THE MINNESOTA COMMISSION

ON

HEALTH PLAN REGULATORY REFORM

FINAL REPORT

STATE OF MINNESOTA

April 1989

Pursuant to 1987 Laws, Ch 370, Article 1, Sections 10 & 11

STATE OF MINNESOTA
State Planning Agency
300 Centennial Building
658 Cedar Street
St. Paul, Minnesota 55155
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April, 1989

TO: All Interested Parties

FR: Lani Kawamura
Commissioner
State Planning Agency

As the Chair of the Health Plan Regulatory Reform Commission, I am pleased to provide you with a copy of the Commission's Final Report.

The Commission's membership reflects the diversity of the Minnesota health care community. The recommendations contained in the Commission's Final Report reflect the majority opinion of the Commission membership in each subject area. As a result, the Commission's final recommendations do not necessarily reflect the opinion of each and every Commission member.

Several members of the Commission have chosen to express their views in separate minority reports. These minority reports have not been reviewed by all Commission members or the Commission as a whole. As a result, the Final Report does not address or respond to every statement and position expressed in the minority reports.

The diversity of the opinions reflected in the Final Report and the minority reports reflect the complexity of these significant issues. The Commission's Final Report is an important and thoughtful contribution to the development of Minnesota's health care policy. The Report should prove highly useful to legislators, policymakers, employers, health care providers, and consumers in understanding and improving Minnesota's health care system.

MINORITY STATEMENT
BY
Kip Sullivan

I do not agree with the following Commission recommendations:

(1) Subjecting all mandates to an evaluation process;

(2) Offering small employers the opportunity to buy stripped down policies;

(3) Allowing HMO's to incorporate as for-profit corporations;

(4) Describing an "employer assessment" (i.e., a payroll tax) as "the most fair and equitable method" of financing MCHA (p. 65).

Nor do I agree with the Commission's unwillingness to examine the efficiency or inefficiency of health plan companies and its failure to examine the possibility of regulating insurance company rates more closely.

I. EVALUATING MANDATES; OFFERING LIMITED-COVERAGE POLICIES TO EMPLOYERS

The Commission spent more time on the mandates than on any other issue. I stated to the Commission on several occasions my concern that the Commission's preoccupation with the mandates could easily be construed to mean that we believed that mandates were a principle cause of inflation in health insurance premiums and that cutting mandates would greatly ameliorate the problem of the unaffordability of health insurance. I do not hold that every mandate on the books now must be maintained, but I am unwilling to recommend the wholesale recall of every mandate in view of the Commission's unwillingness to acknowledge that other factors contribute far more to premium inflation than mandates and in view of the fact that the Commission received little information demonstrating that cutting mandates would make premiums more affordable. For example, the Commission received no evidence indicating that the "alternative provider" mandates add to premium costs. Courtesy of the chiropractors association, I did come across some evidence that direct reimbursement of chiropractors may in fact cut premium costs. We did not even discuss why it is that chiropractors, nurse practitioners and other nonphysician providers must carry the burden of defending mandates which require their direct reimbursement while physicians carry no similar burden. I don't believe we ever received a copy of the study cited on page 7 claiming to find that 25 percent of the uninsured lack coverage because of mandates, nor do I recall discussing that study.

Reducing the incentive for employers to self-insure was the other rationale most frequently cited by Commission members and staff arguing for eliminating mandates. But just as we were offered little evidence to believe that cutting mandates would cause more employers to buy insurance for their employees, so we received little evidence that employers who self-insure do so to escape mandates. What evidence I have seen indicates that firms which self-insure offer plans that are relatively rich. It appears to me that the main reason employers self insure is to cut premium costs by avoiding insurance companies, not mandates.

I. HMO NONPROFIT STATUS

The report notes that the research on the question of whether the for-profit or nonprofit status of hospitals and nursing homes affected their performance is inconclusive. It then recommends that HMO's be allowed to incorporate as for-profit entities on two grounds: (1) that other regulations offer "substantial consumer protection which far exceeds any protection theoretically offered by a nonprofit requirement" (p. 45), and; (2) "it is expected" that HMO's will have a harder time raising capital than will other for-profit health plan companies. The first argument is not convincing. It merely says that the non-profit status is a less powerful protector of consumers than other mechanisms, which, even if true, is no reason to abolish the nonprofit requirement. The second argument is also unconvincing. The Commission should not make policy recommendations on the strength of a statement by our staff that "it is expected" that something will come to pass. Who expects? For what reasons do they expect?

I do not think that nonprofit status guarantees efficiency. I think it is possible for the boards and officers of nonprofit corporations to become as preoccupied with power and net income at the expense of consumers and workers as their counterparts in for-profit corporations, especially where competition is feeble. But I think it is less likely. In the absence of evidence supporting the argument that for-profits provide better health plans at lower prices, the commission should not recommend allowing HMO's to switch to for-profit status.

III. PAYROLL TAXES

The Commission received no evidence indicating that payroll taxes are the "most fair and equitable method" of financing MCHA. The personal income tax, not the payroll tax, fits that description. Payroll taxes typically are not graduated, that is, they do not take a rising percent of income as income rises. Payroll taxes in theory could be graduated, but they are more commonly proportional or flat taxes, that is, taxes that take the same percent of income across all income levels. Moreover, income taxes tax income from all sources, including interest, dividends, rent, and royalities. Payroll taxes tax only wage and salary income. Nonwage incomes are earned in greater quantites by the rich than the middle- or low-income.

IV. COMPETITIVENESS OF THE HEALTH PLAN INDUSTRY

Ideally, a commission which is asked to evaluate all regulations governing a given industry would seek to determine whether competition functions in that industry. If an industry is competitive, there is less justification for government oversight of its behavior. I realize that making such a determination is not an easy task, especially for a commission such as ours that was asked to examine so many complex issues with limited resources. It does not surprise me that we did not take up that question, but I do object to statements strewn throughout the report suggesting that the Commission believes competition is an effective force within the health plan industry. The Commission's failure to examine seriously any proposal to regulate insurance company premiums was a mistake, motivated in part, I believe, by the unsubstantiated belief among a majority of Commissioners that health plan companies compete effectively with one another and therefore are not passing on unnecessary costs to consumers.

March 20, 1989

GOVERNOR'S COMMISSION ON HEALTH PLAN REGULATORY REFORM
-MINORITY REPORT REGARDING CONSUMER INTERESTS

The Governor's Commission on Health Plan Regulatory Reform has developed some excellent recommendations relative to issues concerning the financing of health care for Minnesotans. The Commission also, however, made several recommendations that we, the undersigned members of the Commission, believe work against the best interests of Minnesota consumers of health care. We are therefore adding this minority report on selected issues to the report of the Commission.

The concerns expressed below are held in common by the undersigned. They do not necessarily reflect all concerns held by each signatory.

Briefly stated, our concerns are as follows:

I) **Minimum Benefit Levels** -- In the interest of consumer protection and good health care financing, **we believe a minimum benefit level should be established as a floor for all types of health plan companies.** The Commission was unable to reach a consensus on that proposal and is endorsing the present system, which calls only for voluntary compliance with qualified plan standards by insurers and health service plan corporations.

We believe -- and the Commission agreed at its February 10 meeting -- that this action is not consistent with a motion made and passed by the Commission on September 16, 1988 concerning minimum requirements for conversion coverage.

We further believe that the Commission's recommendation against a minimum benefit level does not provide adequate consumer protection and is inappropriate public policy for Minnesota.

II) **Nonprofit HMOs** -- Minnesota HMOs have traditionally been required to be nonprofit entities. That requirement has served the public well, and has prevented HMO surpluses from being paid to investors rather than being accumulated as reserves for the protection of HMO members.

The Commission has recommended that the nonprofit requirement be dropped. **We see no advantage to the consumer in such an action and recommend that it not be enacted into law.** We do, however, agree that increased regulation of health plan management companies may be appropriate.

III) **Insurers as HMOs** -- The Commission is recommending that for-profit insurance companies be allowed to operate HMOs without complying with the long-standing Minnesota requirement that HMOs maintain 40% consumer representation on their Board of Directors. We believe that consumer leadership and involvement in the policy setting for any plan that combines the financing and delivery of care is good, solid, consumer protection and we oppose allowing insurers (whose leadership may not be Minnesotan) to deliver an HMO product without that level of consumer involvement.

Consumer groups have been actively and successfully seeking citizen representation on the Boards of organizations providing essential human services to consumers -- such as hospitals, nursing homes and insurance plans. We see no reason to take a step in the opposite direction.

The Commission did endorse the continued requirement that consumers be represented on the Boards of HMOs and health service plan corporations but then contradicted itself by recommending that insurers offering the same services be able to circumvent that important level of consumer protection. We do not believe that the creation of powerless "consumer advisory panels" accomplishes the purpose of consumer representation at policy levels.

In the interest of continuing Minnesota's tradition of citizen involvement in essential service industries, we believe any health plan company selling an HMO or managed care plan should be required to have 40% consumer representation on its Board, as it is required under current law.

IV) **Provider Network Restrictions** -- The Commission has approved a cost containment proposal permitting insurers and health service plan corporations to direct their enrollees to certain contracted providers only. As the recommendation is written, and unlike HMO laws (where the Health Department is responsible for assuring that provider networks are appropriate), there would be virtually no limit on the criteria an insurer or health service plan corporations could deem relevant in designing these restrictions. This recommendation, if passed by the legislature, would profoundly change the nature of insurance and health service plan corporations-- significantly limiting the health plan options available to consumers and restricting consumers' interest in open discussion and knowledge about important health care issues.

We therefore believe insurers, PPOs and health service plan corporations should be required (to the extent they avail themselves of the power to restrict their provider networks) to meet the same requirements now in existence for HMOs or, alternatively to make public their criteria for provider selection so that consumers may judge whether the plan meets their expectations as a consumer and uses appropriate criteria in screening providers.

We respectfully urge consideration of this minority report as the recommendations of the Commission are considered. We commend the Governor and the Legislature for creating the Commission and allowing for the level of discussion that occurred.

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Acknowledgments

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Commission on Health Plan Regulatory Reform

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About the Commission

The Commission on Health Plan Regulatory Reform ("the Commission") was created by the Minnesota legislature in 1987. The Commission was established to review and make recommendations concerning state regulation of accident and health insurers, nonprofit health service plan corporations (HSPCs), health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other arrangements that deliver or finance health services. This initiative resulted from legislative recognition of the rapid development of health plan products and the current and potential effect of state regulation on consumer protection and equitable competition.

The membership of the Commission was determined by the Commission's enabling legislation and is representative of the diversity of the health care community. The Commission was chaired by the Director of the State Planning Agency. Other representatives of the Executive branch included the Commissioner of the Minnesota Department of Commerce (MDC) and the Commissioner of the Minnesota Department of Health (MDH). The Legislative branch was represented by two members of the Minnesota House of Representatives and two members of the Minnesota Senate.

Health plan organizations engaged in the payment or the delivery of health care were represented by two health maintenance organizations, one nonprofit health service plan corporation, one accident and health insurer and one preferred provider organization.

Consumers were represented through employers, organized labor and individual consumers. Employers were represented by one public employer representative and two private employer representatives. One of the private employers provides health benefits on a self-funded basis; the other provides health benefits on an insured basis. Organized labor was represented through a national union; consumers were also represented through two representatives of consumer organizations.

The Commission began its work in January of 1988. Throughout 1988 and early 1989, the Commission held eighteen formal meetings. These meetings were open to the public. Meeting agendas and minutes of Commission meetings were mailed to all interested parties. The Commission held two public hearings in order to receive testimony from the general public.

The Commission was jointly staffed by the Department of Health, the Department of Commerce and the State Planning Agency. Commission members also made their internal organizational resources available to the Commission as required. The costs associated with the Commission's work were divided between the private sector and legislative appropriations.

Executive Summary

The last twenty years have witnessed an accelerated development of health benefit plans. These plans are sold through accident and health insurers, nonprofit health service plan corporations (HSPCs), health maintenance organizations (HMOs) and self-insured entities. At present the Minnesota Department of Commerce (MDC) regulates insurance companies and HSPCs and the Minnesota Department of Health (MDH) regulates HMOs. Federally qualified HMOs are also regulated by the federal Office of Prepaid Health Care, Department of Health and Human Services (OPHC).

A variety of state statutes and regulations affect health benefit plans. Many of these statutes and regulations were developed prior to the recent evolution in the health care market. Recognizing that outdated rules and statutes may impede the continued development of health benefit plans and a competitive market, the Minnesota legislature created the Commission on Health Plan Regulatory Reform in 1987. The Commission was asked to review and make recommendations concerning state regulation of health insurers, HSPCs, HMOs, PPOs and other arrangements that deliver or finance health care.

The Commission focused its study on state regulation relating to the cost and financing of health care, access to health insurance and the quality of health care. The Commission evaluated the effect of state regulation on consumers, employers, providers and health plan companies.

HEALTH CARE BENEFITS

A. Mandated Benefits

1. **Commission Deliberations Concerning Core Plan.** Insurers, HSPCs and HMOs are subject to a variety of mandated benefits. Mandated benefit laws have been enacted in order to improve access to certain health services. Although mandated benefit laws may improve access to certain services, the unintended result of these laws may be to decrease access to health insurance, impede product development, create competitive inequities and offer incentives for employers to self-insure. Such unintended consequences may be limited by design of a minimum or core benefit plan.

The Commission was unable to reach a consensus regarding the components of a minimum or core plan. The Commission fully supports increased access to health insurance. A multifaceted approach to the access problem is required. A disciplined approach to mandated benefit laws may be one facet of the solution.

2. **The Mandate Evaluation Process.** Mandated benefit laws may provide needed coverage for some individuals, but also decrease access to health care coverage through increased premium costs. An analysis weighing the anticipated financial and social impact of each mandated benefit will provide valuable information in deciding whether or not to enact such legislation. The Commission recommends that the legislature:

Establish a mandate evaluation process to formally evaluate the social and financial impact of proposed health benefit mandates.

The social and financial impact of proposed mandated benefit laws should be evaluated using the following guidelines and criteria, to the extent that information is available:

The Social Impact

1. *The extent to which the treatment or service is utilized by a significant portion of the population;*

2. *The extent to which health plan coverage is currently generally available;*

3. *If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care;*

4. *If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship;*

5. *The level of public demand for the treatment or service;*

6. *The level of public demand for health plan coverage of the treatment of service;*

7. *The level of interest of collective bargaining organizations in negotiating privately for inclusion of the coverage in group contracts;*

The Financial Impact

8. *The extent to which health plan coverage would increase or decrease the cost of the treatment or service;*

9. *The extent to which health plan coverage would increase the use of the treatment or service;*

10. *The extent to which the mandated treatment or service will be a substitute or alternative for more expensive treatment;*

11. *The extent to which health plan coverage can reasonably be expected to increase or decrease premiums and administrative expenses of health plan companies; and*

12. *The impact of the proposed mandate on the total cost of health care.*

Evaluation Process and Source of Funding

Any current mandate, proposed mandate or amendment to current mandates shall be referred to the mandate evaluation process by the appropriate legislative policy committee.

All interested persons shall submit information relating to the social and financial impact of the proposed mandate. The mandate evaluation process (MEP) shall be coordinated by the Minnesota Department of Health (MDH), in consultation with appropriate state agencies. The MDH shall contract with appropriate experts to prepare a report assessing the social and financial impact of proposed mandates, arrange for public

comment on the proposal and submit a recommendation to the appropriate legislative policy committee.

Each biennium the legislature should appropriate from general revenues base line funding sufficient to evaluate proposed mandates. Proposed mandates shall be accompanied by a fiscal note and the costs associated with a mandate evaluation charged against the base line appropriation.

Moratorium

All mandates proposed during the 1989 legislative session should be referred to a mandate evaluation process.

3. **Recodification of Mandated Benefit Laws.** Mandated benefit laws are codified in four separate chapters of Minnesota statutes. This approach creates difficulties in comprehending Minnesota's mandated benefits. The Commission recommends that the legislature:

Recodify all mandated benefit laws into a single chapter of Minnesota statutes.

B. The Small Employer Plan

A significant number of Minnesota employees working for companies with less than fifty employees do not have health care coverage available through their employment. Access is impeded due to the typically high cost of health care plans for small companies. The current level of mandated benefits, combined with health plan companies' inability to design a health benefit package for small employers contributes to this high cost. Health care access for small employers could be improved through the design of a small employer health plan pilot program with a built-in evaluation process. The Commission recommends:

A small employer health plan should be enacted as a five year pilot program and made available to employers with less than fifty employees who have not offered group health insurance to their employees in the previous calendar year.

A small employer data project should be established to study the needs of small employers, the marketplace reaction to a small employer health plan and the effect of the small employer plan mandates on increased access to group health insurance.

C. HMO Product Definition

The Commission recommends that all health plan companies be permitted to offer a variety of different health benefit plans. During the past twenty years Minnesota consumers have developed expectations as to what benefits are included in an HMO product. To preserve the historical definition of an HMO product while permitting all companies to offer all products, the definition of an HMO product should be reaffirmed. The Commission recommends:

Any health plan product marketed and/or sold as an "HMO product" must meet the following requirements:

1. *HMO labeled products may charge a copayment no greater than 25 percent on all services except that no copayment may be charged on prenatal care, well-child care and other specific health screening measures defined by the MDH;*

2. *HMO products must provide service benefits as defined in Minnesota statutes, including the provision of "comprehensive health services;"*

3. *HMO products must provide first dollar coverage without a deductible;*

4. *HMO products must be provided through a "delivery system" including a provider network, with a service area geographically certified by the MDH;*

5. *HMO products should be allowed to share insurance risk in provider contracts between the provider and the entity offering the HMO products; provider contracts for the purpose of providing HMO products must contain "hold harmless" language;*

6. *Any non-HMO entity offering an HMO product should have consumer representation of 40 percent on its governing board of directors or an advisory board with 40 percent consumer representation.*

D. Lifetime Maximum Mandates

Under current law insurers and HSPCs may impose a lifetime dollar limit on health care benefits ("lifetime maximum"). HMOs may not impose lifetime maximums. This unlimited liability places HMOs at a competitive disadvantage. Unlimited contract liability is inherent in the concept of comprehensive health care, a requirement of HMO products. However, HMOs should be allowed to impose $500,000 limits in certain limited circumstances on a condition-specific basis. A safety net should be established to allow for continuous care of individuals who exceed their contract limits. The Commission recommends:

All health plan companies and/or health plan products should be allowed to establish some form of limitation on contract liability, especially in very high cost, long-term cases, often characterized as "technology dependent." In cases where upper limits on contract liability are exceeded, a health plan safety net must be provided. Construction of a safety net should keep in mind the socially desirable goals of providing patients with continuity of care and controlling costs through managed care products;

Health plan products bearing an HMO label should continue to have unlimited contract liability, except that HMO products should be allowed to establish a $500,000 condition-specific contract liability limitation. It is suggested that acceptable "conditions" be predetermined by the MDH. It is anticipated that such conditions will be characterized as technology dependent. Assuming that MCHA is revised to reflect a more equitable funding base, enrollees exceeding the $500,000 liability limit should be transferred to MCHA. Where possible, managed care systems should be allowed to participate in MCHA so that continuity of care is provided.

E. Continuation and Conversion Mandates

Insurers, HSPCs and HMOs are governed by state conversion and continuation mandates. Employers are subject to federal continuation mandates pursuant to the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). Self-insured plans are subject only to COBRA requirements. The differences within state laws and between federal and state laws with regard to continuation and conversion mandates produce competitive inequities.

Some competitive inequities may be removed by consolidating the state conversion and continuation mandates for insurers, HSPCs and HMOs. No evidence indicates that the provision of generous continu-

ation or conversion coverage creates a significant financial strain for health plan companies. The continuation and conversion mandates ("access mandates") with the most generous coverage should be retained and extended to all health plan companies. The Commission recommends:

1. *All state access requirements for group contracts shall include all COBRA benefits and include all additional state continuation requirements for group coverage.*

2. *All health plan differences should be eliminated by extending the more comprehensive requirements in each instance to all health plans offering coverage in Minnesota. Any health plan that offers comparable Medicare policies without requiring evidence of insurability may use Medicare eligibility as a terminating event.*

3. *Continuation mandates for individual contracts should be retained.*

4. *Maintaining the status quo regarding replacement coverage.*

5. *All access mandates should be recodified in a single chapter of Minnesota statutes.*

HEALTH CARE DELIVERY

A. Quality of Health Care

While quality health care is a major concern within the health care system, only HMOs are subject to state quality assurance regulation. Federally qualified HMOs and competitive medical plans (CMPs) are also subject to federal quality assurance regulations. Diversity in the structure of health plans necessitates a variety of quality assurance regulation. The degree and complexity of regulation is appropriately determined by access limitations and provider incentives. Traditional quality assurance measurements have focused on structure and process rather than outcomes. Patient outcomes are also a highly useful measure of quality health care. Given these factors, the Commission recommends:

The appropriate state agency shall institute varying quality assurance requirements for all health plan products depending upon the degree of provider risk sharing, access limitations and other plan features identified by the appropriate state agency.

Minnesota quality assurance requirements should avoid duplication with other requirements. To the extent feasible and appropriate, Minnesota quality assurance requirements should be result or outcome oriented in order to maximize their effectiveness and usefulness.

B. Health Plan Companies and Consumers

1. **Consumer Complaint Systems.** Consumer complaint regulation has previously focused solely on HMOs. The potential for consumer disagreement is present in all health plan companies. The Commission recommends:

All health plan companies should be subject to consumer complaint and arbitration requirements.

2. **New and Emerging Technology.** As medical technologies develop, the financing of new and emerging technologies by health plan companies has become a significant issue. Health plan companies need to establish internal review processes for making informed decisions concerning the experimental status of new technology. Health plan companies should utilize the expertise of public and private agencies engaged in technology assessment.

Although limited technology assessment has been performed by the MDH and the MDC, the internal agency process is not formalized in statute or rule. The establishment of an internal review process in both agencies is appropriate. The Commission recommends:

> *All health plan companies should develop an internal technology assessment process for the evaluation of the experimental status of new and emerging medical technology. This internal process may include consultation with federal, state and private agencies, establishment of internal advisory panels, consultation with appropriate outside experts and review of scientific literature.*
>
> *The appropriate state agency should establish through statute or administrative rule an expedited review process for the review of medical technology in those cases where the company has concluded that a requested treatment or service is experimental with respect to a particular patient's condition and diagnosis and the state agency determines that a patient's condition is life-threatening. The state agency should consult with appropriate and identified experts, review scientific and medical literature and consider all relevant factors including:*
>
> - *whether final approval has been granted by the appropriate government agency;*
> - *the availability of scientific evidence concerning the effect of the technology on health outcomes;*
> - *the availability of scientific evidence that the technology is as beneficial as established alternatives;*
> - *the availability of evidence of benefit or improvement outside of investigational settings.*
>
> *No health plan company should be required to cover drugs or biologics deemed experimental by the Food and Drug Administration or medical procedures determined to be experimental by HCFA for purposes of Medicare reimbursement.*

3. **Urgently Needed Services.** A review process for addressing disputes between consumers and health plan companies regarding the provision of urgently needed services is not described in either statute or rule. Such a process must be flexible and easily understood by all parties. The Commission recommends the:

> *Identification of a process within the Departments of Health and Commerce for review of urgently needed care appeals that includes the use of appropriate medical experts and identification of those experts.*

4. **Consumer Responsibility for Health Care Utilization & Costs.** Health benefit plan premiums have traditionally been based on variables that are largely beyond the control of insured individuals. Recent research indicates that certain lifestyle factors may be within the control of insured individuals and should be considered in determining health risk. Further study is needed to understand the ramifications of lifestyle ratings. The Commission recommends that:

HMOs, HSPCs and insurers be encouraged to offer actuarially sound discounts and incentives for both group and nongroup contracts for people who have healthy lifestyles. The MDH, in consultation with the MDC, should study this issue and make recommendations to the legislature by January, 1990, for any statutory and rule changes necessary to allow such plans to be offered.

C. Health Plan Companies and Providers

1. **HMO/Provider Dispute Resolution.** The 1988 legislature enacted a mandatory mediation process for HMO/provider disputes. The statute has been invoked on only one occasion since enactment. Mediation did not result in continuation or renewal of the provider contracts. The relationship between HMOs and providers is primarily a private contractual relationship. Disagreements between HMOs and providers are appropriately settled through the judicial system. The Commission recommends:

The mediation statute for HMOs should be allowed to sunset in June, 1990. In the interim, the MDH should continue to evaluate the usefulness of the mediation process.

2. **Provider Risk Sharing.** Current efforts to control medical costs include provider risk sharing. Provider risk sharing contributes to cost containment, but in certain circumstances may also provide an incentive for inappropriate care. The Commission recommends:

Physicians and physician groups should not be permitted to accept 100 percent financial risk for the provision of services provided by other facilities or providers not owned or operated or otherwise subject to the control of the medical group assuming the risk, unless the group can demonstrate adequate financial strength to accept such risk.

Health plan companies should provide stop-loss coverage to physicians and physician groups at levels appropriate to their ability to sustain risk.

3. **Provider Selection and Reporting.** To provide high quality care at competitive prices, health plan companies must select providers who will effectively and efficiently serve consumers. The creation of a data bank containing information on the credentials and practice patterns of providers will assist health plan companies in selectively contracting with providers who meet relevant criteria. The Commission recommends:

Health plan companies utilizing provider networks should be permitted to contract selectively with providers based on relevant criteria developed by the health plan company which may include geographic location, provider qualifications, quality of practice, cooperation with quality assurance/utilization review programs and acceptance of contracted payments,

Health plan companies should be authorized to submit information to the Department of Health concerning the identity of specific providers whose utilization practices exceed the health plan company's average utilization levels by an agreed number of standard deviations.

This information will be maintained by the Department of Health and accessible only to health plan companies licensed to do business in Minnesota.

PRODUCT REGULATION AND HEALTH PLAN COMPANY CORPORATE STRUCTURE

A. Product Diversification

The characteristics of health plan products were originally unique to the statutory classification of the health plan company offering the product. Evolution in the health care industry has blurred these distinctions. In order to offer additional products, some health plan companies have established complex holding company systems. The related costs are high and inefficiencies result. Regulatory inefficiencies should be eliminated in a competitive system if they do not serve an important public interest. The Committee recommends that:

The flexibility of all types of health plan companies to respond to the needs of consumers be increased by:

1. *Amending Chapter 62C to allow HSPCs to offer an HMO product as a line of business, provided that the HMO product is subject to the requirements of Chapter 62D with respect to enrollee contracts, provider contracts, provider networks and provide dispute resolution, quality assurance, consumer complaint procedures and underwriting.*

2. *Amending 62A to allow insurers to offer an HMO product as a line of business, provided that the HMO product is subject to the requirements of Chapter 62D with respect to enrollee contracts, provider contracts, provider networks and provider dispute resolution, quality assurance, consumer complaint procedures and underwriting.*

3. *Amending Chapter 62D to allow HMOs to offer products which satisfy the benefit, copayment, deductible and lifetime maximum requirements of qualified #1, #2 and #3 plans, provided that such products are offered primarily through an HMO provider network and remain subject to appropriate managed care and financial integrity regulation. Qualified #l, #2 and #3 plans offered primarily by an HMO should not be labeled HMO products.*

4. *Amending Chapter 62D to allow HMOs to offer a "combination" or "wrap-around" plan which permits the provision of health services by providers not affiliated with the HMO, without the incorporation of or affiliation with a separate insurance company.*

5. *Amending Chapters 62A and 62C to allow insurers and HSPCs to engage in provider risk sharing with respect to non-HMO products, provided that such products shall be subject to appropriate quality assurance regulation, commensurate with the type and degree of risk sharing and the degree of access to nonparticipating providers.*

B. Managed Care Certification and Self-Insured Plans

State regulation of self-insured plans is restricted by the Employee Retirement Income Security Act of 1974 (ERISA) Business entities who provide "managed care" services to self-insured plans are not subject to regulation specific to utilization review activities or other "managed care" functions. State regulation narrowly drawn to focus solely on the management of health care delivery for self-insured

plans may minimize the likelihood of a successful ERISA challenge. The Commission recommends that the legislature:

Pursue whichever of the following options is most likely to prevail in the face of an ERISA challenge:

1. *Require "managed care certification" for self-insurers that offer health plans incorporating managed care features.*

2. *Require "managed care certification" of third-party administrators, preferred provider organizations or other companies that provide managed care services to self-insured health benefit plans.*

C. HMO Nonprofit Requirement

Minnesota is the only state that prohibits HMOs from organizing as for-profit corporations. Continued application of the nonprofit requirement is not necessary to protect the consumer and is inconsistent with the development of a competitive health care market. Conversion from nonprofit to for-profit status may be a complicated process. The Commission recommends that the legislature:

Permit HMOs to incorporate as for-profit corporations and enact a statutory HMO conversion procedure for existing HMOs.

D. Consumer Representation on Health Plan Company Board of Directors

Minnesota law requires that forty percent (40%) of an HMO's Board of Directors be composed of consumers elected by the enrollees from among the enrollees. Consumer board members contribute to the development of a consumer oriented philosophy in the community and safeguard against dominance by any single group. The Commission recommends:

The consumer board requirements should be maintained for health maintenance organizations and health service plan corporations.

E. Taxation of Health Plan Companies

State and federal taxation of health plan companies varies according to the statutory classification of the company. Due to the complexity of taxation issues, the Commission declines to make a recommendation on the taxation of health plan companies. Future attention to this issue should address the relationship between the taxation of health plan companies and the affordability of health care.

F. HMO Premium Rates

State policy encourages price competition in the health care market. In support of this policy HMOs have not been subject to routine rate regulation by the MDH; reviews are conducted on an exception basis only. This approach is sufficient to respond to consumers' complaints about large premium increases and financial stability concerns related to low premiums. The Commission recommends:

The current regulatory approach to HMO rate review should be maintained.

THE FINANCIAL STABILITY OF HEALTH PLAN COMPANIES

A. Financial Solvency

The type and extent of state regulation of health plan companies' financial stability or integrity varies by statutory classification. Current regulation is adequate to protect consumers. Rehabilitation and liquidation procedures were originally designed for insurers. The liquidation of two HMOs in 1988 demonstrated that these procedures are not well-suited to HMOs. The Commission recommends :

> *The current financial solvency requirements for health plan companies should be retained. Separate rehabilitation and liquidation procedures for HSPCs and HMOs should be established.*

B. Risk Selection

HMOs are required to participate in an annual open enrollment process and have limited ability to underwrite group contracts. As a result, some small businesses are unable to obtain HMO group coverage. A system whereby all health plan companies are permitted to "carve out" high-risk members of a group will improve access to health insurance, provided that alternative coverage is available to the "carved out" individual. Consumer choice and the subsequent enhancement of the competitive system will be increased by requiring all health plan companies to participate in open enrollment in appropriate geographic areas. The Commission recommends:

1. *All health plan companies should be allowed to health screen new or renewed contracts for small group business and exclude individual "high-risk" members. A small group is defined as less than fifty employees. This recommendation requires the creation of an acceptable "safety net" for excluded employees. MCHA is recognized as an acceptable safety net, provided that the current funding base of MCHA is changed. It is further conditioned upon the development of a common definition of "high-risk" members and an assessment against health plan companies of financial "penalties" for exclusion of "high-risk" members from a group.*

2. *When more than one health plan is offered to an employer group, all health plan companies must participate in open enrollment without underwriting restrictions. This open enrollment should apply to initial contract offerings and at least once every two years thereafter. This requirement extends only to Minnesota regions where a health plan company has a certified service area or adequate provider contracts. The current HMO waiver mechanism should be extended to all health plan companies.*

PREFERRED PROVIDER ORGANIZATIONS

PPO and HMO plans are often difficult to distinguish. PPO plans are not subject to the same "managed care" regulation applicable to HMOs. Additional PPO regulation regarding the use of benefit differentials and consumer disclosure of coverage will improve consumer protection and result in the similar regulation of similar products. The Commission recommends:

The MDC should formally adopt administrative rules governing the operation of PPO plans which establish limits on benefit differentials and incorporate the consumer disclosure requirements contained in the NAIC Preferred Provider Arrangements Model Act.

THE MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION

Health care coverage access problems are often experienced by small employers with a "high-risk" group member and by individuals who exceed the lifetime maximums of their benefit contracts. The Minnesota Comprehensive Health Association (MCHA) is an appropriate "safety net" for these individuals. MCHA is the largest high-risk pool in the United States. MCHA deficits are currently funded solely by Minnesota health plan companies. This financing methodology places financial strain on health plan companies and insulates self-insured plans from the costs associated with insuring "high-risk" individuals. The Commission recommends that:

1. *Employers of less than fifty employees be permitted to carve out individuals at the time of initial offering of coverage or at annual renewal, provided that these individuals meet MCHA eligibility criteria and;*

2. *MCHA be used as a safety net for those individuals who exceed the lifetime maximum of their benefit contract, provided that;*

3. *The funding base of MCHA is expanded. The legislature should consider the advantages and disadvantages of an employer assessment. Additionally,*

4. *MCHA benefit plans should provide affordable coverage and incorporate appropriate cost containment procedures and features;*

5. *Mechanisms should be developed to provide continuity of care in the event of transition to and from a MCHA policy.*

STATE AGENCY RESPONSIBILITY FOR HEALTH PLAN REGULATION

Minnesota divides the regulation of health plans between the MDH and the MDC according to company category. Implementation of the recommendations made in this report will be confusing and inefficient under such a division. Confusion and duplication of effort could be avoided and the unique expertise of each agency utilized if regulation is assigned to the MDC and the MDH according to function. The Commission recommends:

The MDC and the MDH should develop a plan for the functional division of regulatory authority. This proposal should be submitted to the 1991 legislature as part of the biennial budget process and should be premised on the following general principles:

1. *Each agency has a legitimate role in health plan regulation. The primary jurisdiction of the MDC should be financial and corporate; the primary jurisdiction of the MDH should be access to health care services and issues of medical care;*

2. *Each agency should exercise its authority independently of the other to the extent possible; overlap in jurisdiction should be avoided.*

INTRODUCTION

The Minnesota health plan market has changed and evolved over the last two decades. Minnesota residents enjoy an increased array of health coverage options. These options include accident and health insurance plans, health service corporation plans, health maintenance organization plans and self-insured plans. With the exception of self-insured plans, each of these health plans is subject to state regulation.

Minnesota and other states have historically approached the regulation of health plans by regulating the corporate organization offering the health plan and underwriting the insurance risk. Insurance companies have been regulated in Minnesota since the early 1800s and are licensed by the MDC. Nonprofit health service plan corporations have been regulated since the 1940s and receive a certificate of authority from the MDC. Minnesota began regulating HMOs in 1973; HMOs are licensed by the MDH.

Accident and health insurers, health service plan corporations and HMOs initially offered distinct products. Insurers offered standard indemnity products which included unrestricted access to providers. Insurers did not directly reimburse providers and directed payment to the insured. Reimbursement was established on a fee-for-service basis. Health service plan corporations contracted with any willing and qualified provider, offered subscribers access to participating and nonparticipating providers and reimbursed providers on a fee-for-service or discounted fee-for-service basis. HMOs contracted with a limited set of providers, limited enrollee access to participating providers and shared financial risk with providers through a variety of reimbursement mechanisms.

Although some differences remain, many past distinctions between health plan company products have gradually faded. The Minnesota health care system has undergone substantial restructuring. Health plan companies now offer similar "managed care" products through similar delivery systems. Although products offered by these companies have changed and evolved, Minnesota health plan regulation has been criticized as a serious impediment to continued product evolution and the development of a competitive health plan market. Employers and individual purchasers have voiced concern over the rising costs of health care, access to health insurance and the potential effect of certain cost containment strategies on the quality of medical care. As a result, all interested parties concluded that a review of Minnesota health plan regulation was needed.

I

OVERVIEW OF CURRENT REGULATORY STRUCTURE

Insurers

Health benefit plans are currently regulated in accordance with the license obtained by the health plan company offering the product. Insurance is defined as a contractual obligation to indemnify another up to a specified amount against loss or damage from specified causes.[1] The McCarran-Ferguson Act, passed by Congress in 1945, identified insurance as a business "affected with the public interest" and specified that it should be regulated by the states.[2]

Accident and health insurers obtain an insurance license from the MDC.[3] Insurers may be organized as stock or mutual companies, reciprocals or fraternal benefit societies. Insurers may be incorporated in Minnesota ("domestic" insurers) or incorporated in another state and licensed to do business in Minnesota ("foreign" insurers). Stock companies are organized as for-profit entities. Mutual companies are member-owned. Fraternal benefit societies are required to operate as nonprofit organizations; reciprocals are not incorporated.

Insurance regulation focuses on organizational structure, the financial solvency of the insurer, policy provisions, mandated benefits, renewal and cancellation requirements, broker and agent licensing, premium rates and unfair trade practices. In a variety of areas, insurers face regulatory burdens not applicable to their competitors. For example, unlike HMOs, insurers are required to provide direct reimbursement to a wide range of allied health practitioners.[4]

In contrast to state regulation of HMOs and HSPCs, state law did not initially contemplate that insurers would directly contract with providers. From its inception commercial health insurance has been synonymous with unrestricted choice of provider. The role of an insurer has historically been to pay claims and finance the patient/physician relationship. In recent years this traditional role has been altered by the development of preferred provider organizations (PPOs). PPO plans contract with a subset of the provider community to create a "preferred provider network." PPO plans use benefit and cost differentials to encourage insureds to utilize these "preferred providers."

In recent years insurers have also entered the HMO market. Current Minnesota law requires insurers to separately incorporate a nonprofit HMO corporation in order to offer an HMO product. Amendments to the federal HMO act removed a similar requirement for federally qualified HMOs in 1988.

[1]Minn. Stat. §60A.02, subd. 3 (1988).

[2]15 U.S.C. §1011 (1988).

[3]Minn. Stat. §60A.01–.31 (1986); Minn. Stat. §62A. 01–.56 (1988).

[4]Minn. Stat. §62A.15 (1988).

Stock and mutual companies pay premium taxes, property and sales taxes, state and federal corporate income tax and Minnesota Comprehensive Health Association (MCHA) assessments. Insurers may use premium tax payments to offset state income tax obligations. Fraternal benefit societies are exempt from all taxes except property taxes but participate in MCHA.

Accident and health insurers are members of the Life and Health Guaranty Association and are also subject to the separate requirements of the National Association of Insurance Commissioners (NAIC).[5] The national operation of the majority of insurers also subjects them to additional regulatory requirements as a result of their multi-state operations.

Health Service Plan Corporations

Health service plan corporations (HSPCs) contract directly with providers to deliver health services to their subscribers, as contrasted with insurers, which indemnify insureds against the costs of such care.[6] Like insurers, HSPCs assume the underwriting risk for the health care costs of their subscribers. Blue Cross and Blue Shield plans pioneered this direct coverage arrangement and still account for the majority of HSPCs nationwide.

Minnesota HSPCs are required by law to be incorporated in Minnesota as nonprofit corporations. HSPCs are regulated by the MDC. HSPC regulation focuses on many of the same elements which are the subject of insurance regulation including organizational structure, financial solvency, policy provisions, mandated benefits, renewal and cancellation requirements, premium rates and unfair trade practices.

Unlike insurers, HSPCs are expected to maintain contractual relationships with providers ("participating providers"). Coverage is also available when services are received from nonparticipating providers. Although in concept HSPCs may restrict an enrollee's choice of provider to participating providers, HSPCs have traditionally contracted with a broad base of providers. As a result, the provider network of an HSPC is often quite extensive and subscribers may enjoy considerable "freedom of choice."

HSPCs share some operational and regulatory traits with both insurers and HMOs. Like insurers, HSPCs are required to directly reimburse an extensive number of allied health practitioners. HSPCs are not authorized to directly provide medical care. As a result, HSPCs have not historically been subject to specific quality assurance regulation. HSPCs' contract relationship with providers is similar in some respects to an HMOs provider network. However, unlike HMO enrollees, HSPC subscribers have historically been permitted access to a large number of nonparticipating providers.

The tax liability of HSPCs is more limited than that of insurers, but more extensive than that of HMOs. Although required by law to do business as nonprofit entities, Minnesota HSPCs pay property and sales taxes and are subject to federal and state corporate income taxes on their "profits" or surplus. HSPCs are subject to MCHA assessments but do not pay premium taxes. HSPCs are also members of the Life and Health Guaranty Association.

Health Maintenance Organizations

HMOs provide or arrange for the provision of comprehensive health services to HMO enrollees on a prepaid, capitated basis.[7] HMOs are required to incorporate in Minnesota and do business as nonprofit corporations. HMOs are regulated by the MDH. In contrast to insurers and HSPCs, HMOs may also be regulated on the federal level, if the HMO chooses to be "federally qualified." Federally qualified HMOs are regulated by the Office of Prepaid Health Care (OPHC), Department of Health and Human Services (DHHS).[8]

HMO regulation covers many of the same areas as insurance and HSPC regulation including

[5]Minn. Stat. §61B.01–.16 (1988).
[6]Minn. Stat. §62C.01–.23 (1988).
[7]Minn. Stat. §62D.01–.30 (1988).
[8]42 U.S.C. 300e–300e–17 (1986); 42 C.F.R. §110.101–1011 (1988).

organizational structure, financial solvency, benefit contracts, mandated benefits and unfair trade practices. Unlike insurers and HSPCs, HMOs are not subject to prospective review of premium rates. With respect to mandated benefits, HMOs are the only health plan company required by law to provide "comprehensive" health care. Comprehensive care includes preventive care, as well as unlimited contract liability. HMOs may not incorporate deductibles into their benefit contracts and have a limited ability to require enrollee cost-sharing through copayments.

HMOs are the only health plan company statutorily responsible for both payment and delivery of health care. As a result, HMOs are subject to extensive regulation of their relationships with providers, including "service area" certification and provider risk sharing. HMOs are also the only health plan company required to operate a quality assurance program. In addition, the dual responsibilities of insurance and health care delivery have resulted in extensive regulation of an HMO's management and organizational structure.

In contrast to insurers and HSPCs, the HMO concept did not initially contemplate the offering of "freedom of choice" to enrollees or the establishment of contractual relationships with "any willing provider." HMOs have limited ability to reimburse nonparticipating providers. These limits have caused some HMOs to form separate insurance companies or enter into contractual relationships with insurers in order to offer indemnity-type benefits to HMO enrollees through combination or wrap-around products.

The tax liability of HMOs is less than that of either insurers or HSPCs. HMOs pay property and sales taxes but qualify for state and federal tax-exempt status and do not pay premium taxes. HMOs are liable for MCHA assessments but are not members of the Life and Health Guaranty Association.

Self-Insured Health Plans

Self-insured plans may be offered by private and public employers, Taft-Hartley union trusts, and multiple employer welfare associations (MEWAs). Numerous studies confirm that self-insurance is increasing.[9] A recent survey by the Office of the Legislative Auditor revealed that almost ten percent of Minnesota firms that offer health benefits offer at least one self-insured plan and that nearly one-quarter of all Minnesota employees are enrolled in a self-insured plan.[10]

State regulation of self-insured plans is limited by the Employee Retirement Income Security Act of 1974 (ERISA).[11] ERISA preempts state law which "relates to" an employee welfare benefit plan unless the law regulates the "business of insurance." ERISA's preemption provisions have been consistently interpreted by federal courts as forbidding state regulation of self-insured health plans.[12]

As a result of ERISA preemption, self-insured plans are not subject to state mandated benefit laws, are not liable for MCHA assessments and do not pay premium taxes. Self-insurers do not participate in the Life and Health Guaranty association and are not subject to many consumer protection laws including the Unfair Claims Practices Act.[13]

Third Party Administrators

Self-insured plans may be administered by employers or by third-party administrators (TPAs). Although ERISA prohibits the regulation of self-insured plans, it does not prohibit the regulation of administrators performing claims processing and other administrative services for self-insured plans. Minnesota licenses "self-insurance plan administrators" and "vendors of risk management services."[14] Licensure is conducted by the MDC and is conditioned upon proof of the necessary organization, background, expertise and financial integrity to supply administrative services.

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[9] *See Health Plan Regulation Report,* Office of Legislative Auditor (1988).

[10] *Id.*

[11] 29 U.S.C. §1001 *et seq.* (1986).

[12] *See, e.g., Metropolitan Life Ins. v. Massachusetts,* 471 U.S. 724 (1985); *Minnesota Chamber of Commerce v. Hatch,* 672 F. Supp. 393 (D. Minn. 1987).

[13] Minn. Stat. §72A.20 (1988).

[14] Minn. Stat. §60A.23, subd. 8 (1988).

Preferred Provider Organizations

Insurance contracts which provide for different amounts of reimbursement to be paid if insureds obtain health services from "preferred providers" are subject to limited state regulation.[15] This regulation requires insurers offering preferred provider organization plans ("PPO plans") to file summary data with the MDC. This data must be filed prior to an initial offering and annually thereafter. Administrative regulations expanding on these statutory requirements have not been promulgated. As a result, the "managed care" practices and techniques adopted by PPO plans are not subject to the same level of regulation faced by HMOs engaging in similar practices.

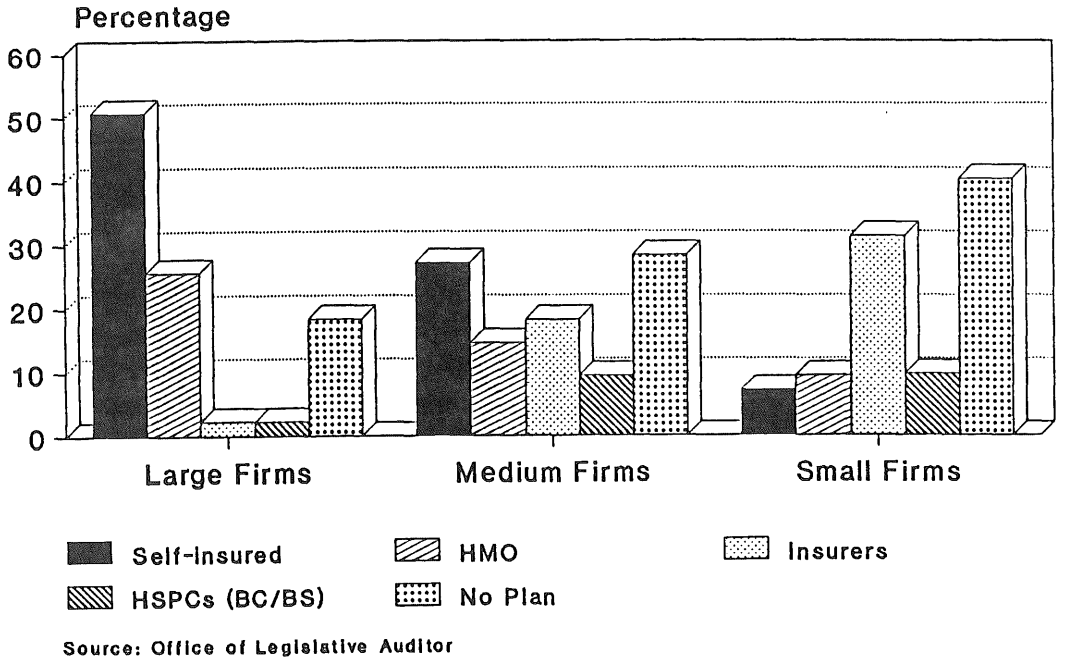
PPO plans offered by self-insured entities are exempt from state regulation pursuant to ERISA's preemption provisions. Organizations established to develop provider networks and provide PPO management services are not subject to regulation specifically directed at "managed care" activities such as utilization review and provider selection and credentialing.

Figure 1.1
CURRENT REGULATION OF MINNESOTA HEALTH PLAN COMPANIES

	Insurers	HSPCs	HMOs
MDH			X
MDC	X	X	
Organizational structure	X	X	X
Board membership		X	X
Financial solvency	X	X	X
Open enrollment			X
Benefit contract provisions	X	X	X
Renewal/cancellation rqmts	X	X	X
Unfair trade practices	X	X	X
Quality assurance			X
Provider contracts	X*	X	X
Provider dispute resolution			X
Provider risk sharing			X
Service area certification			X
Management contracts			X

*PPO plans only

Figure 1.2
MINNESOTA EMPLOYEES IN EACH TYPE OF HEALTH PLAN



Source: Office of Legislative Auditor

[15]Minn. Stat. §72A.20, subd. 15 (1988).

II

HEALTH CARE BENEFITS

A. Mandated Benefits

Overview

State laws regulating the content of benefit plans exist in all fifty states. In 1970, there were only thirty mandated benefit laws in the United States. Every year more mandated benefits are enacted (*see Figure 2.1*). The Blue Cross and Blue Shield Association recently reported that by the end of 1986, the total number of mandates enacted by all fifty states reached 645 (*see Figure 2.2*). This year the number of mandated benefit laws is expected to exceed 700.

Mandated benefit laws require that specific benefits be included in every benefit plan issued in a state (*see Figure 2.3*). States compel health plan companies to provide coverage for diseases ranging from AIDS to chemical dependency and for services ranging from cancer screening to *in vitro* fertilization. Employers and health plan companies have no flexibility to substitute actuarially equivalent benefits. As a result, employers and low income individuals are often required to purchase an expensive smorgasbord of benefits which they neither desire nor need.

Mandated benefit laws are increasingly controversial. A recent study by the National Center for Policy Analysis, a Dallas-based think tank, estimated that as many as 25 percent of the uninsured lack health coverage because mandated benefits make it too expensive.[1] Employers, health plan companies and small businesses maintain that mandated benefit laws increase the cost of health care, eliminate the ability of employers, insureds and companies to tailor a health benefits plan to suit specific needs and force small employers from the insurance market due to increased premium costs.

The limitations imposed by mandated benefits create an incentive for employers to self-insure. The Legislative Auditor estimated in his 1988 report on Health Plan Regulation that nearly 25 percent of all Minnesota employees are enrolled in a self-insured plan. Other surveys cited in the Auditor's report indicate that nationwide between 6 to 80 percent of all employers self-insure health benefits[2] (*see Figure 2.4*). Large employers report a higher incidence of self-insurance (80 percent) than small employers (6 percent). The trend towards self- insurance is expected to continue into the foreseeable future.

Self-insurance removes health benefit plans from the state's regulatory jurisdiction. Self-insurance also eliminates any contribution by employers to the state's risk pool for the medically uninsurable (MCHA). This places increased financial burdens on health plan companies who must fund operating deficits incurred by MCHA. Employers who choose to purchase benefit plans from regulated companies must absorb these extra

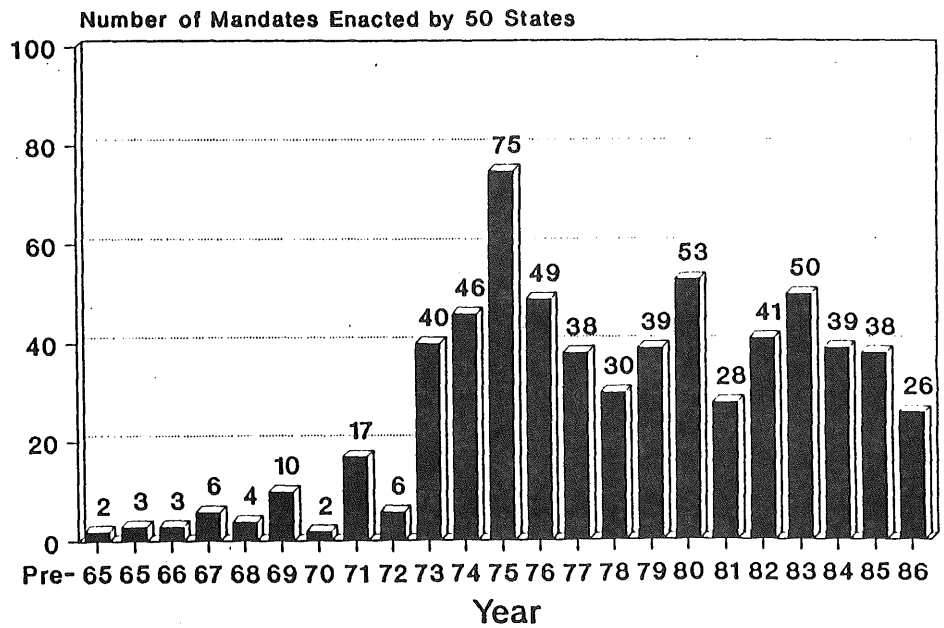
[1] *Freedom of Choice in Health Insurance,* National Center for Policy Analysis (November 1988).

[2] *Health Plan Regulation,* Office of the Legislative Auditor (1988).

Figure 2.1

Health Benefit Mandates

Annual U.S. Enactments Since 1965

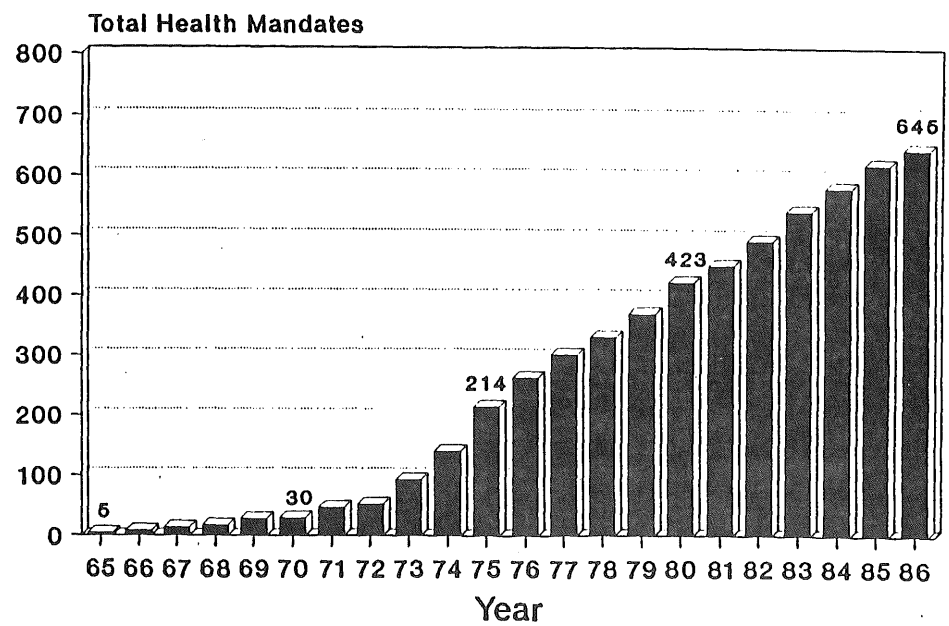


Source: Blue Cross and Blue Shield Association

Figure 2.2

Benefit Mandates—U.S.

Cumulative Total by Year Since 1965



Source: Blue Cross and Blue Shield Association

costs while their competitors who self-insure avoid this additional expense.

Self-insurance allows employers to avoid mandated benefit laws and tailor their benefit plans to meet their specific needs. This freedom from mandated benefits places regulated companies at a competitive disadvantage since mandated benefit laws may prohibit companies from designing their products to respond to employers' and consumers' needs.

Minnesota has been quite prolific in its use of mandated benefits; over twenty mandates are currently "on the books." These laws are codified in four separate chapters of Minnesota statutes.[3] These chapters roughly correlate with the enabling legislation for the three major types of health plan companies. A list of Minnesota's current mandates is reflected in Figure 2.5.

Insurers, HSPCs and HMOs are subject to different mandates. Only HMOs are required to provide "comprehensive care" with unlimited liability. Only HSPCs and insurers are required to directly reimburse certain allied health practitioners ("direct reimbursement" or "provider mandates"). HMOs are permitted to select the type and number of health care providers which provide medical care to HMO enrollees. Mandated benefit laws also differ with respect to the same disease and treatment. For example, HMOs are required to provide inpatient mental health treatment; insurers and HSPCs have no similar requirement.

In addition to mandated benefit laws, Minnesota law subjects health plan companies to qualified plan standards.[4] Qualified plan standards differ from mandated benefit laws. Whereas mandated benefits must be included in every benefit contract issued in Minnesota, qualified plan requirements need not be included in every policy. Alternative benefits may be substituted if they are actuarially equivalent to the qualified plan standards. Insurers and HSPCs may sell nonqualified plans provided that purchasers are offered a qualified plan alternative. HMO plans are statutorily "deemed" to be a qualified plan. HMOs are not permitted to sell nonqualified plans. A list of current qualified plan requirements is set forth in Figure 2.6.

Figure 2.3

MANDATE CATEGORIES

TREATMENT MANDATES
State laws requiring health insurance coverage of specific diseases, conditions or treatments (e.g., mental health, chemical dependency, treatment of temporo mandibular joint disorder (TMJ) and treatment of DES-related conditions).
PROVIDER MANDATES
State laws requiring health insurers to directly reimburse specific types of allied health professionals (e.g., chiropractors, podiatrists, and optometrists).
DEPENDENCY MANDATES
State laws requiring health insurance coverage of certain dependents of the policyholder (e.g., newborns, adopted children and handicapped adults).
CONTINUATION/CONVERSION MANDATES
State and federal laws requiring continuation of health insurance following a change in a family or employment relationship (e.g., termination or layoff from employment).

Minnesota's mandated benefit laws are not part of a cohesive and structured legislative program. Minnesota's mandates do not share a common purpose, sponsor or legislative history. New mandates are added each legislative session. This approach to mandated benefits creates competitive inequities and problems for health plan companies, employers and consumers. Health plan companies are less able to engage in effective price competition when the required benefit plan components differ from company to company. Mandated benefits inhibit product design and create special and unfair advantages for certain companies, depending on the particular set of mandates applicable to that company.

[3]Minn. Stat. §62A.01–.56 (insurers); 62C.01–.23 (HSPCs); 62D.01–.30 (HMOs); 62E.01–.18 (qualified plans) (1988).
[4]Minn. Stat. §62E.01–.18 (1988).

Many employers with limited revenues and operating margins cannot afford the comprehensive health plans required by state law. As a result, many employers may have no choice but to decline to offer any health coverage to their employees.

Although many mandated benefit laws were enacted with the consumer's best interests in mind, the cumulative effect of mandates may negatively impact many consumers. Minnesotans who are employed by small employers may find that they have no access to group insurance through their employer. These individuals must purchase more expensive individual policies or forego health insurance altogether. Many of these individuals will avoid seeking medical care if they lack insurance. Avoidance of medical care may contribute to excessive sick leave and lower productivity and ultimately result in more serious and expensive medical conditions.

Figure 2.4

Percentage of U.S. Employers Who Self-Insure Health Benefits

1 to 99 employees	6%
100 to 249 employees	24%
250 to 999 employees	43%
1,000 to 4,999 employees	71%
5,000 or more employees	80%

Source: Patricia McDonnell, et al.,"Self Insured Health Plans," *Health Care Financing Review,* 8, No. 2 (Winter 1986): 1–16.

Note: This survey included unions, religious organizations, government and post-secondary schools.

1. Commission Deliberations on the Core Plan

Early in its deliberations the Commission recognized that Minnesota's mandated benefit "system" may be contrary to its stated goal of assuring access to health services. Mandated benefits impede product development and encourage employers to self-insure. Self-insurance removes these benefit plans from the state's regulatory jurisdiction. As a result, Minnesota consumers enrolled in these plans do not have the benefit of a variety of consumer protection laws applicable to insured products. Self-insurance allows employers to avoid any liability for MCHA assessments and therefore increases the burdens facing Minnesota health plan companies and employers who do not self-insure.

The Commission tentatively concluded that many of the unintended negative consequences of mandated benefit laws could be corrected through the development of a minimum or core benefit package. A minimum or core benefit package would remove the current competitive inequities resulting from different mandates for different companies, would provide much needed product design flexibility and would consequently allow health plan companies to more effectively compete with self-insured products. Enactment of a minimum benefit plan would also provide small employers with a more affordable insured product. The existence of such a product might allow some small employers to provide group coverage to their employees and slow the trend towards self-insurance.

The Commission based its design of a minimum benefit plan on three basic principles. A minimum plan must 1) be affordable for small employers; 2) provide adequate financial protection against catastrophic loss; and 3) provide coverage for basic health services. The Commission devoted considerable time and resources to the development of a minimum or core plan. Numerous versions of a core plan were proposed, discussed and priced. The Commission's extensive exploration of this concept revealed the difficulty of creating a benefit plan which includes basic health services at a significantly reduced price.

Ultimately the Commission could not reach consensus concerning the appropriate elements of a minimum or core plan and consequently makes no recommendation concerning a core benefit plan. However, the Commission's painstaking work in this area highlights that affordable health care for more Minnesotans will involve certain difficult and inescapable trade-offs. Additional benefits generally produce higher premiums. Higher premiums may impede access to health insurance for some individuals.

Under current law small employers, the self-employed and other individuals have limited choices: comprehensive coverage, catastrophic coverage or no health coverage. Large employers

Figure 2.5

Current Minnesota Mandated Benefits

Disease and Treatment Mandates

Individual and Group Mandates

- Temporomandibular Disorder (TMJ) *(Minn. Stat. §62A.043)*
- Craniomandibular Disorder *(Minn. Stat. §62A.043)*
- DES Related Conditions (Diethylstibestrol) *(Minn. Stat. §62A.154)*
- Reconstructive Surgery (Minn. Stat. §62A.25)
- Scalp Hair Prostheses for Alopecia Areata *(Minn. Stat. §62A.28)*
- Dietary Treatment of Phenylketonuria *(Minn. Stat. §62A.26)*
- Chemical Dependency (voluntary for nongroup) *(Minn. Stat. §62A.149)*
- Treatment of Cleft Lip/Cleft Palate (Minn. Stat. §62A.042)
- Cancer Screening (including Mammogram and Pap Smear) *(Minn. Stat. §62A.30)*

Group Only Mandates

- Services for Ventilator Dependent Persons *(Minn. Stat. §62A.155)*
- Outpatient Mental Health *(Minn. Stat. §62A.152/62D.103)*
- Maternity Benefits *(Minn. Stat. §62A.04)*
- Residential Facility Care for Emotionally Disturbed Children *(Minn. Stat. §62A.157)*

HMO Only Mandates

- Comprehensive Care *(Minn. Stat. §62D.02)*
- In-Patient Mental Health *(Minn. Rules 4685.07, Subp. 3)*

Provider Mandates

- Outpatient Surgical Centers *(Minn. Stat. §62A.153)*
- Government Institutions *(Minn. Stat. §62A.044)*
- Dentists *(Minn. Stat. §62A.043)*
- Registered Nurses *(Minn. Stat. §62A.15)*
- Podiatrists *(Minn. Stat. §62A.15)*
- Chiropractors *(Minn. Stat. §62A.15)*
- Optometrists *(Minn. Stat. §62A.15)*
- Nurse Practitioner or Clinical Specialist in Mental-Health Nursing *(Minn. Stat. §62A.15)*

have the additional choice of an individually tailored self-insurance product. Through self-insurance, larger employers are able to design minimum coverage and thereby obtain what is unavailable to smaller employers and individuals purchasing insured health plans.

Current public policy with respect to health insurance access encourages the majority of Americans to rely on their employer for health coverage. Until Congress addresses this issue on a nationwide basis, states must continue to attempt to craft creative solutions to the health insurance access problem.

The Commission fully supports increased access to health insurance. Resolution of the access problem will likely require a multi-faceted approach on both the state and federal level. The creation of a benefit plan which is more affordable than current mandated products may be part of the solution since it may enable more Minnesotans to purchase insurance which provides basic health coverage. For many Minnesotans, basic health coverage may be preferable to no coverage at all.

Figure 2.6

QUALIFIED PLAN REQUIREMENTS
Minnesota Statutes §62E.06

- Hospital services
- Professional services rendered or directed by a physician
- Diagnostic x-rays and lab tests
- Nursing home care (120 days/yr)
- Services of a home health agency
- Ambulance service
- Radium and other radioactive materials
- Oxygen
- Anesthetics
- Non-dental prostheses
- Durable medical equipment
- Oral surgery
- Services of a physical therapist
- Services of an occupational therapist
- Prescription drugs

2. A Mandate Evaluation Process

The enactment of new and expanded mandated benefits is often a highly political process. Provider groups effectively lobby their respective positions. Specific mandates have often been enacted following emotional testimony which highlights problems which a relatively small number of individuals have faced when attempting to obtain insurance reimbursement for particular services. Although a new mandate may be needed, legislators often lack accurate and complete information concerning the scope of the coverage problem, the interest of the general public in mandating a new service in exchange for higher premiums and the effect of the mandate on the total cost of health services.

At least seven other states have recognized the impact of mandates on health care access and costs. Although specific mandates may address the coverage concerns of certain individuals, mandates may also exacerbate our serious health insurance access problem. As a result, these states have recognized the value of a thorough assessment of the social and financial impact of proposed mandates prior to enactment.

The states which currently require an impact analysis of all proposed mandates include Arizona, Florida, Hawaii, Oregon, Pennsylvania, Wisconsin and Washington. The evaluations are intended to provide legislators with the information necessary to make an informed decision concerning the effect of mandating a specific health benefit. States vary in the manner in which the assessment is performed. Washington requires the proponent of the mandate to provide the analysis; assistance is provided by the state health coordinating council. Pennsylvania requires that the state health cost containment agency contract with three experts to provide an interdisciplinary evaluation. Hawaii has placed the evaluation function in the Office of the Legislative Auditor.

States requiring an impact analysis generally require that each analysis attempt to evaluate the social and financial impact of proposed mandates. Numerous factors are considered including the extent to which coverage is available, the impact of insurance on access to care, the level of public demand for the treatment and insurance

coverage for the treatment, the potential impact of the mandate on premium rates, overall health care costs and rates of utilization and the availability of less expensive treatment alternatives. States generally conduct a broad interdisciplinary analysis of the mandate and provide for public participation in the evaluation process. The analysis is conveyed to the legislature and is strictly advisory. The costs associated with the analysis are funded through general revenues.

Commission Recommendation

Mandate Evaluation Process

The experience of other states which have enacted a mandate evaluation process has been positive. The evaluation process provides legislators with valuable information concerning the potential social and financial impact of a new mandate. Both opponents and proponents of mandates are required to present relevant evidence in support of their respective positions. The Commission recommends that the legislature:

Establish a mandate evaluation process to formally evaluate the social and financial impact of proposed health benefit mandates.

The social and financial impact of proposed mandated benefit laws should be evaluated using the following guidelines and criteria to the extent that information is available:

The Social Impact

1. *The extent to which the treatment or service is utilized by a significant portion of the population;*

2. *The extent to which health plan coverage is currently generally available;*

3. *If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care;*

4. *If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship;*

5. *The level of public demand for the treatment or service;*

6. *The level of public demand for health plan coverage of the treatment or service;*

7. *The level of interest of collective bargaining organizations in negotiating privately for inclusion of the coverage in group contracts;*

The Financial Impact

8. *The extent to which health plan coverage would increase or decrease the cost of the treatment or service;*

9. *The extent to which health plan coverage would increase the use of the treatment or service;*

10. *The extent to which the mandated treatment or service will be a substitute or alternative for more expensive treatment;*

11. *The extent to which health plan coverage can reasonably be expected to increase or decrease premiums and administrative expenses of health plan companies; and*

12. *The impact of the proposed mandate on the total cost of health care.*

Evaluation Process and Source of Funding

Any current mandate, proposed mandate or amendment to current mandates shall be referred to the mandate evaluation process by the appropriate legislative policy committee.

All interested persons shall submit information relating to the social and financial impact of the proposed mandate. The mandate evaluation process (MEP) shall be coordinated by the Minnesota Department of Health (MDH), in consultation with appropriate state agencies. The MDH shall contract with appropriate experts to prepare a report assessing the social and financial impact

of proposed mandates, arrange for public comment on the proposal and submit a recommendation to the appropriate legislative policy committee.

Each biennium the legislature should appropriate from general revenues baseline funding sufficient to evaluate proposed mandates. Proposed mandates shall be accompanied by a fiscal note and the costs associated with a mandate evaluation charged against the baseline appropriation.

Moratorium

All mandates proposed during the 1989 legislative session should be referred to a mandate evaluation process.

Mandated benefit laws may improve access to health care; mandates may also increase costs and thereby reduce access to health insurance. Minnesota's history of enacting new mandates in a piecemeal fashion without a formal evaluation has resulted in an uncoordinated approach to mandated benefits. Other states with similar histories have enacted mandate evaluation procedures and report that the process is beneficial in understanding the need for a new mandate and the likely effect of enactment on access to health care.

In a related area the legislature has previously recognized the importance of a careful and studied approach to new regulation. The credentialing of human services occupations raises similar issues of equity, public interest and the relationship of new state regulation to the cost of health care.[5] The legislature currently relies on the MDH and the human services occupations advisory council to evaluate the necessity and effect of new professional credentialing. This process has allowed for a thoughtful and studied approach to credentialing and has resulted in a more integrated response to a complex issue.

The guidelines suggested by the Commission for use in the evaluation process are adopted from the factors currently used by other states. Other states report that these guidelines are helpful in focusing the analysis and recommendation. Other states rely heavily on outside experts in providing necessary data and analysis. The Commission recommends that Minnesota also consult with outside experts in an effort to obtain a thorough and interdisciplinary analysis.

The Commission recommends that all proposed mandates be referred to the MDH for evaluation. The process recommended by the Commission is strictly advisory. The legislature will review the final analysis and will be free to accept or reject the recommendation. As in other states, the Commission recommends that general revenues be used to fund the MEP process. All Minnesotans will benefit from a thorough review of new proposed mandates since all Minnesotans have a vested interest in adequate *and* affordable health care. Neither the proponent nor the opponent should be forced to bear the costs associated with studying a proposed mandate to determine if it is truly in the public interest to require its inclusion in all benefit contracts.

3. Recodification of All Mandated Benefit Laws.

Minnesota's mandated benefits are currently codified in four separate chapters of Minnesota statutes. Although the initial scheme may have been to codify mandated benefit laws in the health plan company's enabling legislation, mandates currently appear in a variety of chapters. This lack of structure makes it difficult to comprehend Minnesota's mandated benefit laws.

Commission Recommendation

Recodification

The Commission recommends that the Minnesota legislature:

Recodify all mandated benefit laws into a single chapter of Minnesota statutes.

[5]Minn. Stat. §214.13–.141 (1988).

B. The Small Employer Plan

Overview

Many Minnesotans are employed by employers with fewer than fifty employees. Many of these employees do not have employment-based health insurance. During 1988 the Legislative Auditor conducted a random survey of Minnesota employers in order to determine the extent of employment-based health insurance.[6] This survey revealed that although 100 percent of employers of 500 or more employees offer health insurance, only 60 percent of small employers (less than fifty employees) offer at least one group plan. The Legislative Auditor estimated that 29 percent of Minnesota workers are not enrolled in a health plan related to their employment.

National surveys have demonstrated that health insurance premiums are higher in small firms.[7] The cost associated with insurance is a critical factor when deciding whether group insurance will be made available to employees. The current level of mandates and the inability of health plan companies to design a benefit package which is affordable to small employers contributes to the health insurance access problem. Small employers who may wish to offer insurance to their employees have limited options. Large employers have additional options since self-insurance provides the necessary flexibility to design a benefit plan appropriate to the needs of employees and employers.

Access to health insurance may be improved if health plan companies are permitted to sell and small employers are permitted to purchase a benefit plan with less comprehensive benefits and coverage. The availability of this product may encourage small employers to offer health insurance to their employees.

[6] *Health Plan Regulation,* Office of the Legislative Auditor (1988).

[7] *Increases in Health Insurance Coverage Among Small Firms, 1986-1988,* National Association of the Self-Employed (Lewin/ICF, 1988).

Commission Recommendation

Small Employer Plan

The Commission elected to focus on the needs of small employers. The majority of large employers offer health insurance through the vehicle of self-insurance and are free to design their benefit plans to suit their specific needs. Since mandated benefit laws appear to disproportionately impact small employers, the Commission recommends:

A small employer health plan should be enacted as a five year pilot program and made available to employers with less than fifty employees who have not offered group health insurance to their employees in the previous calendar year.

A small employer data project should be established to study the needs of small employers, the marketplace reaction to a small employer health plan and the effect of the small employer plan mandates on increased access to group health insurance.

The Commission worked with several actuaries to develop a benefit plan designed to be attractive to small employers and their employees. High-deductible catastrophic policies are currently available. The Commission therefore sought to design a policy with low deductibles in order to facilitate access to well-child and primary care.

The Commission examined fourteen separate benefit plan designs. The Commission sought to design a benefit plan with a "target" premium for individuals in the $50–$60 range; the goal for a family premium (average family size 2.95) was $150–$170. The Commission ultimately selected a benefit plan with deductible limits of $250 for individuals and $500 for families. Co-insurance levels are set at 80/20; a lifetime maximum of $25,000 is also imposed. Under the Commission's MCHA proposals, individuals who exceed the lifetime maximum of their contract will be automatically enrolled in MCHA (*see Minnesota Comprehensive Health Association,* Chapter

VII). As a result, although the lifetime coverage limits must be low in order to achieve "target" premium rates, individuals who exhaust their lifetime maximums will continue to have access to health insurance under the Commission's proposals.

The "small employer plan" attempts to strike a balance between primary care and more intensive care. The Commission's small employer plan includes well-child care and maternity benefits. Hospital benefits are not limited to a set number of days, although a lifetime maximum of $25,000 is established. A description of the benefits, deductibles, copayments and premiums of the small employer plan is set forth in Figure 2.7.

The design of any benefit plan is ultimately a compromise. The Commission's attempted development of a core plan highlights the difficulty of designing a "perfect" plan which satisfactorily meets the coverage and affordability needs of all people. The Commission's primary goal is to increase health care access through employment and the private insurance market. The availability of a less comprehensive plan may encourage small employers to offer insurance to their employees.

The insurance needs of small employers will vary over time. The Commission therefore recommends that the small employer mandates be enacted as a five-year pilot program. Over a five-year period, the legislature will be able to determine if this approach is attractive to small employers and encourages employers to offer insurance. In order to accurately determine the effect of the small employer plan, the Commission recommends that the legislature establish a small employer data project. This project will gather information on the needs of small employers, their receptiveness to a special benefit plan and the effect of the plan on increased access to health insurance. If the plan proves successful, the legislature may wish to continue the small employer mandates for an additional time period or recommend an alternative approach to increasing employment-based insurance.

C. HMO Product Definition

Overview

Since enactment of the Minnesota HMO Act of 1973, HMOs have been limited to the offering of a single type of product—an HMO product. HMO products must provide for comprehensive health maintenance services, including emergency care, inpatient and physician care, outpatient services and preventive health services.[8] HMOs may not currently offer products with deductibles and must limit copayments to 25 percent. Copayments may not be imposed on preventive and well-child services. Unlike other health plan companies, HMOs may not impose lifetime maximums. As a result, HMOs face unlimited liability.

The Commission concluded that consumers will ultimately benefit from the introduction of new products into the marketplace. Health plan companies will also benefit from increased flexibility to design products desired by employers and individuals. As a result, the Commission recommends that all health plan companies be permitted to offer a variety of different health plan products (*see Product Diversification,* Chapter IV (A)). This increased flexibility is premised on the application of an equal level and type of regulation to products with similar characteristics (*see Quality of Health Care,* Chapter III (A)).

The Commission's recommendation that all health plan companies be permitted to offer all products requires that the Commission reaffirm the characteristics and attributes of products which will carry an "HMO" label in the future. If insurance companies and HSPCs are permitted to offer an HMO product as a line of business, it is important that the historical meaning of the HMO label be preserved. HMO products have been in existence in Minnesota for over twenty years. Over the years the term "HMO" has become synonymous with first dollar coverage, comprehensive care and the receipt of medical services through providers under contract to the HMO. Many consumers expect these characteristics to be part of any health plan referred to in the marketplace as an "HMO plan."

[8]Minn. Stat. §62D.02 (1988).

Figure 2.7

Small Employer Plan

	Single	Family
Premium Cost:	$60.00	$159.00
Deductible:	$250.00	$750.00
Coinsurance:	80/20	80/20
Out-of-Pocket:	$3,000.00	$6,000.00
Lifetime limit:	$25,000.00	$25,000.00

Covered Expenses

- Average semi-private room and board
- Intensive care up to three times average semi-private rate
- Other hospital charges inpatient and outpatient
- Usual and customary surgical and physical charges
- Diagnostic x-ray and laboratory
- Private duty nurse when medically necessary
- Ambulance services
- Medical equipment (e.g., casts and crutches)
- Home health agency under written plan by physician
- Well child care 100% coverage (i.e., no deductible/copay)
- Maternity @ $1,500 maximum per case

Exclusions	Limitations
• Prescription drugs	• Hospital preadmission certification
• Mental health	• Mandatory second opinion
• Chemical dependency treatment	• Restricted weekend admissions
• Extended care facilities	• 1 yr. preexisting condition exclusion

Commission Recommendation

HMO Product Definition

The health insurance marketplace is in a state of rapid transition and evolution. New products are being demanded by consumers and developed by health plan companies. Health plan companies must be free to develop these products and respond to marketplace demands. The term "HMO" has a distinct meaning in the marketplace. In order to facilitate the development of new products while preserving the distinction between HMO products and other managed care plans, the Commission recommends:

Any health plan product marketed and/or sold as an "HMO product" must meet the following requirements:

1. *HMO labeled products may charge a copayment no greater than 25 percent on all services except that no copayment may be charged on prenatal care, well-child care and other specific health screening measures defined by the MDH;*

2. *HMO products must provide service benefits as defined in Minnesota statutes, including the provision of "comprehensive health services;"*

3. *HMO products must provide first dollar coverage without a deductible;*

4. *HMO products must be provided through a "delivery system" including a provider network, with a service area geographically certified by the MDH;*

5. *HMO products should be allowed to share insurance risk in provider contracts between the provider and the entity offering the HMO products; provider contracts for the purpose of providing HMO products must contain "hold harmless" language;*

6. *Any non-HMO entity offering an HMO product should have consumer representation of 40 percent on its governing board of directors or an advisory board with 40 percent consumer representation.*

The criteria adopted by the Commission as essential elements of an HMO product reflect current HMO product requirements. Current law forbids HMO use of deductibles, limits copayments and requires the provision of comprehensive health services through a provider network certified as adequate to meet the needs of the HMO enrollees. HMOs are permitted to share risk with providers and providers are forbidden from seeking payment from enrollees in the event that the HMO does not provide payment for a covered service. The continuation of these characteristics in products labeled "HMO" reaffirms the regulatory status quo.

The consumer board requirement also reflects the current requirement that consumers constitute 40 percent of the governing board of an HMO. The Commission recommends that insurers be permitted to offer an HMO plan as a line of business (*see Product Diversification,* Chapter IV (A)). In order to preserve the consumer orientation of HMO products, the Commission recommends that all entities offering HMO products be required to incorporate consumer representation in some form. HMOs offering an HMO product must continue to retain 40 percent consumer representation (*see Consumer representation on Health Plan Company Board of Directors,* Chapter IV (D)). Non-HMO entities such as insurers and HSPCs who wish to offer an HMO product as a line of business must either structure their governing board to include 40 percent consumers or establish an advisory committee to the governing board to be composed of at least 40 percent consumers. Since many multi-state insurers cannot restructure their governing boards to accommodate the 40 percent consumer requirement, the Commission recommends that non-HMO entities establish an advisory committee to the board of directors. This advisory committee will provide a direct link to the consumer and an avenue for incorporating the consumer's perspective in the development and management of HMO products.

D. Lifetime Maximum Mandates

Overview

Under present law, insurers and HSPCs are permitted to impose a lifetime dollar limit on benefits ("lifetime maximum"). The 1988 legislature raised the minimum lifetime maximum for insurers and HSPCs from $250,000 to $500,000. State law does not allow HMOs to include lifetime maximums in HMO benefit contracts. HMOs must manage unlimited liability.

The requirement that HMOs provide "comprehensive" health care with unlimited liability historically relates to the integration of payment and delivery mechanisms in HMOs. Since HMOs were established to manage and deliver health care, as opposed to the pure financing of medical care, lifetime maximums were viewed as unnecessary.

The lack of lifetime maximums did not create serious problems for HMOs during the early years of the industry's development. However, in recent years medical technology has rapidly advanced. New technology enables seriously ill individuals to survive for longer periods of time. Although continual improvements in medical technology and survival rates must be encouraged, these advances place significant financial burdens on all health plan companies.

Unlimited liability places HMOs at a competitive disadvantage. HMOs are required to cover health care costs which far exceed the legal liability of their competitors. HMOs must purchase reinsurance for this unlimited liability. The premiums associated with unlimited liability exceed the reinsurance requirements of insurers and HSPCs. As a result, HMOs must absorb additional costs associated with unlimited liability which are not required of their competitors.

HMOs also contend that the lack of lifetime maximums produces adverse selection. This adverse selection is compounded by current health plan regulation which requires only HMOs to participate in an annual open enrollment process and severely limits the underwriting of group contracts.

Commission Recommendation

Lifetime Maximum Mandates

Unlimited liability in an age of rapidly advancing medical technology places serious financial pressure on health plan companies. The financial health of health plan companies is critical to maintaining and improving Minnesotans' access to health insurance. It is equally important that seriously ill consumers have uninterrupted access to health insurance. The Commission recommends:

All health plan companies and/or health plan products should be allowed to establish some form of limitation on contract liability, especially in very high cost, long-term cases, often characterized as "technology dependent." In cases where upper limits on contract liability are exceeded, a health plan safety net must be provided. Construction of a safety net should keep in mind the socially desirable goals of providing patients with continuity of care and controlling costs through managed care products;

Health plan products bearing an HMO label should continue to have unlimited contract liability except that HMO products should be allowed to establish a $500,000 condition-specific contract liability limitation. It is suggested that acceptable "conditions" be predetermined by the MDH. It is anticipated that such conditions will be characterized as technology dependent. Assuming that MCHA is revised to reflect a more equitable funding base, enrollee contracts exceeding the $500,000 liability limit should be transferred to MCHA. Where possible, managed care systems should be allowed to participate in MCHA so that continuity of care is provided.

The Commission recommends that state law continue to permit limitations on total financial liability of insurers and HSPCs. Such limits are essential to maintaining the financial well-being of these entities. In order to provide continuity of care in the event that an individual exceeds these limits, the Commission recommends that

these individuals be permitted to enroll immediately in an MCHA contract (*see The Minnesota Comprehensive Health Association,* Chapter VII).

In accordance with the Commission's recommendations with respect to HMO Product Definition (*see HMO Product Definition,* Chapter II (C)), the Commission recommends that in the majority of cases, HMO products continue to have unlimited contract liability. Unlimited contract liability is inherent in the concept of "comprehensive" health care—a requirement of HMO products reaffirmed by the Commission. However, in certain very limited cases the Commission recommends that HMO products be permitted to impose a $500,000 maximum on a per condition basis. The Commission recommends that the MDH establish a list of conditions to which the $500,000 limit may be applied. It is anticipated that the majority of these conditions will involve technology dependent individuals.

The existence of a "safety net" to provide coverage for technology dependent individuals who exhaust the lifetime maximum of an HMO product is essential to implementation of this recommendation. The Commission views MCHA as an appropriate safety net. The use of MCHA as a safety net is contingent on the expansion of MCHA's funding base (*see The Minnesota Comprehensive Health Association,* Chapter VII).

The impact of this recommendation is closely related to the Commission's recommendations with respect to Product Diversification (*see Product Diversification,* Chapter IV (A)). The Commission recommends that all health plan companies be permitted to offer all products as a line of business. HMOs should be permitted to offer non-HMO products which satisfy qualified plan standards, provided that these products do not carry an "HMO" label. Qualified plan standards provide for limitations on contract liability. The net result of these recommendations is that HMOs will be permitted to offer non-HMO products which provide for limited liability. However, if an HMO or other health plan company offers an HMO labeled product, the HMO product must provide for unlimited liability.

The ability of HMOs to offer non-HMO products with limited liability should reduce the competitive inequity resulting from the current requirement of unlimited liability. HMOs will be permitted to offer benefit plans with limited liability, provided that these plans are not referred to as "HMO" plans. Consumers wishing to purchase coverage with unlimited liability will continue to purchase HMO labeled products.

E. Continuation and Conversion Mandates

Overview

The majority of Americans receive health insurance through employment or family membership. Changes in employment status or family membership may consequently result in a loss of health insurance coverage. As a result, the majority of states, including Minnesota, have enacted statutes requiring continued access to health insurance following a change in an employment or family relationship.

Two types of statutes extend health insurance after the alteration of such relationships. "Continuation" laws provide for the continuation of health insurance under a former employer's or spouse's health plan, following the occurrence of certain statutorily prescribed events ("continuation coverage"). "Conversion" statutes provide that after continuation coverage is exhausted, enrollees may convert to an individual policy without health screening or proof of insurability ("conversion coverage"). The Minnesota legislature has also enacted special conversion statutes applicable to HMO enrollees who leave the HMO's service area ("out-of-area conversion") and "replacement coverage" requirements for health plan companies who discontinue specific "product lines" ("replacement coverage"). ERISA prohibits the application of state continuation and conversion statutes to self-insured benefit plans.

Until 1986 continuation and conversion requirements were solely state law requirements. In 1986, federal continuation coverage requirements were enacted as part of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA).[9] These

[9]Pub. L. No. 99-272, §10001, 100 Stat. 222 (1986).

requirements are directed at employers and extend to insured and self-insured health plans. The federal mandates are popularly known as "COBRA coverage." The extension of continuation coverage requirements to self-insured plans eliminated a prior competitive inequity between insured and self-insured plans.

State continuation and conversion requirements are directed at health plan companies[10]. After 1986, many state statutes were amended in an effort to comply with COBRA. Minnesota law exceeds COBRA's requirements in certain circumstances. Different types of health plan companies are also subject to different continuation and conversion requirements.

The areas where Minnesota law currently exceeds COBRA's requirements include continuation coverage for handicapped dependents,[11] disabled workers,[12] surviving spouses,[13] divorced or separated spouses[14] and layoff and termination.[15] Situations which currently invoke differing continuation rights depending on the type of health plan company the insured has selected include the insured becoming eligible for Medicare[16] and loss of coverage due to a break in a marital relationship.[17]

Minnesota law also differs from COBRA in its conversion coverage requirements. Under Minnesota law, conversion coverage is available upon the exhaustion of any type of continuation coverage.[18] In contrast, COBRA does not require employers to offer conversion coverage. Federal law merely requires that if conversion coverage is available to non-continuation enrollees, such coverage must also be extended to insureds receiving continuation coverage.

Although COBRA coverage extends to all employers, including self-insured employers, certain employer groups are exempt from its re-

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[11]Under Minnesota law, a dependent who is incapable of self-sustaining employment and chiefly dependent on the policyholder for support may receive continuation under a group or individual policy for the duration of the handicap. Minn. Stat. §62A.14; 62A.141; 62C.14, subd.5 (1988). Under COBRA, loss of dependency status is a "qualifying event." Coverage is limited to 36 months and applies only to group contracts.

[12]Under Minnesota law, a worker who is "totally disabled" is eligible for continuation coverage for the duration of the disability. Minn. Stat. 62A.147–.148 (1988). Under COBRA, a worker who is terminated for any reason, including total disability, is eligible for continuation coverage for 18 months.

[13]Under Minnesota law, a surviving spouse is eligible for continuation coverage after the death of an insured spouse until the surviving spouse becomes covered under another group health plan. Minn. Stat. §62A.146 (1988). Coverage is available under group and individual policies. Under COBRA, coverage is limited to 36 months following the death of an employee and applies to group enrollees only.

[14]Under Minnesota law, a "break in a marital relationship" creates a statutory right to continuation coverage in both individual and group contracts. This coverage extends until the spouse becomes covered under another group contract, although the divorced or separated spouse's eligibility for Medicare will terinate coverage in an HMO plan. Under COBRA, continuation coverage requires a divorce or legal separation, applies only to group contracts and is limited to 36 months.

[15]Under Minnesota law, a laid off or terminated worker is eligible for 18 months of continuation coverage. Coverage will be terminated prior to 18 months if the former employee becomes covered under another gropu contract. Minn. Stat. §62A.17 (1988). Under COBRA, coverage will continue for 18 months but may terminate upon the occurrence of a number of "terminating events" including coverage under another group health plan, the insured becoming eligible for Medicare and the employee ceasing to pay premiums.

[16]Under COBRA, when an insured becomes eligible for Medicare, the spouse and dependent children are permitted to elect continuation coverage for 36 months. In COBRA's terminology, Medicare eligibility is a "qualifying event." If the spouse who has elected COBRA coverage becomes Medicare eligible, this eligibility will also be a "terminating event." Continuation statutes applicable to HMOs have been amended to conform with COBRA and include Medicare eligibility as a terminating event. Statutes applicable to insurers and HSPCs have not been similarly amended.

[17]A "break in marital relationship" is a terminating event for all health plan companies. However, only HSPCs and insurers require a decree of dissolution. Minn. Stat. §62A.21; 62C.142 (1988). Remarriage will be a terminating event only if the individual is an HSPC subscriber. Medicare eligibility will be a terminating event only if the individual is an HMO enrollee.

[18]Minn. Stat. §62E.16; 62A.17; 62A.21; 62D.104 (1988).

quirements. Exempt employers include the United States government, the District of Columbia, church plans and small employers (defined as normally employing fewer than twenty employees during the preceding calendar year). Minnesota law does not contain similar exemptions from state continuation and conversion requirements.

The differences between Minnesota law and COBRA create some competitive inequities between insured and self-insured plans. Since Minnesota law exceeds COBRA's requirements, insured plans are required to continue health insurance for periods of time which exceed the continuation obligations of self-insured plans. The continuation and conversion requirement differences between health plan companies also contribute to an "unlevel playing field" for health plan companies and consumers.

Commission Recommendation

Continuation and Conversion Mandates

The Commission reviewed the differences between COBRA requirements and the requirements of Minnesota law, the differing continuation and conversion requirements for the different health plan companies and the relationship of these requirements to the Minnesota Comprehensive Health Association. The Commission recommends:

1. *All state access requirements for group contracts shall include all COBRA benefits and include all additional state continuation requirements for group coverage.*

2. *All health plan differences should be eliminated by extending the more comprehensive requirements in each instance to all health plans offering coverage in Minnesota. Any health plan that offers comparable Medicare policies without requiring evidence of insurability may use Medicare eligibility as a terminating event.*

3. *Continuation mandates for individual contracts should be retained.*

4. *Maintaining the status quo regarding replacement coverage.*

5. *All access mandates should be recodified in a single chapter of Minnesota statutes.*

Minnesota has a long tradition of extending generous continuation coverage to certain categories of "vulnerable" insureds such as handicapped dependents, disabled workers, surviving spouses and divorced or separated spouses. Although health plan companies incur additional expenses as a result of these benefits, evidence is lacking that these requirements place significant financial strain on health plan companies. As a result, the Commission recommends that the differences between COBRA and Minnesota law be retained, when such differences result in more generous continuation coverage.

Continuation requirements vary for the different categories of health plan companies. These differences appear to be largely a product of the separate statutory schemes governing the different companies. The Commission recommends that the language of these statutory schemes be analyzed. Where language differences produce different continuation requirements, the more generous benefit requirements should be extended to the other health plan companies. In the case of Medicare eligibility as a "terminating event," health plan companies should be permitted to terminate continuation coverage when the covered person becomes eligible for Medicare, provided that the health plan company offers the covered person a Medicare supplement policy without proof of insurability. In order to prevent similar health plan company differences from arising in the future, the Commission recommends that all continuation and conversion statutes be recodified in a single chapter of Minnesota statutes.

COBRA does not extend to individual contracts. Minnesota continuation requirements apply to individual contracts in the case of handicapped dependents, a surviving spouse, the eligibility of the insured for Medicare, and a divorce

or legal separation. The continuation of coverage under an individual contract means that the insureds are not required to undergo health screening or submit to underwriting in order to continue coverage. Although this practice may result in certain individuals receiving health plan benefits at premium costs which do not accurately reflect their actuarial risk, evidence is lacking that these requirements place an undue financial burden on Minnesota health plan companies.

III

HEALTH CARE DELIVERY

A. Quality of Health Care

Overview

Maintaining quality health care is a significant issue for Minnesota's health care system. Over the next several years, competition in the Minnesota marketplace may partially shift from cost and access to quality. Consumers, employers, health plan companies, providers and regulators are all attempting to define and measure quality medical care.

Employers are making initial inquiries about quality. Some employers are planning to use collective data to make quality-based comparisons of providers and health plans. Public and private sources have proposed methods to encourage the development of new data and its distribution to purchasers in a useful format. Since 1986 HCFA has annually released hospital specific mortality data in an effort to provide better information to consumers concerning health outcomes.[1] Paul Ellwood, Chairman of Interstudy, Inc. recently proposed the introduction of "outcomes management"—a systematic measurement of patient functioning and well-being using pooled clinical and outcome data.[2] Licensing and accreditation bodies are placing increased emphasis on development of quality assurance programs and useful data evaluation systems.[3]

This pursuit of quality is unequally reflected in the regulation of Minnesota health plan companies. Under current state and federal law, only HMOs are subject to quality assurance regulation. Although HSPCs and insurers are subject to trade practice regulation aimed at traditional insurance activities such as claims processing and reimbursement, HSPCs and insurers are not subject to specific quality assurance requirements aimed at measuring or maintaining the quality of medical care provided to consumers. This lack of quality assurance regulation is the result of the historically different statutory roles and obligations of insurers, HSPCs and HMOs with respect to the management of medical care.

Two traditional features of HMO operations—provider risk sharing and enrollee restrictions regarding choice of provider—are considered the original basis for imposing quality assurance requirements on HMOs. HMO providers normally assume some degree of financial risk when providing services to HMO enrollees. This risk assumption may create financial incentives to underserve HMO enrollees. Quality assurance regulation is theoretically designed to counter the potential for underservice inherent in provider risk sharing.

[1] *See e.g.*, R. Dubois et al., *Adjusted Hospital Death Rates: A Potential Screen for Quality Medical Care*, American J. Pub. Health (Sept. 1987).

[2] Ellwood, P., *Shattuck Lecture—Outcomes Management: A Technology of Patient Experience.* 318 N. Engl. J. Med. 1549 (1988).

[3] *See e.g.*, The Joint Commission Guide to Quality Assurance (1988).

Enrollee restrictions regarding choice of provider provide a second theoretical basis for imposing quality assurance requirements on HMOs. The initial concept of an HMO product contemplated that all health care, with the exception of emergency care, would be delivered by providers under contract to the HMO. Although the development of "wrap-around" or combination plans has partially alleviated the access restrictions inherent in the original "closed panel" concept, financial and benefit incentives included in "wrap-around" plans continue to encourage enrollees to obtain health care from HMO providers. As discussed in Chapter VI, *Preferred Provider Organizations*, these incentives are not dissimilar to the benefit and cost differentials currently included in many PPO plans.

Federally qualified HMOs and competitive medical plans (CMPs) are subject to federal quality assurance regulation. The federal HMO Act requires a federally qualified HMO or CMP to establish a quality assurance program which stresses health outcomes.[4] Quality assurance reports must be filed with the Secretary of the Department of Health and Human Services (DHHS).[5]

Special quality assurance regulations apply to HMOs and CMPs serving Medicare and Medicaid enrollees. Federally qualified HMOs who enter into risk contracts with HCFA to provide health care services to Medicare-eligible persons are subject to quality of care review by the applicable Peer Review Organization (PRO).[6] HMOs that provide services to Medicaid-eligible individuals are subject to similar review through the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

Minnesota state law also requires HMOs to operate a quality assurance program.[7] Minnesota rules define an acceptable quality assurance system to include establishment of an internal peer review system, a defined set of quality assurance standards and procedures for selecting providers.[8] The MDH has recently circulated proposed revisions to its current quality assurance rules. The proposed rules expand the quality assurance obligations of HMOs and set forth a more detailed and extensive mandate for quality assurance programs, including the performance of ongoing and focused quality of care evaluations.

In contrast to the state and federal quality assurance regulation of HMOs, insurers and HSPCs are not subject to federal or state quality assurance regulation. The lack of quality assurance regulation is reflective of the dissimilar statutory obligations of insurers and HSPCs. In contrast to HMOs, neither insurers nor HSPCs are legally required to provide or deliver medical care; the legal responsibilities of both entities are limited to the financing or payment of medical care.

The lack of quality assurance regulation also reflects the historical absence of provider risk sharing and access restrictions. Neither insurers nor HSPCs have traditionally engaged in provider risk sharing. An insured person in a traditional fee-for-service system is not required to obtain care from specific providers. Similarly, HSPC subscribers may obtain care from participating and nonparticipating providers.

Notwithstanding these traditional distinctions, insurers are increasingly contracting with providers to offer PPO plans and encouraging insureds to seek services from preferred providers through the use of benefit differentials and other incentives. Both insurers and HSPCs operate utilization review programs. It is anticipated that both insurers and HSPCs may wish to engage in limited forms of provider risk sharing. To the extent that these health plan companies offer health plan products which incorporate managed care techniques, the development of product-related quality assurance programs is consistent with the Commission's goals of regulatory parity and increased consumer protection.

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[4]42 U.S.C. §300e(c)(7) (1986). As of June 1988, four of Minnesota's thirteen state licensed HMOs were federally qualified; three state licensed HMOs were qualified as CMPs.

[5]42 U.S.C. § 300(e)(c)(9) (1986).

[6]42 U.S.C. §1320c-1 et seq. (1986).

[7]Minn. Stat. §62D.04 (1988). Minnesota's requirements are similar to the majority of other states. Of the 47 states which have enacted HMO enabling legislation, 38 states require HMO applicants to develop a quality assurance program. Office of Prepaid Health Plans, U.S. Department of Health and Human Services, *A Report to the Governor on State Regulation of Health Maintenance Organizations* (1987).

[8]Minn Rules 4685.1100; 4685.2100 (1987).

Commission Recommendation

Quality Assurance Programs

The attributes of HSPC plans, PPO plans and traditional indemnity plans, although increasingly similar, continue to be distinct in certain respects. The degree of "managed care" incorporated into these health plans varies from product to product. Similarly, the ability of health plan companies to develop and conduct quality assurance programs varies according to the different attributes of these products. The art and science of quality assurance is evolving, as is an understanding of the impact of such programs on patient outcomes. In light of the current evolution in both quality assurance expertise and health plan product development, the Commission recommends that:

The appropriate state agency shall institute varying quality assurance requirements for all health plan products depending upon the degree of provider risk sharing, access limitations and other plan features identified by the appropriate state agency;

Minnesota quality assurance requirements should avoid duplication with other requirements. To the extent feasible and appropriate, Minnesota quality assurance requirements should be result or outcome oriented in order to maximize their effectiveness and usefulness.

The Commission foresees the development of flexible quality assurance regulation in terms of a continuum of "managed care." As health plan products incorporate access limitations or provider incentives, the degree of such limitations and incentives should correspond to the degree and complexity of quality assurance regulation. For example, it is anticipated that a quality assurance program will be of limited usefulness in a traditional indemnity system where insureds may exercise unrestricted choice with respect to providers and the insurer has no contractual relationship with providers. In that instance, quality assurance may be quite rudimentary. In contrast, a PPO plan which limits provider access through the use of substantial benefit differentials and which contracts with preferred providers has increased capability to perform medical care evaluations.

A wide range of public and private organizations are currently involved in quality assurance. On the federal level, both the Office of Prepaid Health Care (OPHC) and HCFA require development of quality assurance programs. HMOs and CMPs which have entered into Medicare risk contracts are subject to the separate requirements of Peer Review Organizations. Private organizations which have developed quality assurance standards applicable to health plan companies include the National Association of HMO Regulators (NAHMOR), the Accreditation Association for Ambulatory Health Care (AAAHC) and the JCAHO. Compliance with each of these quality assurance programs may be confusing, contradictory and create unnecessary expense for health plan companies. State regulators are therefore encouraged to avoid unnecessary duplication and inconsistency in the development of quality assurance requirements.

The traditional measurements for quality assurance include structure, process and outcome.[9] Traditional quality assurance systems have focused predominantly on structure and process. Although multiple approaches to quality assurance must be employed, the Commission supports the current emphasis on patient outcomes. The Commission recognizes that application of outcome measurements to health plan company data is relatively new and that much work remains in choosing appropriate indicators of quality which adjust for patient risk factors. However, the Commission supports the view that outcomes, when assessed properly, are a highly useful measurement of the quality of health care. State regulation should gradually incorporate outcome measurements into quality assurance regulation, consistent with the state of the art in defining and measuring quality health care.

[9]Donabedian, Avedis, *The Definition of Quality and Approaches to Its Assessment* (1980).

B. Health Plan Companies and Consumers

1. Consumer Complaint Systems

Overview

Consumers are at the center of any health care system. Although the purchaser of a health plan may be an employer group, the actual consumers of health services are individuals and families. Consumers' concerns regarding health plan companies are understandably personalized and frequently focus on the extent of coverage for specific services, the availability of providers and the consumer's obligation to pay premiums, deductibles and copayments. Health plan companies are obligated for all covered services and are encouraged to control costs and reduce unnecessary health care expenditures. These statutory responsibilities inevitably produce disagreements between health plan companies and consumers. These disagreements necessitate the establishment of consumer complaint systems.

HMO consumer complaints are addressed pursuant to a legislatively mandated consumer complaint process.[10] Each HMO is required to establish and maintain a complaint system, including provisions for impartial arbitration, and "reasonable procedures for the resolution of written complaints initiated by enrollees concerning the provision of health care services."[11] The MDH receives and investigates HMO complaints pursuant to its statutory authority to "inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed."[12] Every HMO benefit contract contains a description of the consumer complaint process. Legislation passed in 1988 requires that HMO membership cards contain the HMO's complaint phone number and the MDH complaint number.[13]

HMOs are required to maintain records of consumer complaints for five years and annually report their complaint experience to the MDH.[14] The MDH is contemplating certain changes in the consumer complaint process in its proposed quality assurance regulations. These changes include use of an expedited dispute resolution process for urgently needed services, limitations on a consumer's share of arbitration costs and imposition of fines for violation of the consumer complaint requirements.

Neither HSPCs nor insurers are subject to special requirements for the handling of consumer complaints. It is industry practice for both insurers and HSPCs to maintain an internal consumer complaint system. The MDC receives and investigates consumer complaints regarding insurers and HSPCs as part of its general authority to regulate those companies.

The original rationale for including consumer complaint and arbitration requirements in state HMO regulation appears to have been the potential conflict inherent in the HMO's dual role as a provider and underwriter of health care. Since neither HSPCs nor insurers are statutorily required to provide medical care, the need for specific consumer complaint systems has been less apparent, particularly when HSPCs and insurers voluntarily maintain consumer complaint systems. However, as insurers and HSPCs continue to adopt "managed care" strategies, the need for a mandatory and uniform consumer complaint process is evident.

Commission Recommendation

Consumer Complaint Mechanisms

Although each health plan company has a unique statutory mission, the potential for consumer disagreement with a company's actions or decisions is present in all health plan companies. The Commission recommends that:

All health plan companies should be subject to consumer complaint and arbitration requirements.

[10]Minn. Stat. §62D.11 (1988).
[11]*Id;* Minn. Rules 4685.1700 (1987).
[12]Minn. Stat. §62D.14, subd. 3 (1988).
[13]1988 Minn. Laws, ch. 592.
[14]Minn. Rules 4685.1900–.2000 (1987).

The type and scope of consumer complaint requirements will differ by company type and product. An insurer offering a traditional indemnity product may have limited ability to resolve complaints concerning quality of care. Differences in company type and product will require flexibility in the regulatory design of a consumer complaint process applicable to HSPCs and insurers.

Notwithstanding a need for flexibility, consumers will be best protected through establishment of a basic complaint process. Basic requirements which may be universally applicable to all health plan products and companies include establishment of an internal consumer complaint mechanism which provides specific time frames in which the company must respond to consumer complaints, a private arbitration process utilizing American Arbitration Association guidelines and mandatory notice requirements informing consumers of the existence of a complaint process.

The existence of a mandatory consumer complaint system is consistent with the Commission's goal of increased consumer protection, while at the same time increasing consumer involvement in the "management" of health care. The Commission's desire to incorporate outcomes measurement into quality assurance regulation recognizes the important role which patients and consumers must play in the management of health care in the future. A properly administered consumer complaint system can serve to equitably resolve complaints and educate consumers concerning the costs and economic choices inherent in our health care system.

2. New and Emerging Technology

Overview

Significant disagreements between health plan companies and consumers occasionally center on health plan coverage of new and emerging technology. In these cases, the consumer requests coverage of a new, expensive and possibly unproven technology. The health plan company denies coverage on the ground that the technology is experimental. A dispute arises as to the experimental status of the new technology. Since it is not uncommon for these cases to involve life-threatening circumstances and extremely expensive treatment, experimental treatment cases often raise emotional issues which result in highly publicized pleas for coverage and government intervention. Although the line between medical research and therapeutic treatment is frequently quite thin, it is not the responsibility of health plan companies to fund medical research.

A determination as to the experimental status of new and emerging treatment requires an assessment as to the safety, efficacy and effectiveness of the technology. This is a complex, expensive and time-consuming process. Technology assessment requires accurate and complete information which is free of bias. The value of an assessment is directly proportional to the quality and quantity of available data.

Technology assessment is not an exact science. Well-trained experts from a variety of disciplines may arrive at different conclusions concerning the experimental status of a new technology. Technology assessment may include controlled clinical studies, consensus conferences, informal conferences with experts and surveys of available scientific and medical literature. Relevant factors include the existence of approval from the appropriate regulatory agency (e.g., FDA), the availability of scientific evidence permitting conclusions concerning the effect of the technology on health outcomes, evidence of improvement outside of investigational settings and the existence of equally beneficial treatment alternatives.

The majority of health plan companies engage in some form of technology assessment. Assessments may be performed internally or obtained from outside private and public sources. Public sources which many health plan companies routinely consult concerning the experimental status of new technology include the Food and Drug Administration (FDA), the Health Care Financing Administration (HCFA), the National Institutes of Health (NIH), the Office of Technology Assessment (OTA), the Office of Prepaid Health Care (OPHC) and the quasi-public Council on Health Care Technology (CHCT). The FDA reviews the safety and efficacy of new drugs and biologics. HCFA reviews and commissions technology assessments for the purpose of determining Medicare coverage. The NIH sponsor consensus conferences to evaluate new and emerging technologies.

Private sources of expertise and information include the Council of Medical Speciality Societies (CMSS) , the individual medical "colleges" such as the American College of Surgeons (ACS) and the American Medical Association (AMA). Trade associations such as the Health Insurance Association of America (HIAA), the Blue Cross and Blue Shield Association (BCBSA) and the Group Health Association of America (GHAA) also assist their members by providing scientific and clinical information concerning the safety and effectiveness of new technology.[15]

State government has traditionally played a limited role in technology assessment. The MDH and MDC have engaged in limited and informal technology assessment. In recent years both state agencies have evaluated the experimental status of proposed treatments when insureds have contacted the agencies regarding denial of coverage of new technology. The agencies review the health plan company's evaluation of the case, informally consult with experts and render an opinion concerning whether the company is required to cover the service under its contract and/or state law. This process is not formalized in either statute or administrative rules.

Commission Recommendation

Experimental Technology

In future years the costs associated with new and emerging technology will place increasing pressure on consumers, health plan companies and government. Recent studies indicate that new technology will account for 11.2 percent of the anticipated 21.5 percent increase in medical-benefit costs during 1989. Technology assessment is resource-intensive and requires considerable expertise. Numerous federal agencies and private enterprises devote extensive resources to technology assessment each year. State agencies should not attempt to duplicate the private and public resources currently available. The Commission recognizes that poor technology assessment may subject persons to inadequate, unproven and unsafe treatment. As a result, any centralized decision regarding the experimental status of new technology must be the result of an objective and legitimate process, supported by sound scientific evidence and subject to public scrutiny. Accordingly, the Commission recommends:

All health plan companies should develop an internal technology assessment process for the evaluation of the experimental status of new and emerging medical technology. This internal process may include consultation with federal, state and private agencies, establishment of internal advisory panels, consultation with appropriate outside experts and review of scientific literature.

The appropriate state agency should establish through statute or administrative rule an expedited review process for the review of medical technology in those cases where the company has concluded that a requested treatment or service is experimental with respect to a particular patient's condition and diagnosis and the state agency determines that a patient's condition is life-threatening. The state agency should consult with appropriate and identified experts, review scientific and medical literature and consider all relevant factors including:

- *whether final approval has been granted by the appropriate government agency;*
- *the availability of scientific evidence concerning the effect of the technology on health outcomes;*
- *the availability of scientific evidence that the technology is as beneficial as established alternatives;*
- *the availability of evidence of benefit or improvement outside of investigational settings.*

No health plan company should be required to cover drugs or biologics deemed experimental by the Food and Drug Administration or medical procedures determined to be experimental by HCFA for purposes of Medicare reimbursement.

The Commission recommends that all health plan companies establish specific procedures for the evaluation of new technology. In view of the

[15] *See generally Technology Assessment Directory*, Council on Health Care Technology (1988).

wide range of resources available to health plan companies, it is not necessary to mandate the specific process which health plan companies must follow. New technology should not be evaluated simply by consulting with the company's medical director. Other resources should also be utilized and an internal structure established for responding to consumer questions concerning the experimental status of a new technology.

Expedited state agency review of experimental status decisions should be limited to life-threatening conditions. The review process followed by the agency should be established in statute or rule. At a minimum state agencies should be required to consult with appropriate outside experts, review all relevant scientific and medical literature, consider the evidence concerning effect on health outcomes and evidence of improvement outside of investigational settings. The identity of experts and all documentary evidence relied on by the agency should be immediately available to health plan companies.

State agencies should refrain from requiring coverage of technology considered experimental by established federal agencies. The Food and Drug Administration regulates the use of drugs and biologics and conducts extensive assessments prior to approving a drug for distribution. The Health Care Financing Administration spends approximately $2,000,000 each year for technology assessment. HCFA assessments include review of background papers, literature searches, presentation to expert advisory panels and use of the Office of Health Technology Assessment. A determination by either the FDA or HCFA that a particular drug or procedure is unproven and experimental generally reflects a thorough evaluation of the technology. Private health plan companies should not be required to cover new technology which the federal government refuses to cover under publicly financed programs such as Medicare.

The issue of experimental technology is related to the Commission's recommendation concerning urgently needed services. In both cases, the Commission recommends that state agencies establish an internal procedure for the determination of these disputes. Experimental technology questions require resolution of the scientific status of a particular technology. In contrast, complaints regarding urgently needed services primarily address whether a proposed nonexperimental treatment is medically necessary with respect to a particular patient. Medical necessity questions assume the efficacy of the proposed treatment modality. As a result, medical necessity determinations do not require evaluation of the special factors used in experimental status analysis such as clinical results outside of investigational settings or evidence of safety and effectiveness.

3. Urgently Needed Services

Overview

The 1988 legislature requested that the Commission "make recommendations for expedited review mechanisms for complaints concerning health maintenance organization coverage of an immediately and urgently needed service."[16] Although this legislative mandate is specific to HMOs, the Commission's inquiry concerning urgently needed services applies to all health plan companies and products.

The Commission heard testimony from the MDH indicating that consumer requests for review of urgently needed services are rare. Under current HMO regulations, HMOs are not required to notify the MDH when a request for an urgently needed service is received from a consumer. As a result, the MDH generally learns of such a request if the consumer contacts the MDH for assistance in obtaining the necessary HMO authorization for the service. When the MDH receives notification of a dispute involving an urgently needed service, it is the Department's current custom and practice to review all available facts, discuss the dispute with the consumer and the HMO, consult with medical experts if necessary and subsequently notify both parties of the MDH's conclusions with respect to coverage of the service.

An internal health plan company review process for urgently needed services is not described in either statute or rule. In the MDH's proposed quality assurance rules, an immediate and urgently needed service is defined as a service, which if not received promptly, may result in serious impairment or place the enrollee's health in serious jeopardy. Under the proposed

[16] 1988 Minn. Laws, ch. 434, §23.

rules, when a complaint concerning an urgently needed service is received by the HMO, the HMO must immediately notify the MDH. The proposed rules require an HMO to suspend its normal complaint process and implement an expedited dispute resolution process which is "appropriate to the situation."

The proposed rules do not address the process which must be followed by the MDH in reviewing and responding to complaints concerning urgently needed services. In particular, neither the current nor proposed rules require the MDH to consult with medical experts concerning its decision or to inform the company of the identity of the expert upon whom the MDH relies. As a result, the internal process used by the MDH to reach a decision which may have serious financial repercussions for an HMO and its other enrollees is not clearly understood.

Commission Recommendation

Urgently Needed Services

In the case of urgently needed services, the MDH and MDC must often respond quickly and render a decision with less than perfect information. The necessity for a quick response requires that a state agency's review process be flexible. Despite the need for flexibility, the procedure must be fair and understood by all affected parties. The Commission supports:

Identification of a process within the Departments of Health and Commerce for review of urgently needed care appeals that includes the use of appropriate medical experts and identification of those experts.

The Commission supports the efforts of the MDH in its proposed quality assurance rules to clearly set forth the scope, parameters and requirements of an expedited review process for HMOs. The Commission recommends that the expedited review process used by MDH and MDC be specified in either statute or rule. Basic procedural fairness requires that health plan companies have notice of the process and factors used by a state agency to reach a decision, including the identity and opinions of experts consulted on a specific matter.

Several members of the Commission expressed concern regarding the potential financial impact of certain decisions on health plan companies and their insureds and the necessity for an appeal process. Decisions concerning urgently needed care must be made quickly. The urgency of a particular situation often does not allow for a careful and thorough consideration of a treatment request. Doubts are properly resolved in favor of the consumer. The difficulties associated with quickly rendering these decisions may result in decisions which, upon more careful reflection, are deemed incorrect.

In light of this potential for error, the Commission considered imposing the financial responsibility for an erroneous coverage decision on the appropriate state agency. The Commission ultimately concluded that the imposition of the cost of providing uncovered health care services should not fall on the taxpayer. However, the Commission recognizes the potential inequity associated with forcing other insureds to absorb the costs associated with paying for services erroneously ordered by a state agency. Accordingly, the Commission recommends that the MDH and MDC identify and implement appropriate methods for limiting coverage errors and mitigating the related costs associated with incorrectly ordered coverage.

4. Consumer Responsibility for Health Care Utilization and Cost

Overview

There is now widespread recognition that the leading causes of death and disability in most industrialized nations have shifted from communicable diseases to chronic diseases strongly linked with patterns of personal lifestyle.[17] In light of this evidence, both insurers and employers are increasingly concerned with identification of health risk status and the effect of certain be-

[17] *A Research Agenda for Personal Health Risk Assessment Methods in Health Hazard/Health Risk Appraisal,* 22 Health Services Research (1987).

havioral characteristics on the cost of medical care.

The Commission heard testimony concerning a recently completed four-year study of Control Data Employees which correlated life-style habits with medical costs.[18] This study was performed in conjunction with Milliman & Robertson, a nationwide actuarial consulting firm. The study revealed significant differences in the utilization and cost of medical care by health risk status. The study concluded that high-risk persons use more medical care than other persons and generate higher claim costs. For example, persons who smoke an average of one or more packs of cigarettes a day experience 18 percent higher medical claim costs than those who do not smoke. Persons who do not usually wear seat belts experience 54 percent more hospital days than those who do wear seat belts. Hypertensive individuals are 68 percent more likely to have claims in excess of $5,000 per year than those who are not hypertensive.[19]

The development of data which links lifestyle factors to health care utilization and costs permits the integration of lifestyle factors into the pricing and/or design of health plan products. For example, employers and health plan companies may wish to encourage employees to improve their lifestyles by basing employee contributions for health benefits on the expected claims costs for low- or moderate-risk levels. Employees at higher risk levels for factors within their control (e.g., seat belt use) may be required to make higher contributions consistent with their higher medical costs. Employers with flexible benefit plans may wish to vary the benefit credits available to an employee according to lifestyle risk status.[20] Milliman & Robertson estimates that group costs could rise or fall up to 20 percent based on lifestyle; the impact on individual rates may be even larger. As a result, the integration of lifestyle factors and premium rates may create a powerful incentive for health promotion.[21]

Employers and purchasers are searching for ways to lower health care costs and create incentives for healthier lifestyles.[22] Worksite health promotion programs are increasingly prevalent, particularly with employers of fifty or more employees.[23] Although these programs have had some success, health risk status information may also be used to influence behavior change through the use of different employee contribution rates and benefit levels, consistent with behavioral characteristics within the employee's control. In accordance with this approach, the NAIC has developed a Model Regulation for the Certification of Health Plans or Policies. This Model Act is designed to promote wellness through the use of economic incentives such as premium reductions, benefit enhancements and economic disincentives such as increased deductibles, copayments and surcharges. Economic incentives are available based on use of tobacco, regular exercise, moderate alcohol consumption, blood pressure maintenance, weight control, non-abuse of drugs and seat belt usage. Under the Model Act, economic disincentives may be imposed if an insured misrepresents his status with respect to any of these criteria.

Commission Recommendation

Consumer Responsibility

Consumers, providers and health plan companies are jointly responsible for health care costs. A fundamental principle of insurance is the establishment of premium rates based on risk. As a general proposition, a lower risk should produce a lower premium. Insurers have traditionally rated insurance plans based on age, sex, industry and location—all variables largely beyond the control of an individual insured. Fundamental

[18]James, *Study Lays Groundwork for Tying Health Costs to Workers' Behavior*, Wall St. J., April 14, 1987.
[19]*Health Risks and Behavior: The Impact on Medical Costs*, Milliman & Robertson, Inc., (1987).
[20]Anderson David & Jose II, William, *Employee Lifestyle and Bottom Line, Results from the Staywell Evaluation*, Fitness in Business 2:86-91 (Dec. 1987).
[21]*Id.* at 86.
[22]D.S. Shepard and L.A. Pearlman, *Incentives for Health Promotion at tahe Workplace: A Review of Programs and Their Results*, Mimeo (Boston, Mass.: Center for the Analysis of Health Practices, Harvard School of Public Health, 1982).
[23]Office of Disease Prevention and Health Promotion, Department of Health and Human Services, *National Survey of Worksite Health Promotion Activities*, Final Report. Washington, D.C. (1986).

insurance principles would appear to dictate that individuals with healthier lifestyles which translate into lower health risks should enjoy the benefit of lower premiums. However, the implementation of insurance ratings which link individual lifestyle risks to premiums and coverage raises important public policy issues. The Commission recommends that:

HMOs, HSPCs and insurers be encouraged to offer actuarially sound discounts and incentives for both group and nongroup contracts for people who have healthy lifestyles. The MDH, in consultation with the MDC, should study this issue and make recommendations to the legislature by January, 1990, for any statutory and rule changes necessary to allow such plans to be offered.

The ability of health plan companies to price nongroup and group products based on lifestyle factors requires further analysis. Issues which the MDH should address in its report include the avoidance of "victim blaming," the degree to which particular behaviors are within the control of the individual, methods of differentiating between behaviorally induced health conditions and genetically transmitted conditions, the availability of an effective course of treatment or behavior modification program to support the desired behavior change, the establishment of appropriate remedies in the event of false applications and the effect, if any, of federal and state employment discrimination laws. The MDH may also wish to recommend proper methods for determining that the employee's lifestyle conforms with his or her representations. Issues of privacy and confidentiality will need to be balanced against the requirement that employees demonstrate compliance with lifestyle rating factors.

Although further analysis of lifestyle rating is necessary, this recommendation does not imply that lifestyle factors may not currently be used to determine premium rates. For several years well-established risk factors such as smoking have been considered when establishing premium rates for individual contracts. Since the statutory language governing underwriting for each health plan differs, it is expected that health plan companies will continue to work with their legal counsel to appropriately rate their health plan products until such time as any statutory changes are implemented.

State health plan regulation does not control the premium contribution rates which employers may chose to impose on employees based on lifestyle factors. It is anticipated that employers will continue to explore the use of premium contribution differentials to encourage employees to adopt healthy lifestyles.

C. Health Plan Companies and Providers

1. HMO/Provider Dispute Resolution

Overview

Providers are essential to any managed care delivery system. The importance of providers is particularly evident with respect to HMO plans. Unlike other health plans, HMOs traditionally share financial risk with both institutional and individual providers. In addition, HMOs are required to obtain geographic certification in order to operate within a service area. Geographic certification requires proof of an adequate provider network.[24]

The market penetration of Minnesota's HMOs has forced many providers to acknowledge their dependence on HMOs as third-party payors. Likewise, the interdependence between HMOs and their provider networks is increasingly apparent. This growing interdependence creates the potential for serious disputes and disagreements between HMOs and their providers.

Provider/health plan disagreements have traditionally been viewed as routine commercial disputes which are resolved pursuant to the terms of provider agreements. However, under certain limited circumstances a dispute between an HMO and a provider group may potentially create significant access problems for consumers. In those instances a private dispute may assume public dimensions.

The 1988 legislature recognized the potential for provider/health plan disputes to create consumer access problems and consequent public repercussions. As a result, the legislature enacted

[24]Minn. Stat. §62D.03 (1988).

appears that the terms of a contract renewal or maintenance cannot be satisfactorily negotiated. Alternatively, the Commissioner of the MDH may order mediation if failure to reach agreement may significantly impair access to health care services for HMO enrollees. Mediation must continue for thirty days. Mediation is conducted through the Office of Administrative Hearings or the Office of Dispute Resolution within the State Planning Agency; the costs associated with mediation are borne equally by the HMO and the provider. The mediator has no authority to impose a settlement or bind the parties although any agreement reached as a result of mediation is enforceable.

Mediation has been invoked on only one occasion since the statute's enactment. In that instance, the mediation process did not result in renewal of the provider agreements; enrollees in that service area were provided with alternative or replacement coverage. The Commission heard testimony concerning this process from several members of the public. Public testimony stressed that since mediation is invoked only when the parties have reached an impasse, the probability of a successful resolution is reduced. Mediation normally does not work well when parties are involuntarily required to participate.

Recognizing that mandatory mediation of HMO/provider disputes represents a new approach to the resolution of these matters, the legislature chose to sunset the mediation law in June of 1990. In the interim the bill's sponsors suggested that the Commission make a recommendation concerning continuation of the provision.

Commission Recommendation

HMO Mediation Process

Since the mediation statute has been invoked only once since its enactment, there is little evidence from which to draw conclusions concerning its effectiveness. The Commission recommends:

The mediation statute for HMOs should be allowed to sunset in June, 1990. In the interim, the MDH should continue to evaluate the usefulness of the mediation process.

The Commission considered extending the mediation requirement to all managed care plans. However, lack of experience with the statute coupled with the absence of success in the one instance in which it was invoked, does not support extension to other health plan companies at this time.

The relationship between an HMO and a provider is primarily a private contractual relationship. Disputes arising between private parties are normally resolved in accordance with the terms of the contract. Unresolved disputes between private parties are generally settled through the judicial system. Deviations and exceptions to this process must be supported by credible evidence that an alternative to judicial resolution of such disputes is likely to yield better results.

It is the policy of state agencies to avoid interference in private contractual disputes absent a strong public policy rationale. There is insufficient evidence that our judicial system cannot adequately resolve HMO/provider disagreements. Accordingly, there is an insufficient basis to extend the involuntary mediation statute beyond 1990. If the statute is invoked before 1990 and proves to be effective and necessary, continuation of the statute beyond 1990 and extension of its provisions to other health plan companies should be reconsidered.

2. Provider Risk Sharing

Overview

Methods of third-party payment of physicians and other providers have changed and evolved over the last decade. Historically, most physicians and institutional providers resisted direct relationships with third-party payors and were paid on a retrospective fee-for-service basis. This approach contained incentives for excessive intervention with overpriced procedures. Proposals for reforming these incentives arose virtually as soon as the system was created.

In the early 1970s HMOs embraced new approaches to physician payment. These approaches developed from HMOs' prepaid approach to health care. HMOs generate income from prepaid premiums. Consequently, HMOs are required to budget for the provision of services in advance. Since total income is limited by premium payments, HMOs have a strong need to control costs and no incentive to provide unnecessary or marginal care.

Physicians control to a large extent the volume and type of services consumed by patients. As a result, any effort to control cost requires cooperation by physicians. Third-party payors involved in managed care recognize that physician cooperation can be achieved through a variety of methods, including giving the physician an economic stake in the payor's performance.

In staff model HMOs, providers are primarily employed on a salaried basis. Other HMOs and third-party payors have developed a variety of other financial arrangements designed to encourage physicians to practice in a cost-effective manner. These methods include risk pools and capitation arrangements. Risk pools are usually formed by withholding a portion of each physician's compensation, normally 15 to 25 percent. HMOs may use risk pool funds to cover annual operating deficits. Surplus funds may be returned to physicians on an individual or aggregate basis.

Some HMOs have adopted capitation payment mechanisms. Capitation requires physicians to accept a monthly designated amount as payment in full for each assigned member, no matter how often the physician provides services to each member during the month. Under capitation arrangements, physicians' net income will fluctuate depending on the frequency or extent of patient services. Capitation payments may be negotiated for primary care services, all physician services, including speciality referral services, or all health services, including hospital and other institutional services.

Risk sharing arrangements are currently the focus of study on the federal level. In 1986 Congress acted to prohibit HMOs and CMPs with Medicare risk contracts from engaging in risk sharing arrangements. In 1987 Congress extended the effective date of this prohibition to April 1, 1990. The Department of Health and Human Services was directed to study the issue of financial incentives and report to Congress concerning its recommendations for appropriate risk arrangements. The DHHS expects to complete its report during 1989.

The General Accounting Office (GAO) also recently completed a study of physician incentive arrangements.[26] The GAO study noted that there is little agreement in the health care field regarding the effect of financial incentives on quality of care. Although a thorough literature search was conducted, the GAO could not identify any studies relating HMO physician incentives to the quality of care provided Medicare patients.

Commission Recommendation

Provider Risk Sharing

A primary purpose of physician incentive plans is to encourage physicians to consider the cost implications of alternative courses for diagnosing or treating patients. The goal of risk sharing arrangements is to promote selection of the least expensive course of treatment that meets the patient's needs and results in adequate care.

[26] *Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care* (GAO/HRD-89-29, December, 1988).

The question is where to draw the line between acceptable risk arrangements and physician incentive plans which could adversely affect patient care. Current research does not provide any clear guidance as to where to draw the line on the continuum of current and future risk sharing arrangements. The Commission recommends:

Physicians and physician groups should not be permitted to accept 100 percent financial risk for the provision of services provided by other facilities or providers not owned or operated or otherwise subject to the control of the medical group assuming the risk, unless the group can demonstrate adequate financial strength to accept such risk.

Health plan companies should provide stop-loss coverage to physicians and physician groups at levels appropriate to their ability to sustain such risk.

The Commission supports the continued use of provider risk sharing and recognizes that risk sharing is an important element of managed care. In other sections of this report, the Commission recommends that all health plan companies be permitted to engage in provider risk sharing, provided that such products are subject to appropriate quality assurance regulation (*see Product Diversification,* chapter IV (A)).

Notwithstanding this support, the Commission acknowledges that some incentive arrangements may induce physicians to respond inappropriately, leading to improper patient care. As a result, the Commission has chosen to focus on 100 percent risk for services provided by providers or facilities outside the control of the provider assuming the risk. The Commission recognizes that some physician groups may have the financial strength to accept 100 percent risk and therefore declines to recommend an absolute prohibition on 100 percent risk sharing.

Inappropriate physician risk sharing may be mitigated by incorporating stop-loss protection in certain provider contracts. Stop-loss insurance will establish a ceiling on physician financial liability. The Commission recommends that health plan companies be required to provide stop-loss coverage for extraordinary costs and physicians who cannot sustain 100 percent risk. The existence of stop-loss coverage will protect physicians against the losses associated with catastrophic cases and provide protection from undue financial pressure to control utilization and costs.

Other sections of this report stress the interrelationship between risk sharing and quality assurance programs. The potentially negative effects of risk sharing may be counterbalanced by an effective quality assurance program. Other important factors also provide an incentive for physicians and third party payors to avoid underservice. A delay or avoidance of medical care may necessitate more expensive treatment at a later date. Widespread patient dissatisfaction in a competitive market will likely result in plan disenrollment. It is also important to note that physician behavior is influenced by many factors other than risk sharing arrangements. Professional ethics, potential malpractice liability and the need to retain patients all contribute to the continual prescription of an appropriate level of care.

The actual effect of provider risk sharing on patient care is currently unclear. It is anticipated that federal agencies will provide some guidance on this issue during 1989. Until such time that scientific and medical literature can demonstrate a certain relationship between physician risk sharing and quality of care, the Minnesota legislature should decline to enact any absolute prohibitions on risk sharing. Any such prohibition will seriously damage the ability of Minnesota health plan companies to contain and control rising health care costs. Since increases in costs must be passed on to consumers, prohibitions which limit the ability of employers and health plan companies to control costs will ultimately force consumers to absorb the additional costs resulting from overutilization and inefficient medical practice patterns.

3. Provider Selection and Reporting

Overview

As discussed in the preceding section on provider risk sharing, physicians and other allied health practitioners control the rate and type of resource utilization throughout the health care industry. Physicians prescribe services and drugs, admit patients to hospitals and refer patients to specialists and other providers. The allied health practitioners (e.g., nurses,

chiropractors, podiatrists, dentists, mental health practitioners) are also involved in the diagnosis and treatment of certain limited conditions. As these professional groups continue to practice more autonomously and independently, these groups increasingly influence and control the rate and type of resources used by patients and reimbursed by health plan companies.

Although the vast majority of health care practitioners practice and prescribe well within treatment norms and standards, a limited subset of practitioners routinely exceed the practice norms of their colleagues. Although the prescription of unnecessary care violates ethical canons and professional licensing standards, all health plan companies have experienced the difficulties associated with identifying these individuals and persuading them to alter their practice patterns.

In today's competitive market, health plan companies are carefully evaluating the practice patterns, medical credentials and patient outcomes of providers serving their subscribers or enrollees. Providers who consistently demonstrate poor quality of care, unnecessary expenses and low patient satisfaction create serious problems for health plan companies attempting to provide high quality health care at competitive prices.

Managed care products are increasingly in demand by consumers and employers and frequently involve the use of provider networks. The existence of a provider network normally implies that a consumer's access to any provider-of-choice is restricted. These restrictions may result from the closed panel features inherent in the HMO concept or from the benefit and cost differentials used in PPO plans. When a provider network is limited in any fashion, the need for participating providers to be of a high caliber is apparent.

Commission Recommendation

Provider Selection and Reporting

In order to control costs while maintaining high quality of care, health plan companies must be able to select providers who meet relevant criteria established by the health plan company. The Commission recommends:

Health plan companies utilizing provider networks should be permitted to contract selectively with providers based on relevant criteria developed by the health plan company which may include geographic location, provider qualifications, quality of practice, cooperation with quality assurance/utilization review programs and acceptance of contracted payments.

Health plan companies must be free to decline to contract with particular providers who consistently deviate from the normal practice patterns of colleagues in the community. In order to facilitate a ready identification of those providers, the Commission recommends:

Health plan companies should be authorized to submit information to the Department of Health concerning the identity of specific providers whose utilization practices exceed the health plan company's average utilization levels by an agreed number of standard deviations.

This information will be maintained by the Department of Health and accessible only to health plan companies licensed to do business in Minnesota.

The ability to selectively contract with certain providers is an important element of managed care. Health plan companies may not be able to control cost and quality if deprived of the ability to select the providers with whom they will contract to provide medical care. Consumers often rely on their health plan company to review the credentials and practice patterns of their providers and select high quality professionals. In a competitive market, all companies

must be able to determine the number and identity of providers under contract with the company. Within the constraints of antitrust law, HMOs are currently able to select the number, type and qualifications of providers who can best serve the needs of their enrollees. The same flexibility should be available to HSPCs and insurers, subject to equivalent regulatory oversight.

An essential step in the creation of a quality provider network is identification of providers whose practice patterns routinely do not conform with local norms and standards. Many health plan companies currently maintain provider profiles which enable them to identify specific providers whose utilization rates dramatically exceed the average. Although efficiency and cost containment would benefit from the exchange of this information, health plan companies have historically been hesitant to engage in this practice due to antitrust concerns.

State law which clearly articulates the policy of exchange of provider data and provides for the active supervision of that exchange by the state will minimize any potential antitrust liability. The creation of a data bank in the MDH may satisfy these requirements. This data base is not intended to duplicate the national data base recently created pursuant to the Health Care Quality Improvement Act of 1986. A combined federal and state data collection effort will facilitate more effective provider selection and cost containment.

IV

PRODUCT REGULATION AND HEALTH PLAN COMPANY CORPORATE STRUCTURE

A. Product Diversification

Overview

Minnesota's current regulatory structure contemplates that each type of health plan company will offer only one type of product. Accident and health insurers offer insurance products, HSPCs offer health service plans and HMOs offer HMO products. The characteristics of these products have gradually evolved. Although initially insurers offered only indemnity coverage with unrestricted choice of provider, Minnesota insurers have been authorized to offer preferred provider plans since 1983. HSPCs have refined their products to include more managed care features and HMOs now offer indemnity products as part of "wrap-around" or "combination" plans.

As a result of this product evolution, health plans offered by the various companies have many similar features. Notwithstanding this similarity, certain characteristics continue to be reserved to specific health plan companies. Only HMOs are expressly permitted to engage in provider risk sharing. HMOs are also the only health plan company prohibited from incorporating deductibles into their products. Insurers and HSPCs are forbidden from the direct offering of an HMO product.

These and other limitations on the types of products which may be offered by health plan companies have resulted in the proliferation of complex holding company systems. These systems allow the offering of additional products through the separate incorporation of affiliated companies licensed to offer a different health plan product. The creation of a new corporation each time a different type of product is offered is an expensive process. The corporation must be created and capitalized. Provider networks, benefit contracts and management systems must be developed. Complex contracts between related companies must be developed for the provision of management services, provider networks and other elements of a new health care product. The development of a new company in order to offer a new product often creates unnecessary expense. This expense is ultimately passed on to Minnesota consumers.

Congress recently recognized the inefficiencies inherent in a "one company, one product" regulatory structure. Recent amendments to the federal HMO Act provide that an insurer may offer a federally qualified HMO product as a line of business, without the incorporation of a separate HMO entity.[1] The 1988 amendments also permit HMOs to offer products with deductibles and allow federally qualified HMOs to provide up to 10 percent of basic health services through

[1]H.R. 3235, 100th Cong., 2d Sess., §1 (1988).

nonparticipating providers.[2] These amendments were designed to improve efficiency for federally qualified HMOs through creation of additional flexibility. The amendments enjoyed wide bipartisan support.[3]

Commission Recommendation

Product Diversification

The Commission supports the Congressional policy reflected in the recent amendments to the federal HMO Act. In a competitive system, regulatory inefficiencies should be eliminated if they do not serve an important public interest. As the distinctions between health plan products continue to fade, the inefficiencies inherent in the "one company, one product" approach are increasingly obvious. The Commission recommends that:

The flexibility of all types of health plan companies to respond to the needs of consumers be increased by:

1. *Amending Chapter 62C to allow HSPCs to offer an HMO product as a line of business, provided that the HMO product is subject to the requirements of Chapter 62D with respect to enrollee contracts, provider contracts, provider networks and provide dispute resolution, quality assurance, consumer complaint procedures and underwriting.*

2. *Amending 62A to allow insurers to offer an HMO product as a line of business, provided that the HMO product is subject to the requirements of Chapter 62D with respect to enrollee contracts, provider contracts, provider networks and provider dispute resolution, quality assurance, consumer complaint procedures and underwriting.*

3. *Amending Chapter 62D to allow HMOs to offer products which satisfy the benefit, copayment, deductible and lifetime maximum requirements of qualified #1, #2 and #3 plans, provided that such products are offered primarily through an HMO provider network and remain subject to appropriate managed care and financial integrity regulation. Qualified #1, #2 and #3 plans offered primarily by an HMO should not be labeled HMO products.*

4. *Amending Chapter 62D to allow HMOs to offer a "combination" or "wrap-around" plan which permits the provision of health services by providers not affiliated with the HMO, without the incorporation of or affiliation with a separate insurance company.*

5. *Amending Chapters 62A and 62C to allow insurers and HSPCs to engage in provider risk sharing with respect to non-HMO products, provided that such products shall be subject to appropriate quality assurance regulation, commensurate with the type and degree of risk sharing and the degree of access to nonparticipating providers.*

These recommendations follow the recent changes in the federal HMO Act by allowing HSPCs and insurance companies to offer HMO plans as a line of business without the incorporation of a separate HMO entity. It is anticipated that HMO products offered as a line of business of another regulated entity will continue to be subject to appropriate state HMO regulation.

The foregoing recommendations also contemplate the offering by HMOs of non-HMO managed care plans. Since insurance companies and HSPCs are permitted to offer HMO products, basic equity requires that HMOs be permitted to offer benefit plans which satisfy qualified plan standards. Although HSPCs and insurers are permitted to offer nonqualified plans, the Commission elected to restrict the offering of nonqualified plans to accident and health insurers and HSPCs. Accordingly, HMOs may not offer any products which are less comprehensive than a qualified #1, #2 or #3 plan. This flexibility will allow HMOs to offer products with deductibles and lifetime maximums, provided that these products are not labeled HMO products and meet current qualified plan standards. It is an-

[2] *Id.* at §4.

[3] *See* 16 *Health Lawyers News Report* at 2–3, National Health Lawyers Association (Sept. 1988).

ticipated that HMOs will begin to offer a range of products—from the minimum level of the small employer plan to the comprehensive level of an HMO plan. These non-HMO plans must continue to be offered primarily through the HMO's provider network.

The Commission further recommends that HMOs be permitted to directly offer a "combination" or "wrap-around" plan which permits the provision of health services by providers not affiliated with the HMO, without the incorporation of or affiliation with a separate insurance company. This flexibility was technically created by the legislature in 1987 when it amended Chapter 62D to allow HMOs to offer "supplemental benefits" through nonparticipating providers.[4] This amendment may not be implemented until the MDH adopts administrative rules relating to insolvency, financial reserves, claims processing and marketing.

Since it has been almost two years since the legislature enacted this provision, the Commission urges the MDH to give a high priority to promulgation of these rules. In the interim the Commission urges the MDH to consider following the Congressional policy of permitting up to 10 percent of basic health services to be offered by non-affiliated providers without the promulgation of additional administrative rules. In the alternative, the Commission recommends that the MDH consider the adoption of administrative rules which impose minimum additional requirements on the offering of "combination plans" structured to limit out-of-plan utilization to 10 percent or less.

In accordance with modification of the "one company, one product" approach, the Commission recommends that Chapters 62A and 62C be amended to expressly allow insurers and HSPCs to engage in provider risk sharing. Both chapters are currently silent on the issue of provider risk sharing. Provider risk sharing is an important feature of managed care. When properly structured, risk sharing creates incentives to deliver and prescribe care in a cost-conscious and high quality manner. Encouragement of the development of new managed care products by all health plan companies lies at the heart of the Commission's recommendations in this area. Since provider risk sharing is a critical element of managed care, it is essential that all health plan companies be permitted to incorporate provider risk sharing into all company products.

The existence of provider risk sharing in many HMO products provides a partial theoretical basis for mandatory quality assurance programs. As discussed in Chapter Three, the Commission recommends that all health plan products be subject to varying quality assurance requirements. The degree of provider risk sharing is an important determinant of the scope and degree of quality assurance regulation. It is therefore anticipated that any health plan product offered by an insurer or HSPC which incorporates some degree of provider risk sharing will be subject to a corresponding level of quality assurance regulation.

B. Managed Care Certification and Self-Insured Plans

Overview

The foregoing product diversification recommendations are based on the premise that all health plan companies should be permitted to offer a range of products and be subject to equivalent "managed care" regulation. Current health plan company statutes apply only to insured plans. Self-insured plans are not subject to state regulation concerning the "management" of health care financed through a self-insured health benefit plan.

The state's ability to regulate self-insured plans is restricted by ERISA. ERISA prohibits the imposition of state regulation which "relates to" a self-insured employee welfare benefit plan. Judicial decisions have limited states' ability to impose mandated benefit laws, state risk pool assessments and mandatory insurance coverage requirements on self-insured employers.[5]

[4]1987 Minn. Laws ch. 337, §64.

[5]*See e.g., Metropolitan Life Ins. Co. v. Massachusetts,* 471 U.S. 724 (1985); *Standard Oil Co. of California v. Agsalud,* 633 F.2d 801 (9th Cir. 1980), *affirmed mem.* 434 U.S. 801 (1981); *St. Paul Elec. Workers Welfare Fund v. Markman,* 490 F. Supp. 931 (D. Minn. 1980).

State regulations which have been the subject of prior judicial interpretations of ERISA's preemption provisions have not focused on regulation of the management of health care delivery. Many self-insured managed care plans are actively involved in utilization review and case management. Through these processes, self-insured employers and/or their third-party administrators are involved in decisions which prospectively affect access, delivery and the quality of health care.

The regulation of health care delivery systems is a product of the state's "police power" to protect the health, safety and general welfare of state residents. This constitutional authority underlies the state's ability to license and regulate health care providers such as hospitals, home health agencies and physicians. In the unlikely event that a self-insured employer were to purchase a state licensed hospital for use by its self-insured employees, it is doubtful that state regulation of the hospital would be preempted by ERISA. Similarly, the Commission questions whether state regulation of managed care services closely related to the delivery of health care are within the scope of ERISA's preemption provisions.

The current regulation of Minnesota health plan companies reflects a legislative determination that entities which are involved in the management of health care delivery must demonstrate a special competence and expertise. Management of utilization review programs, development of provider networks, imposition of access restrictions and other features of managed care plans requires special qualifications and capabilities.

Commission Recommendation

Managed Care Certification

The imposition of state regulation directly or indirectly affecting self-insured plans may be subject to an ERISA challenge. The probability of a favorable judicial ruling will turn on a variety of factors including the narrowness of the regulation and the care with which it is implemented. The Commission recommends that the legislature:

Pursue whichever of the following options is most likely to prevail in the face of an ERISA challenge:

1. *Require "managed care certification" for self-insurers that offer health plans incorporating managed care features.*

2. *Require "managed care certification" of third-party administrators, preferred provider organizations or other companies that provide managed care services to self-insured health benefit plans.*

The Commission recommends that the definition of "managed care" be carefully crafted to include only characteristics which directly affect the availability and quality of medical care. These features may include pre-admission certification, concurrent review programs, case management services which require discharge to specific providers and establishment of "closed panel" plans.

A variety of independent and free-standing entities including TPAs, PPOs and free standing utilization review organizations provide managed care services to self-insured plans. Although TPAs are currently licensed, the licensure requirements do not extend to managed care services. PPOs and other intermediary organizations are not licensed under state law. As an alternative to the direct regulation of self-insured employers or plans, the legislature may wish to consider the regulation of intermediary organi-

zations providing administrative and managed care services to self-insured plans.

C. The HMO Nonprofit Requirement

Overview

The HMO nonprofit requirement is unique to Minnesota. Minnesota is the only state which currently prohibits HMOs from organizing as for-profit corporations.[6] Within the overall framework of Minnesota health care regulation, the nonprofit requirement is the exception rather than the rule. Other providers including hospitals, nursing homes and home health agencies are permitted to select the organizational form which best suits their business needs and strategy. Third-party administrators, preferred provider organizations and accident and health insurers perform many of the same services performed by HMOs and may elect to operate as for-profit or nonprofit organizations.

HMOs are "commercial" nonprofit organizations, as opposed to "donative" nonprofit organizations which receive the majority of their funding from charitable organizations. As commercial nonprofit organizations, HMOs derive their income from the sale of goods and services in normal commercial transactions where consumers are expected to pay the fair market value of the product. HMOs are not expected to provide charity care and are permitted by statute to terminate coverage to individuals who fail to pay premiums or copayments.

In the early years of the HMO movement, federal grants and subsidies were only available to HMOs incorporated as nonprofit entities. As a result, many HMOs chose to begin business as nonprofit corporations. The HMO industry is now mature and federal subsidies and grants are no longer available. Federal law does not restrict federally qualified HMOs to the nonprofit form. Recent national surveys have estimated that 65 percent of all HMOs are organized as for-profit enterprises.[7]

[6] *A Report to the Governor on State Regulation of Health Maintenance Organizations*, Office of Prepaid Health Care, Department of Health and Human Services (1987).

[7] *Medical Benefits* 5:10 (May 30, 1988).

The precise role of organizational form in the transformation of the American health care system from a service to a commercial industry has been the subject of considerable research and debate in recent years.[8] With respect to hospitals and nursing homes, researchers have attempted to evaluate the impact of organizational form on cost and quality. The majority of these studies have been inconclusive and contradictory.[9] Some researchers have concluded that the degree of physician control over the direct provision of care is the most influential factor in providing quality health care.

HMOs are intensively regulated by both state and federal agencies. State regulation determines benefit plan content, the terms of provider contracts and management agreements, financial reserve and net worth requirements, quality assurance programs, consumer complaint procedures, consumer board requirements and open enrollment and underwriting restrictions. Federally qualified HMOs are also regulated by the Office of Prepaid Health Care (OPHC). HMOs which enter into Medicare risk contracts are subject to additional regulation by the Health Care Financing Administration (HCFA). These regulations provide substantial consumer protection which far exceeds any protection theoretically offered by a nonprofit requirement.

Commission Recommendation

HMO Nonprofit Requirement

Fifteen years have passed since the Minnesota HMO Act was originally enacted. During this period, the majority of Minnesota HMOs have been successful. Consumers, providers, HMOs and regulators have gained considerable

[8] *See generally* Marmor, Schlesinger & Smithey, *A New Look at Nonprofits: Health Care Policy in a Competitive Age*, 3 Yale J. Reg. 313 (1986).

[9] *See generally* Herzlinger, *Who Profits from Nonprofits?* 65 Harv. Bus. Rev. 93 (1987); Sloan & Becker, *Cross-Subsidies and Payment for Hospital Care* 8 J. Health Pol. Pol'y. & L. 660 (1984); Clark, *Does the Nonprofit Form Fit the Hospital Industry?* 93 Harv. L. Rev. 1416 (1980).

experience with the industry. The HMO Act has often been amended to incorporate knowledge and experience gleaned over time. Fifteen years of experience with the nonprofit requirement indicates that the continued application of the nonprofit requirement is not necessary to protect the Minnesota consumer. The Commission recommends that the Minnesota legislature:

Permit HMOs to incorporate as for-profit corporations and enact a statutory HMO conversion procedure for existing HMOs.

It is expected that HMOs will be increasingly disadvantaged in the marketplace by the nonprofit requirement. The nonprofit requirement impacts the ability of Minnesota HMOs to access new capital. Recent amendments to the federal HMO Act allow insurers to offer federally qualified HMO products as a line of business. These amendments are consistent with the national trend towards multiple product offerings by large, vertically integrated health care organizations.

The nonprofit requirement deprives consumers of additional HMO products. For-profit health plan companies are increasingly offering HMO look alike products with which nonprofit HMOs must compete. The rapid growth of PPO products offered by for-profit insurers and self-insured arrangements indicates that consumers are searching for efficient managed care products with many HMO features. Experience in other states indicates that consumers desire a variety of managed care products and will purchase an HMO product from a for-profit company. HMO regulators in the other forty-nine states which permit for-profit HMOs do not report any increased problems associated with for-profit status.

Existing HMOs which desire to convert to for-profit status must undertake a conversion process. This conversion process will require that the fair market value of the HMO be paid to a charitable organization. This charitable contribution is necessitated by the basic nonprofit requirement that the assets of a nonprofit not inure to the benefit of any private person or entity.

Conversion from nonprofit to for-profit status may be a complicated process. The regulatory experience of other states indicates that enactment of a statutory conversion process may be useful to both HMOs and regulators. A statutory conversion process may establish the minimum contribution requirements, the methodology for valuing the HMO and the factors to be considered when establishing a payment method and schedule.

The Commission does not anticipate that the majority of Minnesota HMOs will seek for-profit status. Some HMOs may continue to do business as nonprofit corporations for a variety of reasons, including community perception, company philosophy and the expenses associated with a for-profit conversion. Amendment of the HMO Act to permit for-profit HMOs will permit Minnesota HMOs to individually evaluate the advantages and disadvantages of nonprofit status. HMOs voting to retain nonprofit status may use this characteristic as a distinguishing factor in the marketplace.

The existence of a for-profit alternative will contribute to "leveling the playing field" between HMOs and their for-profit competitors in the managed care industry. The availability of for-profit status may also provide consumers with additional choices. These benefits are consistent with a state commitment to the development of a competitive health care market.

D. Consumer Representation on Health Plan Company Board of Directors

Overview

Minnesota's HMO law requires that 40 percent of an HMO's Board of Directors be composed of consumers elected by the enrollees from among the enrollees.[10] Although the federal HMO law originally required that one-third of a federally qualified HMO's Board of Directors be enrollees, this requirement was repealed in 1988.[11] Health service corporation plans are required to maintain a twelve member Board of Directors; one-third of these directors must be individuals who are not directly or indirectly connected with the

[10]Minn. Stat. §62D.06 (1988).

[11]H.R. 3235, 100th Cong., 2d Sess. (1988).

provision of health services.[12] Accident and health insurers are not subject to consumer board requirements.

The majority of states with HMO enabling legislation do not have a statutory requirement regarding consumer board representation. As of 1987, forty-seven states had enacted HMO enabling legislation. Of these forty-seven states, eleven states require consumer representation and thirty-six do not.[13]

Research on the effects of consumer board participation on HMO performance has generally concluded that since consumers do not form a self-conscious or unified constituency, their direct effect on HMO performance is limited. Although the effect of consumer participation may be limited, consumer board representation appears to contribute to the development of a consumer-oriented philosophy in the community.[14]

Commission Recommendation

Consumer Board Requirements

The HMO consumer board requirement has been in place since enactment of the Minnesota HMO Act in 1973. The requirement has not impeded HMO development. Consumers have played a valuable role in HMO development in this area. The Commission recommends:

The consumer board requirements should be maintained for health maintenance organizations and health service plan corporations.

Consumers play a significant role in shaping the health care policy and business strategies of Minnesota's HMOs and HSPCs. Consumers provide an important link to the community at large and to the enrollees or subscribers of health plan companies. The consumer board requirement has not impeded HMO development in this area and provides a valuable safeguard against dominance of health plans by any single special interest group.

The Commission has previously recommended that HMOs be allowed to operate as for-profit corporations. In accordance with this recommendation, for-profit HMOs incorporated in Minnesota will continue to be subject to the HMO consumer board requirement. In a related decision regarding the labeling of HMO products, the Commission recommends that insurers and health service plan corporations wishing to offer an HMO product as a separate line of business be required to restructure their governing boards to include 40 percent consumer representation or provide for the creation of an advisory body to the governing board which provides for 40 percent consumer representation (*see HMO Product Definition,* Chapter I (D)). As a result, any health plan company offering an HMO product will be subject to consumer participation requirements.

E. Taxation of Health Plan Companies

Overview

A variety of nonprofit health care organizations are eligible for tax exemption under various provisions of Minnesota statutes and the Internal Revenue Code. The majority of nonprofit health care organizations qualify for tax-exempt status as "charitable organizations" under I.R.C. §501 (c)(3) or "social welfare organizations" under I.R.C. §501 (c)(4). In general, health service plan corporations and health maintenance organizations are classified as "social welfare organizations." Federal tax-exempt status provides exemption from federal income tax, although tax-exempt entities continue to be subject to tax on unrelated business activities. Federal tax-exempt status results in partial tax-exempt status on the state level.

[12]Minn. Stat. §62C.07 (1988).

[13]*A Report to the Governor on State Regulation of Health Maintenance Organizations,* Office of Prepaid Health Care, Department of Health and Human Services (1987).

[14]*See generally* Anderson, O.W.; Harold, T.E., Butler, B.W.; Kohrman, C.D.; Morrison, E.M., *HMO Development: Patterns and Prospects* (1985); Luft, H.S. *The Operations and Performance of Health Maintenance Organizations: A Synthesis of Findings from Health Services Research* (1981).

Although most nonprofit organizations in the health care industry pay no federal income tax, many pay other federal and state taxes. For example, Minnesota health service plan corporations and health maintenance organizations pay state property and sales taxes.

Under current tax law, HMOs are not subject to federal income tax, Minnesota's 9.5 percent corporate income tax or the 2 percent gross premiums tax. In contrast, under a new section of the Internal Revenue Code enacted in 1986, HSPCs are subject to a federal income tax.[15] In 1987 HSPCs also became subject to Minnesota's 9.5 percent corporate income tax and an alternative minimum tax calculated on the basis of a company's annual sales, property and payroll. As nonprofit corporations, HSPCs are exempt from the gross premiums tax.

Accident and health insurers are subject to property and sales tax, federal income tax, Minnesota's 9.5 percent corporate income tax and the 2 percent gross premiums tax. Insurers are permitted to offset their premium tax obligations against their state corporate income tax liability. In many instances, premium tax payments exceed income tax obligations. Minnesota's accident and health insurers are also subject to a "retaliatory tax" in many states.

The differing tax status of HMOs, HSPCs and accident and health insurers contributes to an unlevel competitive playing field. Accident and health insurers alone are subject to gross premium taxes. However, accident and health insurers are the only health plan companies permitted to operate as a for-profit enterprise. HSPCs are subject to federal and state income tax although they are required to operate as nonprofit entities. HMOs are also limited to nonprofit status but are not subject to federal or state income tax.

The differences in tax status of Minnesota's health plan companies is not unique to Minnesota. Across the country lawmakers are struggling with current tax exemption policy. On the federal level, Congress is seeking to expand the unrelated business income tax. Numerous states are beginning to challenge the tax-exempt status of nonprofit health care providers. In the wake of the federal taxation of HSPCs, many states, including Minnesota, have considered extending the premium tax to HSPCs and HMOs.

The Commission recognizes that tax status is intimately connected with a variety of complex issues including the degree of subsidy which states should accord to commercial nonprofit organizations, the appropriateness of using the tax system to facilitate this subsidy, the role or the character of the "good" produced by the tax-exempt organization and the effect of taxation on the price or availability of necessary products.

In light of the limited time available to consider these complicated issues, the Commission elected to refrain from issuing a formal recommendation regarding the taxation of health plan companies. In future deliberations concerning the taxation of health plan companies, the Commission encourages the legislature to accord special emphasis to the relationship between tax status and the affordability of health care. The taxation of health care finance and delivery systems has implications which reach far beyond increased state revenues. Since nonprofit institutions have limited sources of capital and revenue, any increase in taxation must necessarily be reflected in increased costs to consumers. Increased costs may result in loss of necessary health care coverage for consumers who are already financially stressed. This loss of coverage, the consequent lack of health care and increased provider bad debt have potentially serious ramifications which exceed the societal gain resulting from increased state revenues.

The legislature should remain cognizant of the exponential effect of imposing increased income taxes on accident and health insurers. The majority of states have enacted "retaliatory" tax statutes pertaining to the taxation of foreign insurers doing business in that state. Under a "retaliatory" tax statute, a foreign insurer is subject to the tax laws and rates of the insurer's home state, to the extent that the home state tax is greater than the tax imposed by the foreign state. The constitutionality of "retaliatory" tax schemes has been upheld by the United States Supreme Court.[16]

The effect of "retaliatory" tax schemes is that an increase in the tax liability facing Min-

[15] I.R.C. §501(m) (1988).

[16] *Western & Southern Life Ins. Co. v State Board of Equalization*, 451 U.S. 648 (1981).

nesota insurers will result in an exponential increase in tax liability for Minnesota's domestic insurers. This increase places Minnesota companies at a competitive disadvantage and discourages companies from establishing their corporate headquarters in this state.

F. HMO Premium Rates

Overview

Minnesota's public policy with respect to health care markets is to encourage and foster competition. As a result, Minnesota has not embraced economic or rate regulation of health care providers such as hospitals and health maintenance organizations. HMO premium rates must be in accordance with accepted actuarial principles but are not subject to direct regulation.[17]

Rate regulation differs for HSPCs and insurers. Both types of companies are required to file premium rates with the MDC sixty days before implementation.[18] Rates which are not disapproved may be implemented after the sixty-day period has expired. Insurers and HSPCs must disclose anticipated loss ratios and file actual loss ratio experience with the MDC on an annual basis. In some cases, Minnesota law specifies loss ratios for specific types of policies.[19]

Consumer complaints concerning unreasonably high rates are handled through the routine complaint processes established in the MDC and MDH. Regulatory concerns regarding excessively low rates may be addressed by the MDC pursuant to its present rate filing system. HMO rates may also be reviewed as part of the MDH's general audit authority.

Rate regulation is theoretically designed to protect the consumer from excessively high or unrealistically low premium rates where imperfections in the market limit the ability of competitive pressures to produce appropriate rates. Within the last five years HMOs and their competitors have engaged in vigorous price competition. Several years ago at least one HMO offered an HMO Medicare contract free of charge for a limited period. In contrast, after several years of relatively modest premium increases many employers are currently facing premium increases ranging from 15 to 30 percent.

[17]Minn. Stat. §62D.12, subd. 6 (1988).

[18]Minn. Stat. §62A.02, subd. 3 (1988).

[19]Minn. Stat. §62A.48, subd. 4 (1988) (loss ratios for Medicare supplement and long-term care policies).

Commission Recommendation

HMO Premium Rates

In accordance with Minnesota's basic philosophy with respect to rate regulation of health care providers, the Commission concluded that competition is the preferable method of determining premium rates. The Commission recommends:

The current regulatory approach to HMO rate review should be maintained.

Recent premium increases are not unique to Minnesota. Nationwide premiums have increased an average of 22 percent.[20] Premium increases are generally attributed to medical inflation, the growth of new and expensive technology, increased demand and utilization and expanded cost shifting from the public to the private sector.

Although a thorough assessment of the competitiveness of Minnesota's health care market is beyond the scope of the Commission's statutory charge, premium rates in Minnesota appear to follow the trends in other states. Evidence is lacking that the current regulatory system results in unfair or actuarially unjustifiable rates. It appears that both the MDH and the MDC have sufficient statutory authority to respond to consumer complaints concerning sizable premium increases and respond to financial stability concerns resulting from unreasonably low premiums.

The Commission also noted that insurers are increasingly refusing to do business in states with strict rate controls. For example, the Golden Rule Insurance Company recently ceased marketing its policies in several states which have attempted

[20]Wall St. J., Oct. 25, 1988 at B1, col.1.

to regulate premium prices. Unless serious problems arise, the legislature should not abandon a policy which is consistent with basic principles of competition.

V

THE FINANCIAL STABILITY OF HEALTH PLAN COMPANIES

A. Financial Solvency

Overview

The financial stability of health plan companies is critical to the provision of adequate health plan coverage for Minnesota consumers. Insurers, HSPCs and HMOs are subject to state regulation of their financial stability or integrity. Like other health plan regulation, these requirements are codified in the separate enabling statutes of the three major categories of health plan companies. Financial solvency regulation addresses surplus and liquidity requirements, reinsurance provisions and net worth and working capital requirements. Health plan companies are also subject to special rehabilitation and liquidation procedures.[1]

Insurers have traditionally been subject to the most comprehensive financial solvency regulation. Insurers have been regulated by states for a significantly longer period of time than HSPCs or HMOs. As a result, states have more regulatory experience with insurers. Industry standards are also well developed and clearly reflected in NAIC guidelines.

An insurer seeking licensure by the MDC must demonstrate an initial net worth of $1.5 million.[2] Requirements may be higher for companies writing multiple lines of insurance. Insurance companies must also submit and maintain liquid deposits of cash or securities in the amount of $500,000.[3] Specific investment restrictions and reserve requirements also apply to insurers.[4] In addition to these statutory benchmarks, the MDC evaluates the adequacy of a company's ongoing surplus and net worth using NAIC standards.

If an insurer's financial condition is impaired, several alternative courses of action are available. If the impairment has not reached a critical stage, the MDC may require the company to submit a formal plan of correction.[5] If the impairment is more severe, the MDC may initiate formal proceedings for rehabilitation or liquidation. In such cases, the MDC assumes broad powers over the affairs of the impaired company.[6] If an insurer's impairment limits its ability to perform its contractual obligations to insureds, policyholders are protected through the Life and Health Guaranty Association.[7] The Association is a nonprofit entity empowered to assess all insurers in Minnesota amounts sufficient to fulfill the remaining obligations of an impaired company.

[1]Minn. Stat. §60B.01–.61 (1988).
[2]Minn. Stat. §60A.07 (1988).
[3]Minn. Stat. §60A.10 (1988).
[4]Minn. Stat. §62A.11 (1988).
[5]Minn. Stat. §60A.111 (1988).
[6]Minn. Stat. §60A.05; 60A.051; 60A.25–.28; 60B.01–.61 (1988).
[7]Minn. Stat. §61B.01–.16 (1988).

HSPCs are subject to separate financial solvency requirements. HSPCs are required to have an initial surplus of $400,000.[8] HSPCs must thereafter maintain a surplus equal to the greater of $300,000 or two months of average claims and administrative expenses incurred in the previous calendar year. HSPCs limited to vision or dental services must maintain a surplus equal to the greater of $300,000 or 10 percent of the previous year's claims and expenses. HSPCs are not allowed to hold in surplus more that four months of incurred claims and expenses; surplus amounts exceeding this "reserve corridor" must be returned to subscribers through premium reductions or additional benefits.[9] If an HSPC's financial integrity is impaired, the MDC may require the company to submit a formal plan of correction.[10] If the impairment is serious, HSPCs are subject to state rehabilitation and liquidation provisions.[11] HSPCs participate in the Life and Health Guaranty Association.

HMOs are also subject to financial solvency requirements. At the time of initial licensure an HMO must demonstrate that it is "financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees."[12] In making this determination, the MDH may require satisfaction of net worth and working capital requirements. Arrangements with providers including hold harmless provisions and risk sharing mechanisms may also be considered.[13]

Prior to the 1988 legislative session, HMOs faced few quantitative financial requirements. Following the liquidation of two HMOs, the 1988 legislature amended these requirements to increase and quantify the financial solvency provisions applicable to HMOs. Existing HMOs are now required to maintain the greater of cash deposits equal to 33 percent of an HMO's "uncovered expenditures" for the preceding calendar year, or $500,000.[14] This requirement is phased in over two years.

The 1988 legislature also increased the net worth and working capital requirements for HMOs.[15] Net worth requirements for new organizations must equal one month's expenses or $1,500,000, whichever is greater.[16] Existing HMOs are required to increase their net worth to one month's expenses or $1,000,000, whichever is greater, and are permitted to phase in this requirement over five years.[17] In addition, HMOs must maintain a positive working capital.[18] New investment restrictions were also imposed on HMOs.[19]

Until 1988 HMOs were subject to the same rehabilitation and liquidation procedures as HSPCs and insurers. In 1988 the legislature transferred authority to initiate and conduct such proceedings from the MDC to the MDH.[20] Administrative experience with the liquidations of More HMO Plan and Health Partners demonstrated that several sections of the Insurers Rehabilitation Act were not well-suited to an HMO. As a result, the legislature provided that HMO rehabilitators and liquidators may deviate from the basic provisions of chapter 60B, where such deviation is necessary to accommodate the unique features of an HMO's structure and business.[21]

HMOs are not members of the Life and Health Guaranty Association. The 1988 Minnesota legislature created a "safety net" for HMO enrollees who lose coverage due to an HMO insolvency. In the event of an insolvency HMO enrollees may obtain MCHA policies without proof of insurability.[22] Coverage is available for ninety days in the case of individual contracts. In the case of group contracts, MCHA coverage may continue until the end of the group contract or for ninety days, whichever is longer. MCHA ex-

[8]Minn. Stat. §62C.09 (1988).
[9]*Id.*
[10]*Id.*
[11]Minn. Stat. §62C.12 (1988).
[12]Minn. Stat. §62D.04, subd. 1(e) (1988).
[13]*Id.*
[14]"Uncovered expenditures" means the costs of health care services that are covered by an HMO for which an enrollee would also be liable in the event of the organization's insolvency. Minn. Stat. §62D.041, subd. 1 (1988).
[15]"Net worth" means admitted assets, as defined in §62D.044, minus liabilities. Minn. Stat. §62D.02, subd. 15 (1988). "Working capital" means current assets minus current liabilities. Minn. Stat. §62D.042, subd. 1(b) (1988).
[16]Minn. Stat. §62D.042, subd. 2 (1988).
[17]Minn. Stat. §62D.042, subd. 3 (1988).
[18]Minn. Stat. §62D.042, subd. 6 (1988).
[19]Minn. Stat. §62D.045 (1988).
[20]Minn. Stat. §62D.18, subd. 1 (1988).
[21]Minn. Stat. §62D.18 (1988).
[22]Minn. Stat. §62D.181 (1988).

penses resulting from an HMO insolvency are shared by MCHA members through the normal MCHA assessment process.

The use of MCHA as a safety net for HMO insolvency subjects insurers, HSPCs and HMOs to the financial burden of an HMO insolvency since all health plan companies are required to be members of MCHA and share responsibility for its annual deficit. As a result, insurers and HSPCs are required to share the financial liability resulting from an HMO insolvency. Since HMOs are not members of the Life and Health Guaranty Association, HMOs do not share a reciprocal responsibility for HSPC and insurer insolvency.

Commission Recommendation

Financial Solvency

The Commission reviewed the current financial solvency requirements, the recent experience with HMO insolvencies and the 1988 amendments to the HMO Act. The Commission recommends:

The current financial solvency requirements for health plan companies should be retained. Separate rehabilitation and liquidation procedures for HSPCs and HMOs should be established.

Testimony and evidence reviewed by the Commission did not reveal any serious problems with the financial solvency regulation of insurers and HSPCs. Accordingly, the Commission concluded that the current regulation of the financial solvency of these health plan companies is adequate.

Two HMOs were declared insolvent during 1987. The 1988 legislature responded to those insolvencies by significantly increasing the deposit and net worth requirements for HMOs. Separate procedures to protect the consumer in the event of another HMO insolvency were also enacted. There have been no new HMO insolvencies during 1988. The additional protections offered by the 1988 amendments to the HMO Act provide substantial new protection for both HMOs and consumers. There is no demonstrated need to impose additional financial solvency regulation on HMOs at this time.

The Commission does recommend that separate rehabilitation and liquidation provisions be enacted for HSPCs and HMOs. The current rehabilitation law is modeled after an NAIC model act and is geared exclusively to insurers. Numerous features of an HMO's structure and business differ from insurers'. Unlike insurers, HMOs enter into contracts with providers and are statutorily responsible for the delivery of health care services to HMO enrollees. The Commission recognizes that during a rehabilitation or liquidation incentives will generally be needed to retain providers and pay providers in a timely fashion. Flexibility is needed with respect to the establishment of creditors' priorities and the ability of the rehabilitator to change premium rates, amend and assign provider contracts and transfer HMO enrollees to solvent HMOs. These and other features specific to prepaid managed care plans should be incorporated into an HMO rehabilitation and liquidation law.

B. Risk Selection and Underwriting

Overview

Under present law, only HMOs are required to participate in an annual open enrollment. This open enrollment requires HMOs to accept group enrollees without health screening or underwriting. State law requires HMOs in operation for twenty-four months to conduct an annual open enrollment period of at least fourteen days. During this fourteen-day period, an HMO must accept all otherwise eligible individuals in the order in which they apply, without regard to age, sex, race, health or economic status. Very limited underwriting restrictions are permitted for individual and non-group HMO contracts.[23]

In limited circumstances HMOs are permitted to apply to MDH for a waiver of annual open enrollment requirements and for authorization to impose underwriting restrictions. In order to

[23]Minn. Stat. §62D.10, subd. 4 (1988); Minn. Rules 4685.0100, subp. 10 (1987).

qualify for a waiver, an HMO must demonstrate that these restrictions are necessary to preserve its financial stability, prevent adverse selection or avoid unreasonably high or unmarketable premiums.[24] HMOs have rarely applied for a waiver of open enrollment or underwriting limitations.

Unlike HMOs, insurers and HSPCs may underwrite group contracts and are not required to participate in an open enrollment process. In the context of group contracts, insurers and HSPCs are permitted to health screen and impose preexisting condition limitations of up to twenty-four months on new groups and new group members.[25] HMOs are not permitted to health screen or exclude preexisting conditions in group contracts.

In addition to the underwriting restrictions imposed on HMOs, none of Minnesota's health plan companies are currently permitted to "carve out" high-risk individuals from a group contract. As a result, small employers are often unable to obtain group coverage at affordable rates. These employees often do not have access to group policies and must apply for more expensive coverage in the individual market.

Commission Recommendations

Risk Selection

The Commission's primary goal with respect to risk selection and underwriting is the expansion of health coverage to Minnesota residents. In reviewing the current underwriting and open enrollment requirements, the Commission sought to balance the needs of health plan companies to control adverse selection with the needs of Minnesota employers and employees to access the broadest possible range of health insurance options. The Commission recommends:

1. *All health plan companies should be allowed to health screen new or renewed contracts for small group business and exclude individual "high-risk" members. A small group is defined as less than fifty employees. This recommendation requires the creation of an acceptable "safety net" for excluded employees. MCHA is recognized as an acceptable safety net, provided that the current funding mechanism is changed. It is further conditioned upon the development of a common definition of "high-risk" members and an assessment against health plan companies of financial "penalties" for exclusion of "high-risk" members from a group.*

2. *When more than one health plan is offered to an employer group, all health plan companies must participate in open enrollment without underwriting restrictions. This open enrollment should apply to initial contract offerings and at least once every two years thereafter. This requirement extends only to Minnesota regions where a health plan company has a certified service area or adequate provider contracts. The current HMO waiver mechanism should be extended to all health plan companies.*

The current limitations on the ability of health plans to carve out individuals from small groups seriously disadvantages small employers and their workers. Health plan companies should not, however, be encouraged to eliminate bad risks from small groups. In order to fairly accommodate both interests, health plan companies and employers should be permitted to carve out certain high-risk individuals, provided that substantially similar coverage is available for the carved out individual through MCHA. In order to discourage employers and health plan companies from excluding individuals, a penalty will be assessed against the health plan company and the fine paid to MCHA. It is the Commission's intention that the definition of a high-risk individual include only those individuals who can actuarially be predicted to utilize health services at levels which substantially exceed normal levels.

[24] *Id.*

[25] Minn. Rules 2740.1300 (1987). A health condition will be deemed to be preexisting if the condition is diagnosed prior to the effective date of the policy and medical care and treatment was rendered or prescribed during the 90 days immediately prior to the application for the policy. Special rules apply if an insurer is a "succeeding carrier" under the carrier replacement rules. Minn. Rules 2744.0100–.0500 (1987).

Consistent with the Commission's recommendations with respect to MCHA, it is anticipated that this carve out ability will be limited to small employers of less than fifty employees. The majority of health plans experience-rate their group contracts. As a result, it is often small employers who are eliminated from the group market since even one high-risk employee in a small group may raise premiums to unaffordable levels. These employers may also be inadvertently discouraged from hiring disabled workers. In addition, since HMOs are not permitted to underwrite employer groups, HMOs frequently shy away from the small employer market.

The Commission contemplates that carved out employees will continue to participate in the company's health plan if the health plan company offering the plan is an MCHA provider. If the company's plan is not available through MCHA, the employer will purchase a "substantially similar" individual policy from MCHA. These proposals do not contemplate that the low risk members of a family with one high-risk member will also be "carved out." Family members and dependents of the "carved out" employee will continue to be covered under the employer's master group contract. The six-month preexisting condition clause for these "carved out" individuals will be waived in order to assure continuity of coverage. The Commission encourages MCHA to develop mechanisms by which HMOs and other managed care plans may be offered as MCHA products. Further analysis and description of the "carve out" proposal is set forth in the Commission's recommendations concerning MCHA.

With respect to open enrollment, the Commission concluded that open enrollment requirements should be extended to all health plans where an employer offers more than one plan. The Commission recognizes that an open enrollment process may encourage adverse selection and may be abused by employees with prior knowledge of their intent to use certain services. However, the open enrollment process also allows employees who are dissatisfied with a specific health plan to "vote with their feet." Most open enrollment changes are not the product of adverse selection. Employees may elect to switch plans due to premium increases, a change of residence or a change in marital or dependent status.

The advantages to the consumer of a mandatory open enrollment process outweigh the disadvantages to the health plan companies. Extending open enrollment to other health plan companies will increase the administrative expenses of health plan companies newly required to participate in this process. However, since HMOs are currently the only health plan company required to participate in open enrollment, the "playing field" is appropriately leveled by requiring all health plan companies to participate. Under the Commission's proposal, open enrollment must occur at least once every two years. In the alternative year, health plan companies will be free to negotiate the terms of any voluntary open enrollment process.

The extension of open enrollment to insurers and HSPCs is not intended to alter the ability of health plan companies to screen employees who have previously refused any group health coverage ("new entrants"). The Commission also recognizes that many health plans are not geographically accessible to every state resident. As a result, if the health plan company demonstrates that potential enrollees will experience insufficient geographic accessibility in certain regions, the open enrollment process should be waived for those regions.

VI

PREFERRED PROVIDER ORGANIZATIONS

Overview

Preferred provider organizations (PPOs) are a rapidly growing sector of the health insurance market. The American Medical Care Review Association (AMCRA) has estimated that approximately 535 PPOs were operational nationwide at the end of 1987.[1] AMCRA further estimates that over 40 million people currently have the option of patronizing providers who have contractually agreed to provide services to PPO plan enrollees ("preferred providers") Interstudy has reported that national surveys demonstrate dramatic membership growth in PPO plans and other hybrid alternative delivery arrangements.[2] The Legislative Auditor recently reported similar growth in PPO plans in Minnesota[3].

Preferred provider organization and preferred provider organization plan ("PPO plan") are not statutorily defined terms.[4] Nationwide, states have been slow to formally define and extensively regulate PPOs and PPO plans. These products have developed in a variety of creative formats which are difficult to strictly define. Despite the absence of a legal definition, the majority of PPO plans appear to share certain basic characteristics including: 1) a delineation between preferred and non-preferred providers; 2) the selection of preferred providers using specific criteria such as affiliation with specific hospitals or demonstration of cost conscious practice patterns; 3) the use of incentives to encourage insureds to select preferred providers, although lesser coverage is available when non-preferred providers provide care; and 4) the payment of providers on a negotiated or discounted fee-for-service basis.

Under Minnesota law neither the PPO nor the preferred providers directly assume actuarial or insurance risk. Insurance risk in a PPO plan is borne by an accident and health insurer or a self-funded arrangement.

The Current Regulation of PPOs

Minnesota enacted "pro-PPO" legislation in 1983. This legislation amended state insurance statutes to permit insurers to pay different reimbursement rates to preferred providers.[5] The legislation requires insurers underwriting PPO plans to file summary information with the MDC, in-

[1]American Medical Care and Review Association, *Directory of Preferred Provider Organizations and the Industry Report on PPO Development* (1987).

[2]*See From HMO Movement to Managed Care Industry: The Future of HMOs in a Volatile Healthcare Market,* Interstudy Center for Managed Care Research (1988) ("Managed Care Report").

[3]Office of Legislative Auditor, *Health Plan Regulation* (1988).

[4]This report will use the term "PPO" to refer to an *organization* established to develop a provider network and provide administrative and managed care services to self-insured employers and insurers. The term "PPO plan" will be used to describe the *health benefit plan* underwritten by an insurer or employer which incorporates selective contracting features.

[5]Minn. Stat. §72A.20, subd. 15 (1988).

cluding the name and address of the PPO plan, the names and addresses of preferred providers and the terms of preferred provider agreements. The MDC maintains a record of all PPO plans, including records of complaints received relating to such plans.

Insured PPO plans are not completely unregulated. Since an insured PPO product is underwritten by a licensed insurer, insurance regulation applies to insurance contracts which incorporate "PPO" features. However, certain features of PPO plans such as benefit differentials, provider contracting and reimbursement and quality assurance and utilization review activities are not the subject of current insurance regulations. As a result, many of these managed care features which are the subject of regulation when incorporated in HMO benefit plans are not equally regulated when included in insurer-sponsored PPO plans. PPO plans which are offered and underwritten by self-insured employers are not regulated by the state; direct state regulation of these products is preempted by ERISA.

The absence of managed care regulation of PPO plans has raised concerns relative to consumer protection and regulatory parity. From the consumer's vantage point, a PPO plan may be virtually indistinguishable from an HMO plan. Although HMO products were initially "closed panel" arrangements, the development of "combination" or "wrap-around" plans allows HMO enrollees to select nonparticipating providers and receive insurance reimbursement after satisfaction of deductibles and payment of co-insurance. These cost sharing features are similar to the benefit differentials used by PPOs to encourage insureds to receive care from preferred providers.

The majority of PPO plans also incorporate many of the utilization review and cost containment features typically seen in HMO products, including preadmission certification and concurrent review.[6] Similarly, both HMOs and PPO plans provide care through a panel of providers and monitor physician practice patterns.[7] These and other managed care features have led at least twenty-five other states to develop additional insurance regulation specific to PPO plans.[8]

Commission Recommendation

PPO Plans

The Commission reviewed the various regulatory strategies pursued by other states, including the National Association of Insurance Commissioners (NAIC) Preferred Provider Arrangements Model Act. The Commission noted that the MDC has drafted and circulated proposed PPO rules. The Commission recommends:

The MDC should formally adopt administrative rules governing the operation of PPO plans which establish limits on benefit differentials and incorporate the consumer disclosure requirements contained in the NAIC Preferred Provider Arrangements Model Act.

The Commission supports the continued development of PPO plans. The availability of PPO plans provides an attractive alternative to consumers and enables insurers to incorporate various "managed care" features into traditional insurance products. Any regulatory scheme developed for PPO plans should be flexible and attempt to accommodate the variety of PPO products currently in the market.

The Commission is primarily concerned with the use of large benefit differentials which effectively create a "closed panel" or exclusive provider organization (EPO) and adequate consumer disclosure of the terms and conditions of PPO plan coverage. The MDC should establish reasonable benefit differential limits which will enable a PPO plan to effectively "channel" insureds to preferred providers without substantially limiting access to providers. The majority of states which have established differential

[6]Minnesota Coalition on Health, *Purchasers' Guide to Managed Health Care* (1988) ("Purchaser Guide").
[7]*Managed Care Report* at 26.
[8]Rolph, Elizabeth, et al., *State Laws and Regulations Governing Preferred Provider Organizations*, The Rand Corporation (1986) ("Rand Study").

limits have prohibited differentials in excess of twenty to twenty-five percent.

PPO rules should also establish consumer disclosure requirements. Consumers should be informed of the distinction between preferred and nonpreferred providers, differentials in benefit levels when health care services are obtained from preferred and nonpreferred providers and an explanation of the differences in deductibles, copayments and maximum out-of-pocket expenses.

Recommendations of the Commission in other areas will impact PPOs and PPO plan regulation. With respect to quality assurance, the Commission recommends that all health plan products be subject to quality assurance requirements (*see Quality of Health Care,* Chapter III(A)). The type and degree of such requirements is contingent on the degree of provider risk sharing, access limitations and other plan features. The Commission also recommends that insurers be allowed to engage in provider risk sharing with respect to non-HMO products, provided that such products are subject to appropriate quality assurance regulation (*see Product Diversification,* Chapter IV(A)). As a result, quality assurance regulation may be extended to certain PPO plans, commensurate with the degree and type of provider risk sharing and access limitations.

The Commission further recommends that the MDC or MDH develop an urgent care process and a process for determining coverage of new and emerging technology (*see New and Emerging Technology,* Chapter III(B)). These review processes will also apply to insured PPO products.

Finally, although direct state regulation of self-insured plans is preempted by ERISA, the Commission recommends that the Minnesota legislature pursue the "managed care certification" of PPOs and other companies which provide managed care services to self-insured plans (*see Managed Care Certification and Self-Insured Plans,* Chapter IV(B)). The implementation of this recommendation may subject some PPOs to new state regulation.

VII

THE MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION

Overview

The Minnesota Comprehensive Health Association (MCHA) was created in 1976, as part of the Minnesota Comprehensive Health Association Act.[1] MCHA is a risk pool for individuals who have chronic medical conditions which cause insurers to refuse coverage. These individuals are commonly referred to as the medically uninsurable.

Minnesota residents are eligible to enroll in MCHA if they have been rejected by a carrier within six months of their MCHA application. Individuals who have been offered policies with restrictive riders or preexisting condition limitations, or who are suffering from certain "presumptive conditions" are also eligible for coverage. A six-month waiting period applies to the majority of MCHA contracts. Premiums are generally capped at a maximum of 125 percent of the average rate charged by the five largest insurers.[2] In recent years, the MDC has not allowed MCHA to charge the 125 percent premium maximum.

Although MCHA was originally established as a high-risk pool for the medically uninsurable, the categories of individuals eligible for MCHA coverage have expanded in recent years to include individuals who are not medically uninsurable. These new categories include individuals who lose coverage under Medicare supplement policies for reasons other than nonpayment of premiums,[3] individual policyholders who are not provided with "replacement coverage"[4] and individual and group enrollees of an insolvent HMO.[5] These categories of enrollees are not subject to the six-month preexisting condition exclusion.

MCHA is organized as a Minnesota nonprofit corporation and operates under the direction of the MDC. MCHA is administered by a licensed carrier selected by the Board of Directors after a competitive bidding process. Insurers, fraternals, health service plan corporations and HMOs are required to maintain membership in the Association. These "contributing members" are required to share MCHA's annual losses in amounts equal to the ratio of each member's total Minnesota health insurance premiums to the total Minnesota health premiums received by all "contributing members." Although self-insured employers provide approximately 35 percent of the total health coverage in Minnesota, self-insured employers are exempt from direct MCHA assessments pursuant to ERISA's preemption clause.[6]

[1]Minn. Stat. §62E.10–.18 (1988).

[2]Minn. Stat. §62E.08 (1988).

[3]Minn. Stat. §62E.14, subd. 4 (1988).

[4]Minn. Stat. §62E.14, subd. 6 (1988).

[5]Minn. Stat. §62D.181 (1988).

[6]*See St. Paul Electrical Workers Welfare Fund v. Markham*, 490 F. Supp. 931 (D. Minn. 1980).

Prior to 1987, HSPCs and HMOs were not subject to MCHA assessments; only insurers were classified as "contributing members". Insurers were allowed to offset their MCHA assessment against their premium tax liability. In 1987 the premium tax offset was repealed and HMOs and HSPCs were included within the definition of "contributing members." Based on the most recent premium information available (1986), the percentage of premiums for the various health plan companies is approximately: HMOs—50 percent; Blue Cross and Blue Shield of Minnesota—15 percent; health insurers—35 percent.

MCHA is the largest high-risk pool in the nation. According to a recently released report from the General Accounting Office (GAO), Minnesota's risk pool has the largest enrollment and has experienced the greatest losses.[7] From the end of 1983 through June, 1988, the number of MCHA contracts doubled from 6,043 to 12,293.[8] The 1987 incurred claim ratio was 192 percent; this yielded an operating loss of $11,280,000—the highest operating loss in the history of MCHA.[9] A $12,000,000 deficiency is projected for fiscal year 1988.

MCHA assessments are passed directly to consumers in the form of higher insurance premiums. Since self-insured employers are not subject to the MCHA assessment, enrollees of self-insured plans do not experience similar increases in premium rates. This inequity places small employers who are not able to self-insure at a distinct disadvantage. The financing of MCHA deficits by health plan companies alone also adversely impacts Minnesotans who purchase individual products. Individual coverage is often significantly more expensive than group coverage; this additional expense is compounded by the MCHA assessment.

The MDC is required to report to the Legislature, in consultation with the Commission, on the current means utilized to finance the annual operating deficits incurred by MCHA, the financial impact of the current deficits on MCHA's contributing members and recommend alternative sources of funding the operating deficit.[10] Of the fifteen states surveyed in the GAO report, twelve states share operating deficiencies among risk pool members. One state funds its pool from general revenues, one state funds deficits through a tax on hospital revenues and one state uses a combination of general revenues and member assessments.[11]

MDC Report to Legislature

In accordance with the legislative mandate, the MDC consulted with the Commission concerning its recommendations. These recommendations are designed to mitigate the serious access to health insurance problems experienced by small employers who employ a high-risk individual, provide a "safety net" to Minnesota residents who exceed the lifetime maximum of their benefit contract and provide a more equitable funding base for MCHA.

1. Small Employer Carve Out

The majority of health plans experience rate employer group coverage. In recent years the competitive nature of the insurance market, combined with the rising cost of new medical technology, has produced higher premiums and more restrictive underwriting practices. Small employers are increasingly unable to afford health coverage if they have one or two high-risk group members.

Small employers have also found it difficult to obtain *any* health coverage if their group contains one high-risk individual. Small group products are not as profitable as other lines of business. As a result, fewer small group products are available for purchase by small employers. Consequently, small employers may arrange for individual health benefit plans for their employees. These products are often more expensive than group coverage and may be unavailable to employees with preexisting health conditions.

Unaffordably high premiums or inability to obtain any health coverage penalizes small employers who hire high-risk individuals, as well

[7] *See Health Insurance: Risk Pools for the Medically Uninsurable*, General Accounting Office, Human Resources Division (1988) (GAO Report).

[8] Report to Commission on Health Plan Regulatory Reform from Minnesota Comprehensive Health Association (1988).

[9] *Id.*

[10] 1988 Minn. Laws ch. 612, §28.

[11] *GAO Report* at 16.

as the other healthy members of the employer's group. Since the majority of Minnesota's business establishments have less than 100 employees,[12] the lack of small employer access to health insurance caused by the presence of high-risk individuals creates serious access problems for many Minnesota residents.

In order to remedy this problem, MDC recommends that small employers be permitted to carve out high-risk individuals from their group contracts and purchase substantially similar individual coverage for the carved out individual through MCHA. MCHA's preexisting condition clause will be waived for carved out individuals. MCHA's Board of Directors will establish "carve out" eligibility criteria. These criteria will assure that small groups properly benefit from this flexibility without permitting an improper influx of MCHA enrollees who are more appropriately underwritten by the regular health insurance market.

2. Safety Net for Seriously Ill Individuals

Minnesota law currently requires that the minimum lifetime maximum which may be incorporated into a benefit contract is $500,000. HMOs are not permitted to impose any lifetime maximum. Self-insured plans have no minimum requirement. Although the vast majority of individuals will never reach the lifetime maximum of their benefit contract, the rapid expansion of expensive technology will result in the exhaustion of the $500,000 maximum for certain classes of insureds such as technology dependent children. Under current law, these individuals are eligible for MCHA coverage but are subject to the six-month preexisting condition requirement.

The MDC recommends that MCHA be used as a "safety net" for individuals who exhaust their lifetime benefits. Under the MDC proposal, these individuals will be automatically accepted by MCHA and will not be subject to the six-month preexisting condition waiting period.

[12]*See* Minnesota Comprehensive Health Association Report to the Minnesota Legislature from the Minnesota Department of Commerce (1988) (MDC MCHA Report).

3. Expanded Funding Base for MCHA

The small employer carve out and the use of MCHA as a safety net for seriously ill individuals are contingent on the expansion of the funding base for MCHA. MCHA's deficits are currently funded by commercial insurers, health service plan corporations and HMOs. These deficits have been substantial in recent years and have resulted in year-end loses for many health plan companies. These losses are ultimately borne by consumers who purchase insured products. Large employers have the option of self-insurance, thereby avoiding the additional costs associated with the MCHA assessment. Only employers and individuals who purchase insured products are forced to absorb these additional costs.

The MDC recommends that the funding base of MCHA be expanded through an assessment of all Minnesota employers. This assessment will apply regardless of whether an employer offers health benefit coverage. The MDC estimates that an employer assessment will amount to a $.50 employee assessment per month based on the 1986 MCHA assessment of a $10,000,000 deficit.[13]

Commission Recommendation

MCHA

MCHA serves an important role in the provision of health insurance for Minnesota residents. In recent years the categories of individuals eligible for MCHA coverage have been expanded beyond the medically uninsurable to include senior citizens who lose Medicare supplement coverage, individuals lacking HMO replacement coverage and HMO insolvency coverage. The MDC proposals include further expansion of MCHA to include "carved out" employees and seriously ill individuals who have exhausted the lifetime maximum of their benefit contract. The continued use of MCHA as general "safety net" requires a redistribution of MCHA's funding obligations. The Commission recommends that:

[13]MDC MCHA Report at 19.

1. *Employers with less than fifty employees be permitted to carve out individuals at the time of initial offering of coverage or at annual renewal, provided that these individuals meet MCHA eligibility criteria and;*

2. *MCHA be used as a safety net for those individuals who exceed the lifetime maximum of their benefit contract, provided that;*

3. *The funding base of MCHA is expanded. The Legislature should consider the advantages and disadvantages of an employer assessment. Additionally,*

4. *MCHA benefit plans should provide affordable coverage and incorporate appropriate cost containment procedures and features;*

5. *Mechanisms should be developed to provide continuity of care in the event of transition to and from a MCHA policy.*

The Commission's support of the MDC recommendation concerning the small employer carve out is consistent with the Commission's conclusions regarding risk selection. With respect to risk selection, the Commission recommends that all health plan companies be permitted to underwrite and health screen small groups of less than fifty employees and exclude high-risk members (*see Risk Selection,* Chapter V(B)). The small employer carve out will enable small employers who are currently unable to obtain health insurance due to the presence of one or more high-risk individuals in the employer's group to purchase a group product for the remainder of their employees. The Commission supports the MDC recommendation that MCHA develop stringent criteria in order to appropriately limit the number of individuals eligible for "carve out" coverage.

The recommendation concerning seriously ill individuals is consistent with the Commission's conclusions concerning lifetime maximums (*see Lifetime Maximums Mandates,* Chapter II(D)). The Commission recommends that all health plan companies be permitted to establish some limitations on contract liability, particularly in extremely high cost cases. Public policy requires that the cost of underwriting these cases be spread among the widest possible funding base. When the benefit limits of the contract have been exhausted, MCHA will become the responsible payor. The shifting of financial responsibility to MCHA will enable health plan companies to better absorb the cost of these cases, while providing continuity of care to individuals who would otherwise be subject to a six-month exclusion period under current MCHA requirements.

The implementation of any further expansion of MCHA, including the small employer carve out and the safety net for seriously ill individuals, is contingent on expansion of MCHA's funding base. MCHA is the largest risk pool in the United States and continued enrollment growth is predicted. The premium tax offset for accident and health insurers has been repealed. Due to the combined market share of HMOs and Blue Cross and Blue Shield of Minnesota, nonprofit organizations with limited sources of capital must absorb almost 70 percent of MCHA's rapidly growing deficits. These deficits undermine the financial stability of these organizations and result in higher premiums which must be absorbed by individuals and employers who do not self-insure their benefit plans.

The MDC and the Commission explored a variety of funding sources including the use of general revenues, an employer assessment and a medical services tax. A medical services or hospital bed tax was rejected as inequitable since it would require the sickest individuals to support MCHA's deficits. General revenue funding was rejected due to its lack of reliability. State revenues fluctuate from biennium to biennium. Experience with the Minnesota Catastrophic Health Expense Protection Act (CHEPP)[14] supports the need for a dedicated and reliable source of funding. The CHEPP program was enacted at the same time as the MCHA legislation. CHEPP was consistently underfunded by the legislature and finally completely defunded in 1981. Despite the lack of funding for almost eight years, the CHEPP program has not been repealed. The existence of the CHEPP program without adequate funding creates an expectation of "entitlement" on the part of some Minnesota residents. Similar problems may arise by the use of general revenues to support the MCHA operating deficits.

[14]Minn. Stat. §62E.51–.55 (1988).

The majority of Minnesota residents receive health insurance through their employer. An employer assessment is the most fair and equitable method of redistributing the cost of providing health care for some of Minnesota's most vulnerable residents. This assessment will be imposed regardless of whether an employer offers health insurance. An employer assessment will enable MCHA's operating deficits to be spread across all employers. Minnesota health plan companies will no longer be forced to absorb these large and often unpredictable losses and pass these expenses along to employers and individuals who purchase insured products.

Although it is imperative that the funding base of MCHA be expanded, it is equally important that MCHA continue to improve cost control mechanisms. MCHA currently uses pre-admission authorization and concurrent review of hospital stays. The 1988 legislature authorized the MDC to grant MCHA the power to implement a provider payment schedule. The Commission recognizes that MCHA is a statewide program which must be available in each of Minnesota's eighty-seven counties. Notwithstanding the difficulty of implementing cost containment mechanisms on a statewide basis, the Commission recommends that MCHA continue to develop and implement additional forms of cost containment. MCHA may wish to consider extending utilization review mechanisms to certain forms of outpatient treatment and the use of other managed care tools where appropriate.

The use of MCHA as a safety net and as a coverage option for individuals carved out of an employer group contracts will result in increased transition in and out of MCHA. Since high-risk individuals generally have significant health care needs, it is essential that mechanisms be developed to ensure continuity of care when these high-risk individuals transfer to MCHA. The Commission recommends that MCHA develop a strategy for providing continuity of care when these high-risk individuals become eligible for MCHA coverage. These mechanisms may include shifting the risk of loss to MCHA while continuing to allow an MCHA enrollee who has been carved out of a small employer group plan to receive care through the same managed care delivery system.

VIII

STATE AGENCY RESPONSIBILITY FOR HEALTH PLAN REGULATION

Overview

Minnesota divides the regulation of health plan companies between two state agencies. The MDC regulates the activities of HSPCs and accident and health insurers; the MDH regulates the activities of HMOs. The existing division of regulatory responsibility is reflected in Figure 8.1.

The historical reasons for this division of labor reflect the history of the development of health insurance. Initially established during the Depression before the advent of commercial health insurance, Blue Cross and Blue Shield Plans pioneered the introduction of health benefit coverage. When the Blues' experience demonstrated the demand for health coverage and the possibility of profitability, insurance companies began to develop health insurance as a separate line of business.

State insurance regulation began in the 1800s and has traditionally been located in a "Department of Insurance." State insurance regulation of other insurance products such as property and casualty insurance was relatively well developed by the time health insurance products were created. Since state regulation has traditionally been based on the license of the entity selling the product, insurance departments naturally assumed responsibility for regulating this new line of business.

Although different in concept and operation, Blues' plans were perceived by state regulators as similar to their insurance company counterpart. Across the country Blues' plans were established under special state legislation and were tax exempt. This special legislation generally subjected Blues' plans to more extensive regulation than that of commercial carriers. The regulation of HSPCs is typically located within state insurance departments.

HMOs did not flourish until Congress enacted the HMO Act of 1973. HMOs have traditionally differed from both commercial insurance and HSPCs. HMOs are responsible for both the financing and delivery of health care. HSPCs and insurers have traditionally been responsible only for the payment of claims.

The combined responsibility of financing and medical care delivery resulted in more intensive state regulation of HMOs. HMOs are required to operate quality assurance systems and must demonstrate the capability of providing care in each geographic "service area." This emphasis on medical care delivery justified placing state regulation of HMOs with the MDH.

The development of managed care has resulted in the use of provider networks, access restrictions, utilization review systems and provider risk sharing by entities other than HMOs. From the consumers' vantage point, PPO

products offered by insurers, HSPC products and HMO wrap-around products may be virtually indistinguishable. As insurers, HSPCs and HMOs continue to develop similar products, the different approaches to regulation exemplified in the separate enabling statutes create regulatory and competitive inequity.

Throughout this report, the Commission has emphasized the importance of eliminating "accidental" and unnecessary regulatory and competitive inequities. Consistent with this theme, the Commission has recommended that all companies be permitted to offer all types of health plan products, that similar products be subject to similar quality assurance and consumer complaint regulation, that all companies be permitted to engage in provider risk sharing and provider selection based on relevant criteria and that all companies be required to participate in open enrollment.

Implementation of these recommendations under the current regulatory structure will be difficult and involve unnecessary duplication of effort. The development of expertise and regulation in the areas of managed care and financial stability by two state agencies is inefficient and will likely result in divergent and contradictory approaches to similar issues. As a result, if the regulatory status quo is maintained each type of health plan company will face a different state agency and dissimilar regulation with respect to similar products and activities.

Commission Recommendation

State Agency Responsibilities

Each agency has a legitimate role in health plan regulation. It is important that each agency be free to exercise its regulatory authority independent of the other. The Commission recommends:

The MDC and the MDH should develop a plan for the functional division of regulatory authority. This proposal should be submitted to the 1991 legislature as part of the biennial budget process and should be premised on the following general principles:

1. *Each agency has a legitimate role in health plan regulation. The primary jurisdiction of the MDC should be financial and corporate; the primary jurisdiction of the MDH should be access to health care services and issues of medical care;*

2. *Each agency should exercise its authority independently of the other to the extent possible; overlap in jurisdiction should be avoided.*

During preliminary discussions between the Departments of Health and Commerce, the agencies have concluded that a functional regulatory approach may require that the MDC be the licensing agency for all companies. Under this functional approach the MDC may be responsible for issues of corporate governance, financial solvency, underwriting, rate review, consumer complaints in indemnity plans, claims processing, management agreements between nonprofit health plan companies and for-profit management companies and TPA licensing.

The MDH would be responsible for issuing a "certificate of authority" for all managed care plans, determining provider network issues, including service area certifications and provider contract approval, quality assurance systems, prior authorization and other utilization review issues, consumer complaints relating to questions of medical necessity, experimental technology and urgently needed services and access to services. Under this functional regulatory scheme, the MDH will issue a "certificate of authority" certifying that any managed care plan satisfies its independent standards and review. The proposed division of regulatory authority is reflected in Figure 8.2.

Preliminary discussions between the Departments indicate that a functional regulatory approach will be a complex undertaking. Under this approach it is quite likely that all health plan companies will be subject to regulation by both agencies. However, a functional approach allows all companies to benefit from the unique expertise developed by each agency. Medical care issues

Figure 8.1

Existing Division of Regulatory Responsibilities Between MDH and MDC

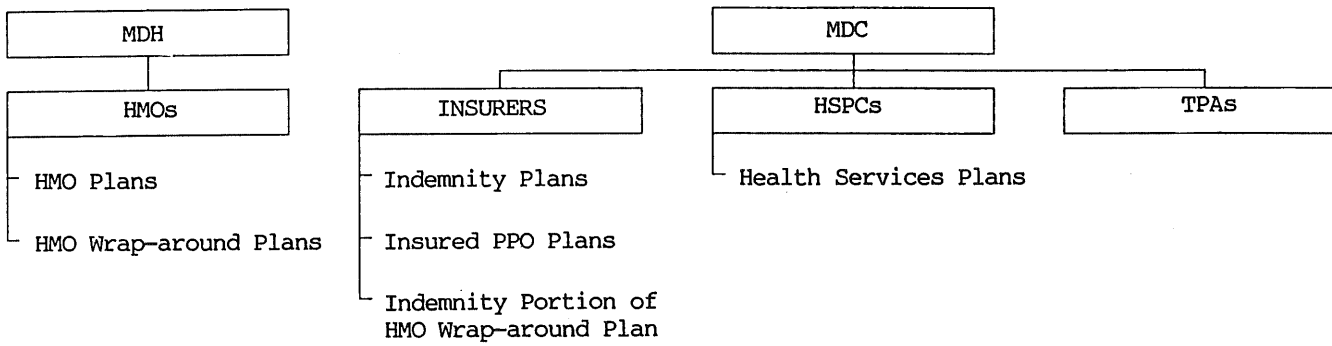
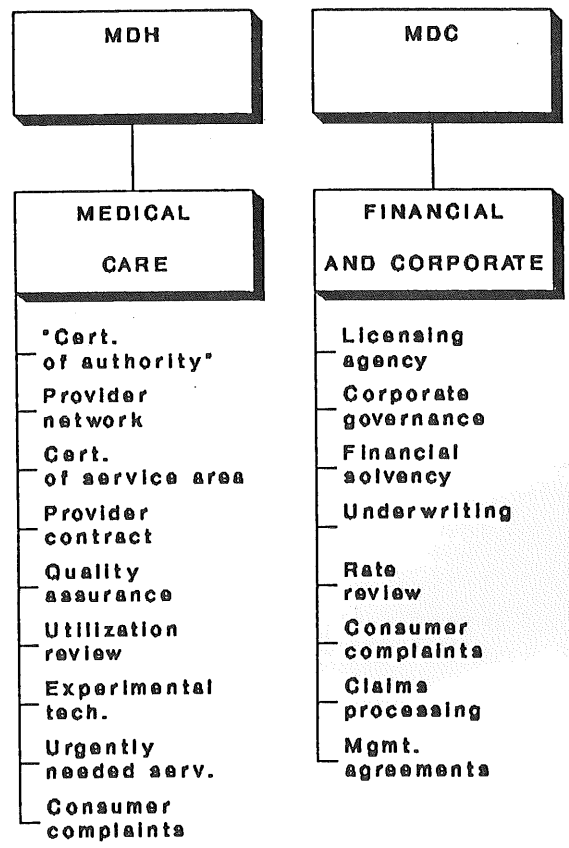


Figure 8.2

Proposed Division of Regulatory Responsibilities Between MDH and MDC



are more appropriately resolved by the MDH; financial solvency questions should be decided by the MDC.

The recommendation outlined above will require extensive development and refinement before implementation. Numerous questions remain to be resolved such as the regulation of benefit contracts—a subject which involves issues in each agency's jurisdiction under the proposed division. Both state agencies intend to work closely with the health plan companies to develop a division of labor which is not unduly burdensome to the companies required to function under their respective regulatory authorities.

IX

SUMMARY

Minnesota is a recognized leader in the development of managed care and health plan regulation. Future regulation must continue to change and respond to evolving marketplace conditions and consumer preferences. A stagnant and unresponsive regulatory climate is harmful to consumers, employers, providers and health plan companies. Health plan regulation must continue to provide adequate protection to consumers. It is equally crucial that future health plan regulation facilitate rather than impede increased access to health care and health insurance.

Health plan regulation is exceedingly complex. Virtually all health plan regulation impacts the cost, quality and availability of health care. Regulatory requirements initially viewed as separate and autonomous are often highly interdependent. Quality assurance regulation is closely related to access limitations and provider risk sharing arrangements designed to control costs. Mandated benefit laws improve access to specific benefits and frequently increase the overall cost of health care, thereby potentially pricing certain individuals out of the health insurance market. Requirements related to the corporate structure of health plan companies may ultimately limit product diversification and consumer choice.

Future statutes and administrative rules must identify and balance the impact of regulation on health care access, cost and quality. Competitive equity requires that health regulation be applied equally to similar products. Future regulation should be fair, flexible and reflect a thorough understanding of the interdependence of cost, quality and access regulation. Until such time that the federal government enacts a comprehensive health insurance system, Minnesota and other states must continue to develop regulatory programs which support our private health insurance system and improve access to health care for all Minnesotans.

GLOSSARY OF TERMS

1. **Adverse Selection**—the tendency of individuals who are most likely to need medical care to seek insurance coverage for that service. Adverse selection is a recognized obstacle in the efficient operation of insurance markets and results from the unequal distribution of information between the insured and insurer.

2. **COBRA Coverage**—a federal requirement that group enrollees be allowed to continue their enrollment in an employer's group, following a change in circumstances that would otherwise result in the cessation of health plan coverage.

3. **Combination or Wrap-around Plans**—a benefit plan offered by HMOs whereby an indemnity policy is "wrapped around" or "combined" with an HMO policy to allow HMO enrollees to obtain health care from non-HMO providers.

4. **Community Rating**—a requirement that federally qualified HMOs establish premiums in accordance with approved actuarial factors.

5. **Competitive Medical Plan**—a state licensed legal entity which enters into a Medicare risk contract to provide services to Medicare enrollees. CMPs are accorded greater flexibility in the design of benefit packages than federally qualified HMOs.

6. **Copayment**—a set dollar amount or percentage of covered expenses that an insured is required to pay under a health benefit plan.

7. **Deductible**—a set dollar amount which an insured must pay or "satisfy" before health plan coverage is effective.

8. **Disease and Treatment Mandates**—state laws requiring health plan companies to provide coverage for specific treatments or the costs associated with specific diseases.

9. **ERISA Preemption**—the preemption by ERISA of state laws relating to an employee welfare benefit plan.

10. **Health Benefit Plan**—a generic term used throughout this report to include an indemnity policy (issued by insurers), a subscriber contract (issued by a health service plan corporation) and a certificate of coverage (issued by HMOs).

11. **Health Maintenance Organization**—a nonprofit Minnesota corporation providing comprehensive health care to enrollees on a fixed and prepaid basis, without regard to the frequency or extent of services.

    Staff model HMO—an HMO that delivers health services primarily through physicians employed by the HMO.

Group model HMO—an HMO that delivers health services primarily through a single independent group practice.

IPA model HMO—an HMO that delivers health services primarily through contracts with independent practitioners.

Network model HMO—an HMO that delivers health services through contracts with two or more independent group practices.

12. **Health Plan**—a generic term used to refer to a particular product offered by a health plan company. For example, Blue Cross and Blue Shield of Minnesota, a health service plan corporation, offers the Aware Gold health plan.

13. **Health Plan Company**—a generic term which includes accident and health insurers, health service plan corporations and HMOs.

14. **Health Service Plan Corporation**—a nonprofit Minnesota corporation providing health services to subscribers in exchange for periodic prepayments.

15. **Insured**—a generic term used to refer to individuals covered under indemnity policies, subscriber contracts or health maintenance contracts.

16. **Insurer**—a corporation, association or business trust licensed to indemnify persons against loss from specified causes. Throughout this report, the term "insurer" is used to refer to those insurance companies licensed in Minnesota to sell accident and health insurance.

17. **Lifetime Maximum**—the maximum dollar amount of benefits which a health benefit plan will provide during the lifetime of the insured.

18. **Maximum Out-of-Pocket**—the maximum annual amount that an insured must pay for health care expenses covered under a health benefit plan.

19. **Moral Hazard**—a principle of health economics which recognizes that the presence of insurance reduces the care taken by the insured to avert the hazard.

20. **Open Enrollment**—a state law requirement that HMOs in operation for more than two years "open" their enrollment to all group enrollees for at least 14 days each year, during which time otherwise eligible individuals must be accepted by the HMO without regard to health status.

21. **Participating Provider**—a provider who has entered into a contractual relationship with a health plan company and therein agreed to abide by certain requirements of the health plan company as a condition to reimbursement.

22. **Preferred Provider Organization Plan**—a selective contracting arrangement whereby insurers or self-insured entities contract with individual providers or an organized provider network (PPO) for the provision of health care services.

23. **Prospective Payment System**—a standardized payment system implemented in 1983 by Medicare whereby certain institutional providers receive a fixed amount of reimbursement based on the diagnosis of the patient.

24. **Provider Mandates**—state laws requiring insurers and health service plan corporations to directly reimburse certain allied health professionals and institutional providers for services provided to an insured or subscriber under a health benefit plan.

25. **Qualified Plan**—a health benefit plan offered by an insurer or health service plan corporation which satisfies specific statutory requirements and is approved by the MDC as a qualified plan. An HMO contract of coverage is statutorily "deemed" a qualified plan.

26. **Self-insurance Plan**—a health plan providing medical, hospital, accident, sickness

or disability insurance as an employee fringe benefit, which is not directly insured by an insurer, health service plan corporation or HMO.

27. **Third Party Administrator**—any entity which administers, for compensation, a plan of self-insurance.

28. **Utilization Review**—a system of cost control used by insured and self-insured health plans. Utilization review programs include pre-admission certification, concurrent review and retrospective review.

GLOSSARY OF ACRONYMS

1. **AAAHC**—Accreditation Association for Ambulatory Health Care.
2. **ADS**—Alternative Delivery System.
3. **AMCRA**—American Medical Care Review Association.
4. **ASO**—Administrative Services Only.
5. **CMP**—Competitive Medical Plan.
6. **COBRA**—Consolidated Omnibus Reconciliation Act of 1985.
7. **DRGs**—Diagnosis Related Groupings.
8. **EPO**—Exclusive Provider Organization.
9. **ERISA**—Employee Income Retirement Security Act of 1974.
10. **FDA**—United States Food and Drug Administration.
11. **HCFA**—Health Care Financing Administration.
12. **HMO**—Health Maintenance Organization.
13. **IOM**—Institute of Medicine
14. **IPA**—Independent Practice Association.
15. **IRC**—Internal Revenue Code.
16. **JCAHO**—Joint Commission on Accreditation of Healthcare Organizations.
17. **MCHA**—Minnesota Comprehensive Health Association.
18. **MDC**—Minnesota Department of Commerce.
19. **MDH**—Minnesota Department of Health.
20. **MEP**—Mandate Evaluation Process.
21. **MET**—Multiple Employer Trust.
22. **MEWAs**—Multiple Employer Welfare Arrangements.
23. **NAHMOR**—National Association of HMO Regulators.
24. **NAIC**—National Association of Insurance Commissioners.
25. **NIH**—National Institutes of Health.
26. **OHTA**—Office of Health Technology Assessment.
27. **OPHC**—Office of Prepaid Health Care, United States Department of Health and Human Services.
28. **OTA**—Office of Technology Assessment.
29. **PPO**—Preferred Provider Organization.

30. **PPS**—Prospective Payment System.

31. **PROs**—Peer Review Organizations.

32. **TPA**—Third Party Administrator.

APPENDIX A

Public Testimony

The following organizations and individuals provided public testimony to the Commission (in alphabetical order):

Dr. John Allenburg
Minnesota Chiropractic Association

American Diabetes Association

Allyson Ashley
Department of Human Services
Mental Health Division

Paul Begich
Chiropractic Association

Peter Benner
AFSCME

Leslie Blicker
Community Clinic Consortium

Jan Buelow
Minnesota Association of Community Health Services

Allen Cohen
Consumer

Betsy Cole
Quality Tool Inc.

Bill Conley
Minnesota Mental Health Association

Mary Beth Curry
Minnesota Hospital Association

John Doman
Minnesota Council of Child Caring Agencies, Inc.

Pastor James Engel
Representing the chiropractic profession

Karin Hangslaben
American College of Nurse Midwifes
Minnesota Chapter

Don Hansen
Precise Products Corp.

Michael A. Hatch, Commissioner
Minnesota Department of Commerce

Mike Hickey
National Federation of Independent Businesses

Insurance Federation of Minnesota

Interstudy

Gail A. Jensen, Ph.D.
School of Public Health and
Department of Economics
University of ILlinois, Chicago

Ellen Joseph
Clear Corporation

Dr. Howard Juni
Minnesota Pharmaceutical Association

Judith Kahn, M.S.W.
Pathfinders

Becky Kajander
Representing nurse practitioners

Greg Lindberg
Hennepin County Office of Planning and Development

Susan Margenau
Minnesota Board on Aging

Duane F. McDonald, D.D.S.
Minnesota Dental Association

Minnesota Comprehensive Health Association

Minnesota Medical Association

Metropolitan Senior Federation

John F. Murphy
Minnesota Chamber of Commerce and Industry

Bobb Murray
Consumer

Gretchen Musicant
Minnesota Nurses' Association

Harold and Shirley Myrmel
Consumers

Luanne Nyberg
Children's Defense Fund of Minnesota

Judith Popp-Anderson
Minnesota Association of Treatment Programs

James C. Reinertsen, M.D.
Park Nicollet Medical Center

Joseph L. Rigatuso, M.D.
Minnesota Medical Association
Subcommittee on Medical Services
Council on Medical Practice and Planning

Paul Sanders, M.D.
Minnesota Medical Association
Board of Trustees

Dominic Sposeto
Optometric Association and
Dental Association

Robert J. Steil
Health Insurance Association of America

Dr. Dan Whitlock
Children's Home Health Care Task Force—
Minneapolis Children's Medical Center

Kevin Wilkins
Employers Association, Inc.

Patricia Winget
MedCenters Health Plan

Dr. Richard Zarmbinski
Representing the chiropractic profession