOs which pay providers on salary or through capitation would likely have difficulty determining paid coverage per enrollee.

6. Allow HMOs greater freedom to require cost sharing mechanisms such as deductible and copayment features.

When consumer responsibility for payment of health care is completely removed, or is largely removed from the consequences of purchasing health care, as may now be the case with some employer subsidized HMO policies, they are unlikely to buy economically.
Employee groups are often the primary force in choosing the extent of health plan coverage, while the employer may be the primary payer. Allowing HMOs more freedom to integrate consumer consumer cost sharing features might lead to more responsible health care choices by consumers, and a more level the playing field among HMOs and insurers. The disadvantage here is the same as in Option number 5. Prohibiting copayments for preventive health services is part of the incentive for HMOs to do preventive care. It is also questionable whether the enrollee would be sufficiently knowledgeable or motivated to buy health care economically even with copayments.

Attachment A.

TYPICAL BENEFITS SCHEDULE FOR A GROUP INSURANCE CONTRACT

Calendar year deductable	$ 500
Number of family members needed to satisfy their deductable	2

Coinsurance percentage:

Other than nervous and mental disorders - After the deductable 80% of the next $5,000 in a calendar year; 100% thereafter each calendar year.

Nervous and Mental Disorders - After the deductable, 50% up to $2,500 each calendar year.

Lifetime Maximum:	
Other than nervous and mental disorders	$ 1,000,000
Nervous and mental disorders	$ 25,000
Out of Pocket expense limit	$ 3,000
Diagnostic X-Ray and Laboratory Benefit	$ 500
Accidental Medical Benefit	$ 300

Limitations Due to Pre-Existing Conditions:

If a covered individual receives care or treatment for an injury or sickness during the three months before that person's effective date of coverage, no expenses will be covered for that particular injury or illness.

Expenses will be covered for that particular injury or illness after the earlier of:

- Three months during which no care or treatment has been received; or
- Twelve months of continuous coverage under this plan.

This limitation does not apply to any individual eligible for coverage on the original effective date of this plan, nor to a dependent handicapped person or newly adopted child.

Attachment B.

A SUMMARY OF MINNESOTA REGULATIONS OF UNDERWRITING SERVICE LIMITATIONS AND COPAYMENTS BY HEALTH PLAN COMPANIES

1. Health Maintenance Organizations (HMOs)

A. General Provisions (Minnesota Rules 4685.0800)

There may be no limitations or exclusions other than those allowed by Minnesota statutes. Where exclusions are allowed, it is the express policy of the commissioner of health to favor limitations rather than exclusions and the commissioner may limit the extent of limitations and/or exclusions which may be included in any health care plan to ensure that comprehensive health care services are reasonably available to enrollees.

B. Restrictions (Minnesota Rules 4685.0800, subp. 3.)

Reasonable restrictions are permissible. These include but are not limited to restrictions on the frequency or length of time a health maintenance service is provided (e.g., repeated, frequent physical exams), or the denial of service that is not reasonably required to maintain the enrollees in good health (e.g., physical exams requested only for the protection or convenience of third parties).

C. Copayments (Minnesota Rules 4685.0800, subp. 4. and 4685.0100 subp. 6.)

Reasonable enrollee copayments; those charges in addition to fixed, prepaid sums, to supplement the cost of providing covered comprehensive health maintenance services, are allowed. Copayment may also be defined as the difference between an indemnity benefit and the charge of a provider for health services rendered. Any amount of copayment is reasonable when imposed on service which may be excluded completely, provided the copayment is not greater than the cost or charge of that particular service.

Copayments may not exceed 25 percent of the costs or charges of a particular service, except those copayments imposed on services which may be excluded completely, out-of-area and emergency care services, preventive health care services and prescription drug benefits.

Copayments may be imposed on out-of-area services and emergency care by providers who do not have arrangements with the HMO in the form of a reasonable deductible, plus a 25 percent coinsurance feature, plus all charges which exceed a specified annual aggregate amount not less than $25,000.

No copayments may be imposed on preventive health care services (incldg. immunization, well-baby care, periodic screening and prenatal care. This does not prevent a copayment on maternity services in general.

D. Limitations/ Exclusions (Minnesota Rules 4685.0700 Subp. 3.)

Permissible **limitations and/or exclusions** from comprehensive health maintenance services may include:

A. corrective appliances and artificial aids;
B. cosmetic surgery;
C. dental services;
D. routine refractions, fitting & provision of contact lenses/eyeglasses
E. ambulance transportation
F. hemodialysis or other procedures for treatment of chronic renal failure, of organ transplants, and/or experimental procedures, to the extent not covered by a policy of insurance, a nonprofit health service plan contract, or other program of coverage;
G. custodial and/or domiciliary care;
H. injuries incurred while on military duty, to the extent not covered or available in another program of coverage;
I. home health care services;
J. services not prescribed by a physician under contract with the enrollees HMO;
K. maternity services which related to a conception occurring prior to the effective date of coverage of the enrollee;
L. outpatient treatment of mental and emotional conditions and alcohol and other chemical dependency, except there may be no limitation applied to diagnosis and referral to sources of care;
M. **limitations** upon prescription drugs, except during hospitalization;
N. such limitations or exclusions on inpatient hospital care as are authorized below. Each HMO may have:

1.) Limitations on the number of days of inpatient hospital care, depending on the nature of the coverage, which at least correspond to the following minimum levels of coverage:

a. Group contracts - 365 days of care per period of confinement, for a condition arising from a single illness. If the enrollee group rejects in writing such limits in favor of lesser limits, the coverage may be limited to no less than 180 days, with no more than 90 days between periods of confinement.

b. Individual contracts - 90 days of care per period of confinement for a condition arising from a single illness or injury.

c. For inpatient hospital care out of the HMOs service area, the coverage may be limited to 60 days in a contract year.

2. Insurance Companies and Health Service Plan Corporations

A. General Underwriting Provisions (Minn. Stat. Ch. 72A.20, Subd. 9 & 19.)

No life or health insurance company shall engage in any selection or underwriting process unless the insurance company establishes before hand substantial data, actuarial projections, or claims experience which support the underwriting standards used by the insurance company.

B. Qualified Plan Minimum Benefit Limitations (Minn. Stat. 62E.06)

In addition to specific minimum benefits (or actuarial equivalents) which must be offer to be certified as a qualified plan, a **number three** qualified plan can underwrite the following:

1. $150 annual deductible per person
2. 80% coinsurance (enrollee pays 20% of covered services)
3. coverage shall be limited to a lifetime benefit of not less than $250,000.

A **number two** qualified plan can underwrite a deductible that shall not exceed $500 per person.

A **number one** qualified plan can underwrite a deductible that shall not exceed $1,000 per person.

A qualified plan may include provisions consistent with generally accepted underwriting practices that provide that any pre-existing condition diagnosed prior to the effective date of the policy, and for which medical care or treatment was rendered or prescribed during the 90 days immediately prior to the application, can be excluded from payment of benefits beginning on the effective date of the policy and ending two years after the policy has been continuously in force.

B. Non-Qualified Plans

While insurance companies must offer a qualified plan to employers who make available a health plan to employees, employers and individuals who decline qualified plans may obtain policies with further restrictions.

Restrictive rider. "Restrictive rider means a document or contractual provision adding certain conditions to the policy's or contracts coverage, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk.