Administration

MANAGEMENT
ANALYSIS DIVISION

REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

JANUARY 1993

Pursuant to 1992 Laws, Chap 549, Article 1, section 18

Minnesota Department of Health
717 Delaware Street Southeast
P.O. Box 9441
Minneapolis, MN 55440-9441
(612) 623-5000

January 25, 1993

The Honorable Arne Carlson
Governor
130 State Capitol Building
St. Paul, Minnesota 55155

Patrick E. Flahaven
Secretary of Senate
231 State Capitol Building
St. Paul, Minnesota 55155

Edward A. Burdick
Chief Clerk, House of Representatives
211 State Capitol Building
St. Paul, Minnesota 55155

Dear Gentlemen:

Pursuant to Laws of Minnesota 1992, Chapter 549, Article 1, Section 18, the commissioners of health and commerce have completed a joint study of the regulation of health maintenance organizations. The commissioners contracted with the Management Analysis Division of the Department of Administration to conduct the study and to prepare the report. The results of the study, including a consensus plan prescribed in the law, are contained in the enclosed report.

Sincerely,

Bert McKasy
Commissioner of Commerce

Marlene E. Marschall
Commissioner of Health

Enclosure

REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

Minnesota Department of Administration
Management Analysis Division
January 1993

203 Administration Building 50 Sherburne Avenue St. Paul, MN 55155

To obtain these materials in Braille, audiotape, large print or other forms, call

Kim Renstrom
(612) 296-7058 or TDD Relay (612) 297-5353

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INTRODUCTION

Health care financing and delivery systems in the state and nation are under considerable stress. The issues of cost containment, access to care, quality of care, and the financial stability of health care plans are key among current concerns. The health care industry is making dramatic adaptations to meet the needs of the marketplace. Simultaneously, recent state legislation, including MinnesotaCare (formerly HealthRight), and potential changes that could result from presidential and congressional action may substantially alter the marketplace.

Regulation of health plans

State regulation of health care plans seeks to monitor and improve cost containment, quality of care, access to care, and health plan solvency. One aspect of health care regulation is the configuration of regulatory responsibilities among the state agencies that regulate health plans. The chief regulators of health plans, including health maintenance organizations (HMOs), are the Minnesota departments of Health and Commerce.

HMOs are nonprofit Minnesota corporations that provide comprehensive health care to their enrollees on a prepaid, fixed-cost basis that is not dependent on the frequency or extent of services provided. They are regulated primarily under Chapter 62D of Minnesota Statutes by the Department of Health.

The respective roles of the departments of Health and Commerce have been examined periodically by the legislature. Among reasons for the reviews is concern that the marketplace has been changing substantially while regulation has not kept pace. Another concern is that the specialized expertise of the two departments — in financial regulatory matters for Commerce, and in health-care-related issues for Health — could be better applied under a different configuration of regulatory responsibilities.

Historically, insurance (indemnity) products, including accident and health policies, have been regulated by the Department of Commerce. Health insurance was seen as essentially a financing mechanism for the provision of health care. In contrast, since their creation in 1973, HMOs were seen to represent a special category of health plan that incorporated aspects of "managed care." That is, HMOs combined health care delivery with health care financing. HMOs, it was hoped, would help to contain costs while providing quality health care and access. The tradeoffs inherent in this combination, and the need for expertise in the regulation of health care delivery, made it seem appropriate that a health agency regulate HMOs.

Redefining roles in HMO regulation

The appropriate placement of regulatory authority for HMOs is an issue currently being considered. A key question is what arrangements will promote the best use of the special areas of expertise of the two agencies while minimizing the potential negative effects of two HMO-regulating entities. Commerce is widely regarded as best equipped and expert in regulation of financial matters, including solvency regulation, while Health is regarded as most proficient in knowledge and expertise in the area of "managed care," including matters of quality of care and access. In some regulatory reconfigurations recommended by health commissions and others in the recent past, it is seen as desirable that Commerce assume authority for financial regulation of HMOs. Neither department has favored this option. Instead, both departments' preference has been that all responsibility for HMO regulation reside with either Health or Commerce.

Study objective, approach, and scope

The legislature directed a study of HMO regulation in the MinnesotaCare legislation. The departments of Health and Commerce were directed as follows:

> The commissioners of health and commerce shall jointly study the regulation of health maintenance organizations. The commissioners shall examine the level and type of regulation that is appropriate for the department of health and for the department of commerce and shall report to the legislature by January 15, 1993. The report must contain a consensus plan to transfer authority over the financial aspects of health maintenance organizations to the commissioner of commerce, while allowing the commissioner of health to retain authority over the health care quality aspects of health maintenance organizations [1992 Laws, Ch. 549, Art. 1, Sec. 18].

The departments contracted with the Management Analysis Division of the Department of Administration to conduct the study and prepare a report for the 1993 Legislature.

This report incorporates a consensus plan, in accord with the statutory directive, proposing that duties now being performed in the Department of Health with respect to the financial aspects of HMO regulation be transferred to the Department of Commerce. The statute, through the requirement of consensus, says that the two departments must agree to the terms of that transfer of responsibilities.

The role of Management Analysis in this study was to (1) develop the issues based on interviews and review of documents, (2) propose and discuss with the departments alternative responses that might meet the study requirements, (3) facilitate development of the consensus plan, and (4) prepare the study report.

Although a wide range of options for HMO regulation has been proposed in the past, some are not considered in this report because they do not relate to the statutory directive. These include continuation of HMO regulation in the Department of Health and transfer of all or substantially all HMO regulation to the Department of Commerce.

The scope of the statutory directive excluded some related issues from the study. The study does not address the question of current HMO regulation effectiveness or efficiency. That is, it was not attempted to determine whether health care costs are lower, health care is more accessible, quality of care is better, or financial solvency is more ensured as a result of current regulation, or might be improved as a result of implementing another configuration of regulation.

Organization of the report

The first part of the report provides an overview of health care issues and a history and status of state HMOs. Next, the configuration of state regulatory authority for health plans, including HMOs, is described. Following that is a discussion of the issues concerning the division of regulatory responsibilities for HMOs between the Department of Health and the Department of Commerce. This section includes a description of the issues and options that have been discussed in the recent past, including the efforts toward a reconfiguration of responsibilities giving Commerce responsibility for financial regulatory matters for HMOs. In the last report section, the consensus plan is presented. This section includes a discussion of the issues reviewed during the study and details of the consensus plan.

HMO AND HEALTH PLAN OVERVIEW

The United States spent about $817 billion in 1992 on health care — representing about 14 percent of the gross national product. Other developed countries spend no more than 10 percent of GNP for health care.

Although the U.S. health care system has many strengths, by some important measures it does not compare well internationally. For example, of the world's 24 industrialized countries, the United States ranks 21st in infant mortality, 17th in male life expectancy, and 16th in female life expectancy. More than 35 million Americans (about 14 percent) have no health care coverage, most of them employees of small businesses and their dependents. Other countries, including Canada, Japan, and those of Western Europe, have universal health care coverage.

According to the Minnesota Department of Finance's November state financial forecast for the 1994-95 biennium, health care expenditures will account for 14 percent of the state budget. Health care spending is projected to grow by 36 percent — larger growth than for any other part of the state budget.

In Minnesota, total health care expenditures were reported by the Minnesota Health Care Access Commission to be in the range of $9 billion to $10 billion for 1990. A more recent estimate by the Lewin/ICF health care consulting organization, as reported in the Minnesota Health Care Commission's *Cost Containment Plan*, preliminary draft, released Jan. 21, 1993, was that 1991 Minnesota health care expenditures were $13 billion to $14 billion. Despite this considerable cost, the Minnesota Health Care Access Commission noted in its January 1991 *Final Report*:

> [T]here is little consensus about what we are getting in return, about the efficiency and effectiveness of care. . . . Our health care system may be the most advanced in terms of procedures and technologies, but it is far from advanced in its capacity to use limited resources wisely.

Health care financing

The costs of U.S. health care are paid by both government and the private sector. According to the U.S. Health Care Financing Administration, government programs paid 42 percent of the $666 billion spent on U.S. health care in 1990 (17 percent Medicare, 11 percent Medicaid, and 14 percent other government programs), while private sources accounted for 58 percent (33 percent private health insurance, 20 percent out of pocket, and 5 percent other private payment).

HMOs and other health plans

Before 1965, health care coverage for most Americans came from either nonprofit health service plans (Blue Cross and Blue Shield) or accident and health insurance offered through life insurance companies. These plans usually paid for treatment from an essentially unrestricted choice of licensed providers. Insurance coverage generally provided payment to health care providers — doctors and hospitals, for example — on a fee-for-service basis.

Health maintenance organizations differ from the traditional Blue Cross and Blue Shield and insurance (indemnity) coverage in that HMOs provide prepaid coverage with comprehensive care, including preventive care. HMOs were first organized in the 1930s. HMO membership in the United States rose rapidly during the 1980s, from 8 million in 1979 to 39 million in 1992.

1973 Health Maintenance Act

Nearly 20 years ago, the Minnesota Legislature enacted the Health Maintenance Act of 1973 (Chapter 62D), which enabled creation of health maintenance organizations, with the objectives explained as follows:

> Faced with the continuation of mounting costs of health care coupled with its inaccessibility to large segments of the population, the legislature has determined that there is a need to explore alternative methods for the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these services.
>
> It is, therefore, the policy of the state to eliminate the barriers to the organization, promotion, and expansion of health maintenance organizations; to provide for their regulation by the state board of health [since 1977, the Department of Health]; and to exempt them from the operation of the insurance and nonprofit health service plan corporation laws of the state except as hereinafter provided.
>
> It is further the intention of the legislature to closely monitor the development of health maintenance organizations in order to assess their impact on the costs of health care to consumers, the accessibility of health care to consumers, and the quality of health care provided to consumers [M.S. 62D.01, Subd. 2].

Minnesota HMOs

Minnesota is one of just four states with HMO enrollment exceeding 25 percent of the state population (the others are California, Massachusetts, and Oregon). Total HMO enrollment in Minnesota in 1991 was about 1.2 million — almost 27 percent of the state's population. Enrollment peaked in 1987 and is now slightly below that level. In the Twin Cities metropolitan area, nearly 45 percent of the population belongs to HMOs; outside the Twin Cities metro area, enrollment is about 7 percent. Information about the state's HMOs is presented in Table 1.

Recent mergers have concentrated the Minnesota HMO market in two organizations that currently serve nearly 90 percent of state's HMO enrollees. The two Medica HMOs represented about 40 percent of the HMO market in 1991. The recently merged Group Health and MedCenters entity represents about 48 percent of the HMO market.

HMO financial results

The state's HMOs have improved the financial results of operations dramatically since 1987, which was a low point for health plans nationally and in the state. The combined surpluses (surplus is used instead of profits because HMOs are nonprofits) for the HMOs were: 1987 $44.4 million (loss); 1988 $2.4 million (loss); 1989 $27.5 million; 1990 $57.1 million; 1991 $75.4 million.

HMO products

The traditional HMO product is "managed care." HMOs provide or arrange delivery of basic health services to enrolled members in a described geographic service area, in exchange for prepaid fixed premiums. These organizations thus combine administration and financing of prepaid health care with the delivery of care.

Table 1. Basic information about state HMOs

HMO	Headquarters location	Parent, owner, or manager	1991 enrollment (rounded)
Blue Plus	Eagan	Blue Cross and Blue Shield Minnesota	70,000
First Plan	Two Harbors	Blue Cross and Blue Shield Minnesota	9,000
Group Health/ MedCenters	Minneapolis	Group Health, Inc.	Group Health: 295,000 MedCenters: 259,000
Central Minnesota Group Health Plan	St. Cloud	Group Health, Inc.	17,000
Mayo	Rochester	Mayo Foundation	4,000
Medica Choice	Minnetonka	United HealthCare	352,000
Medica Primary	Minnetonka	United HealthCare	129,000
Metropolitan Health Plan	Minneapolis	Hennepin County	29,000
NWNL Health Network	St. Paul	Northwestern National Life Insurance Co.	20,000
U Care	Minneapolis	University Affiliated Family Physicians	11,000

Beyond the basic HMO product, another one has developed that combines the traditional product with indemnity (insurance) — a "combination" or "wrap-around" plan, or "supplemental coverage." HMO enrollees receive comprehensive coverage in the HMO and also indemnity coverage when they use providers outside the HMO. These combination plans have become popular and now account for about a third of HMO enrollees.

HEALTH CARE REGULATION

The development of health plans has resulted in plans that are regulated very differently. Rapid evolution of the market in recent years, especially the trend to managed care plans, may be outpacing suitable adaptations in regulation. The Minnesota Commission on Health Plan Regulatory Reform, in its April 1989 *Final Report Summary*, noted:

> 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.

Framework for regulation

The regulation of health plans in Minnesota is split between the departments of Commerce and Health. Commerce regulates the activities of health service plan corporations (Blue Cross and Blue Shield) and accident and health insurers. Health regulates the activities of HMOs. Table 2 on the next page depicts the regulatory authority of the two health plan regulating departments.

The reasons for this split are based in the history of Blue Cross and Blue Shield, health insurance and the much later development of managed care plans. Blue Cross and Blue Shield plans pioneered the introduction of health benefits coverage during the 1930s. When that experience proved successful, insurance companies began to develop health insurance plans.

Insurance regulation by states started in the last century. The function has traditionally been located in an insurance department, which in recent times is often a commerce department. Because state insurance regulation has traditionally been based on the license of the organization selling the product, insurance departments assumed responsibility for regulating health insurance as a new product line of the insurers. The products of Blue Cross and Blue Shield plans were perceived as similar to insurance, so regulation went to the state insurance departments.

HMOs became a major force in the marketplace following Congress' enactment of the Health Maintenance Act of 1973. HMOs have been more thoroughly regulated than other plans. For example, only HMOs are required to operate quality assurance programs and demonstrate their ability to provide care in each geographic service area they serve. Because HMOs are so involved with health care delivery, state regulation of HMOs in some states (about one-fifth of the states) became the responsibility of health departments, rather than insurance departments.

The marketplace for health care coverage has evolved so that nearly all health plans have elements of managed care. As a result, both Health and Commerce regulate health care quality and health plan financial matters to some extent. Health regulates health care quality with rules for quality evaluation and audits to verify compliance under M.S. 62D.04 and Minn. Rule 4685.1100. Commerce regulates health care quality through its review of insurance policies,

Table 2. Current configuration of state health plan regulation

Type of health plan	State regulator	Primary statute
Health maintenance organizations	Health	Chapter 62D
Health insurance companies	Commerce	Chapter 62A
Health service plan corporations	Commerce	Chapter 62C
Preferred provider organizations	Commerce	M.S. 72A.20, Subd. 15 (subject only to filing requirement)
Self-insured plans	Unregulated	—

employing M.S. 62A.02, Subd. 3, which permits disapproval of policies where contract provisions are "unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation."

Some similarities and substantial differences appear in the scope of regulation of these plans:

- **Insurance.** The regulation of insurance health plans covers financial solvency, policy provisions, organizational structure, mandated benefits, renewal and cancellation requirements, broker and agent licensing, rates of premiums, and unfair trade practices.

- **Health service plan corporations.** HSPCs are required to be incorporated as nonprofit corporations. Regulation concerns financial solvency, policy provisions, organizational structure, mandated benefits, renewal and cancellation requirements, rates of premiums, and unfair trade practices.

- **Health maintenance organizations.** In Minnesota, HMOs must be organized as nonprofits and must operate only in this state. HMOs are subject to regulation of their relationships with providers, including service area certification and provider risk sharing. Regulation also covers financial solvency, organizational structure, benefit contracts, mandated benefits, and unfair trade practices. HMOs are required to provide "comprehensive" health care, including preventive care. They are not subject to prospective review of premium rates. HMOs are the only plan type that must operate a quality assurance program.

- **Preferred provider organizations.** Insurance contracts that provide for different amounts of reimbursement if insureds obtain health services from "preferred providers" are subject to limited regulation. Insurers that offer PPO plans file summary data regarding the financial reimbursement to entities designated as preferred providers.

- **Self-insured plans.** These plans are unregulated, yet represent a growing and very important part of health care coverage. Self-insured plans are discussed in the appendix of this report.

HMO regulation

The Health Maintenance Act of 1973 directed that the commissioner of health regulate HMOs. This placement of regulatory responsibility for health plans was a departure from existing practice; the Department of Commerce up to then regulated all health insurance products and other health plans. The rationale for Health regulating HMOs was that HMOs represented more than just a financing mechanism for health care (that is, health insurance), they also incorporated the delivery system. The combination of financing mechanism and delivery system in one entity represented an innovative approach to providing health care.

Because regulation of the delivery system of HMOs prominently included considerations of quality of health care provided and access to care, Health was thought to be the more appropriate locus of regulatory responsibility. The regulator had to be cognizant of a potential for conflict between the goals of cost containment and of ensuring health care access and quality. An additional reason that Health was chosen was the assumption and intention that HMOs ought to be promoted and fostered as a new form of health care delivery, a function that could be better performed by the Department of Health.

Although Health was given the responsibility for regulation, the legislature considered that the Department of Commerce could also have a regulatory role in support of Health. The law directs that:

> The commissioner of health, in carrying out the obligations under section 62D.01 to 62D.30, may contract with the commissioner of commerce or other qualified persons to make recommendations concerning the determinations required to be made. Such recommendations may be accepted in full or in part by the commissioner of health [M.S. 62D.24].

Prior to 1988, regulation of HMO insolvency (rehabilitation and liquidation matters) was the responsibility of the Department of Commerce. Statutes provided that "the commissioner of commerce may independently, or shall at the request of the commissioner of health, order the rehabilitation or liquidation" of HMOs. The commissioner of commerce was to supervise rehabilitation or liquidation under the procedures in Chapter 60B ("insurers rehabilitation and liquidation"), "except to the extent that the nature of health maintenance organizations render such law clearly inappropriate" [M.S. 62D.18 (1986)]. In 1988, the legislature transferred responsibility for regulation related to insolvency, rehabilitation, and liquidation of HMOs from Commerce to Health.

In the regulation of HMOs under Chapter 62D, Health is directed to use provisions of statutes that cover other health plans regulated by Commerce. For example, Health relies on various sections of chapters 60A (general insurance powers), 60B (insurers rehabilitation and liquidation), 60K (insurance agent licensure), 61A (life insurance), 62A (accident and health insurance), 62E (Minnesota Comprehensive Health Act), and 72A (regulation of trade practices). This list is not complete for all statutory cross references, but covers most major references to Commerce-administered provisions. For these items, Health and Commerce often must coordinate the interpretation and application of the provisions. However, in certain cases interpretation of the same statutory language has been different for HMOs than for insurers and other health plans.

Recent statute changes have added new features and greater complexity to the scheme of regulation for health plans and HMOs. These reflect the difficulties in placing responsibilities for new programs when two departments share or split health plan regulatory functions.

Regulation of HMOs for Medicare Select policies

The responsibility to regulate plans that offer Medicare Select policies, including HMOs, was given to the Department of Commerce by the 1992 Legislature. Medicare Select is a new Medicare supplement insurance product, authorized in the federal Omnibus Budget Reconciliation Act of 1990 as a three-year, 15-state program, and initiated in Minnesota in 1992. Medicare Select differs from traditional medigap plans because purchasers of the Medicare Select policies are expected to use the services of designated health care providers.

Any health plan that will offer Medicare Select policies or certificates must first have the policies and plan of operations approved by the commissioner of commerce. Commerce reviews the offerings for compliance with M.S. 62A.318 and for adequacy of the plan of operation. The plan must include a grievance procedure, quality assurance program, list of network providers, provider agreements, a service area map, corporate documents, and other information requested by the commissioner.

Regulation under MinnesotaCare

Although MinnesotaCare is intended to make broad and substantial changes to the health care delivery system in the state, the law apparently was not intended to make major changes to the division of regulatory responsibilities between the departments of Commerce and Health. Development of integrated service networks may substantially alter regulation of health plans, both for ISN and non-ISN entities (see Minnesota Health Care Commission's *Cost Containment Plan*, preliminary draft).

Under MinnesotaCare, Health is given authority over a variety of health cost containment provisions, and responsibility for data collection and research on health care outcomes and development of outcome-based practice parameters. The commissioner can approve arrangements among health plans and providers that are likely to lower costs or increase the access or quality of health care, including granting antitrust exemptions for these purposes. The act also directs the commissioner of commerce to pursue an exemption from the Employee Retirement Income Security Act of 1974 preemption that will permit the state to, among other things, regulate self-insured health plans to the same extent as insurance companies. MinnesotaCare and integrated service networks are discussed further in the appendix of this report.

Events and trends that will affect regulation

Although it is not the purpose of this study to attempt to comprehensively integrate considerations of larger health care issues into the discussion of the division of regulatory responsibilities between the two departments, many of these trends and events will undoubtedly figure in to any consideration of regulation. Among the trends and issues are the greatly expanding self-insured programs, MinnesotaCare issues including integrated service networks (and other industry merger issues), employer purchasing coalitions, and potential federal actions in health care such as a managed competition approach. The issues listed here are discussed in the appendix of this report.

'Level playing field' issues

Both insurer and HMO representatives interviewed for this study indicated their organizations were under some competitive disadvantages from regulatory requirements. These issues were generally characterized as "level playing field" issues; that is, other entities, because of differences in regulation, had important competitive advantages. These issues are discussed briefly to evaluate the extent to which they relate to the subject of this study — the division of regulatory responsibilities for HMOs.

Significant differences are apparent in the state's regulation of different types of plans. Some of the major issues, as summarized and updated from the Office of the Legislative Auditor's February 1988 *Health Plan Regulation*, are:

(1) **Mandated benefits and providers.** Unlike accident and health insurers, HMOs are not required to guarantee access to nonphysician providers. But HMOs must provide comprehensive services, while other plans have more flexibility in plan design.

(2) **Ability to limit providers and enrollees.** HMOs and preferred provider organizations (discussed in the appendix to this report) have much more flexibility in selecting providers for their plans. Accident and health insurers may not discriminate against any licensed provider, and a health service plan must include any licensed provider willing to accept the plan's terms. On the other hand, HMOs have less flexibility than other plans to discriminate against potential enrollees, because they must have open enrollment in groups once a year in which group members are accepted without health screening.

(3) **Financial requirements.** Unlike health service plans and accident and health insurers, HMOs have not been subject to review of premium rates. However, as certain provisions of the MinnesotaCare law are implemented, HMOs will be subject to premium rate review beginning in 1993. Requirements for start-up capital and ongoing reserves are different for HMOs than for insurers and health service plans. Net worth requirements are lower for HMOs than for insurers and health service plans.

(4) **Taxation.** Accident and health insurers pay Minnesota's 2 percent premium tax. HMOs and health service plans will begin paying a 1 percent premium tax in 1996. Self-insured plans do not pay the premium tax. Accident and health insurers are subject to state income tax if their liability exceeds their premium tax liability. HMOs are exempt from the income tax, while Blue Cross and Blue Shield recently became subject to state and federal taxes.

(5) **Minnesota Comprehensive Health Association.** All plans, except self-insured plans, are now required to be contributing members of the Minnesota Comprehensive Health Association (discussed in the appendix of this report).

(6) **Quality assurance.** Under state and federal law, only HMOs among the plans must develop internal systems for quality assurance and mechanisms to receive and handle enrollee complaints.

It is apparent that important differences in the requirements for plans and regulation of plans can affect their competitiveness in the marketplace. This is particularly noteworthy when the characteristics of plan products are becoming more and more alike. The Minnesota Commission on Health Plan Regulatory Reform, in its April 1989 *Final Report*, found that:

Although some differences remain, many past distinctions between the 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.

The "level playing field" issues are especially prominent because most plans of all types are moving toward providing managed care products. Thus, the historical reasons for some of these differences in regulation may be less important now. It is clear, however, that the issues most often characterized as "level playing field" issues have much less to do with how regulation is split between the two departments than with differences in statutory requirements that apply to each type of plan. In essence, the provisions of statutes governing each plan would be enforced by either department according to the terms of the statutes. Although the statutes have been adapted to some of the new characteristics of the market, most essential features that apply to particular plan types remain in place.

On the other hand, to the extent that each agency is more or less well equipped to deal with particular issues of regulation, there likely are differences in how each department would enforce the same statutory provision with respect to plans in its jurisdiction. It was noted in some interviews that some provisions of statutes that apply to plans under each agency are indeed interpreted differently.

It is not at all clear that a reconfiguration of regulatory authority between the two departments will address major concerns that attend these developments in the marketplace or the questions of "level playing field."

DIVISION OF HMO REGULATORY RESPONSIBILITIES

Several recent studies have addressed the issues of the division of regulatory responsibilities for HMO regulation and health plan regulation in general. One of those studies, and a bill introduced in the 1992 legislative session, attempted to define the division of responsibilities between the departments with greater specificity. The history is reviewed below.

Legislative Auditor, *Health Plan Regulation*, February 1988

The legislative auditor recommended that the state view all health plans, including HMOs, as systems of financing health care, and regulate similar health plans consistently. The report said there were regulatory roles for both Commerce and Health. It recommended that "one agency, with expertise in monitoring the financial integrity of health plans and in protecting consumers, should regulate all managed health care plans," therefore recommending that the legislature transfer most regulatory responsibility for HMOs to the Department of Commerce. The report said the Department of Health is most qualified to deal with quality assurance issues and that therefore this department should have responsibility for quality assurance activities for all managed health care plans.

The Department of Health would review quality assurance and dispute resolution mechanisms of the health plans, and would maintain a staff of qualified individuals who would arbitrate disputes between enrollees and their plans about the quality of care received or necessity for certain services. Commerce would make use of this expertise and refer questions to Health on these issues. Health also would monitor the situations where managed health care plans are required to demonstrate to a state regulator that they have the appropriate number and type of providers in each geographic area they serve.

The report also noted that some regulatory functions would require coordination between the departments because the activities involved are of a dual nature. "Clearly," according to the report, "the agencies would need to develop protocols for addressing certain issues that have aspects of both quality assurance and contract compliance."

Minnesota Commission on Health Plan Regulatory Reform, April 1989

The Minnesota Commission on Health Plan Regulatory Reform in its 1989 report noted that the regulation of health plans between Health and Commerce is done according to company category and "implementation of the recommendations made in this report will be confusing and inefficient under such a division."

The commission also noted, "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 will face a different state agency and dissimilar regulation with respect to similar products and activities."

The commission recommended that regulation be assigned to the departments of Health and Commerce "according to function" in order to avoid "confusion and duplication of effort." It recommended that the agencies develop a plan for the 1991 Legislature that was premised on the following general principles:

> Each agency has a legitimate role in health plan regulation. The primary jurisdiction of Commerce should be financial and corporate; the primary jurisdiction of Health should be access to health care services and issues of medical care.
>
> Each agency should exercise its authority independently of the other to the extent possible; overlap in jurisdiction should be avoided.

Under the functional configuration of regulation presented in the commission report, Commerce would be the licensing agency for all companies and would 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 third-party administrator licensing. Health would issue the certificates of authority for all managed care plans and be responsible for 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.

Table 3. Responsibilities - Commission model

Health: Medical care	Commerce: Financial and corporate
Certificate of authority	Licensing agency
Provider network	Corporate governance
Certificate of service area	Financial solvency
Provider contract	Underwriting
Quality assurance	Rate review
Utilization review	Consumer complaints
Experimental technology	Claims processing
Urgently needed services	Management agreements
Consumer complaints	

The departments worked to develop a function-based division of regulation according to the recommendations of the commission. Based on work done up to the time of publication of the study, the commission noted:

> 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.

The scheme for a revised configuration of regulatory responsibilities from the Regulatory Reform Commission report is presented in Table 3. Although this plan listed specific regulatory functions, detail was left out. (In the appendix to this report, Table A1 shows how the responsibilities would have been redistributed between the departments under the commission proposal. It does so by overlaying the proposal's elements on the statutory provisions of Chapter 62D under which HMOs are regulated. The purpose is to illustrate where the plan lacks specificity and how it assigned functions between the departments within the HMO regulation framework.) The report acknowledged that more work had to be done to make the recommendations workable. The commission concluded, "The recommendation outlined . . . 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."

Minnesota Health Care Access Commission, January 1991

The Minnesota Health Care Access Commission noted that "the state's system of health plan regulation would benefit from streamlining and consolidation," and recommended that the state adopt the Regulatory Reform Commission recommendations concerning the division of responsibility for health plan regulation:

> Specifically, we recommend that the Minnesota Departments of Commerce and Health develop a plan for the functional division of regulatory authority. . . . The plan should be premised on the following principles:
>
> The primary jurisdiction of the Department of Commerce will be regulations pertaining to financial integrity and corporate structure.
>
> The primary jurisdiction of the Department of Health will be regulations pertaining to health care delivery and health care quality.
>
> Each agency should exercise its authority independently of the other to the extent possible, and avoid jurisdictional overlaps.

H.F. 431, 1992 legislative session

House File 431 created a division of HMO regulatory responsibilities along functional lines between the departments of Health and Commerce. The bill would have made Commerce the lead agency in HMO regulation and transferred responsibility for many functions that were with Health.

The functions that would be transferred to Commerce included many primarily financial in nature, such as determinations of net worth, deposits, working capital, investment restrictions, and insolvency matters. It also would have transferred to Commerce authority over reviews of provider agreements and operation of the complaints system. Both departments had authority over some issues, such as evidences of coverage and required replacement coverage.

In the appendix of this report, Table A2 shows in detail the distribution of regulatory responsibilities under H.F. 431. The accompanying notes describe the respective responsibilities of the departments under the plan.

The division of responsibilities proposed in H.F.

431 presented difficulties for the two departments. For example, Health noted the following problems with the bill in documents exchanged among the parties dealing with the bill:

- Review and approval of provider agreements, which under the bill were transferred to Commerce, were considered by Health to involve primarily health delivery issues.

- Health care complaints and "similar health care issues" would be transferred to Commerce, but Health believed it is most qualified to deal with them.

- Enforcement powers that would be transferred to Commerce would deprive Health of needed enforcement authority over some matters of health care and access.

- Transfer of authority over rehabilitation and liquidation of HMOs to Commerce would leave Health unable to retain special examiners to assist Commerce with serious access and quality problems.

- The authority to make determinations involving unreasonable expenses in agreements with health care providers would be transferred to Commerce, and these involved health care issues.

- Commerce was made the final authority when the two departments disagreed over which department had jurisdiction over any matters, and Health believed it should have that authority.

- Health also noted that the authority over matters of health care access for nonprofit health service plans and preferred provider organizations should have been transferred to Health in the bill.

In general, Health believed that it should be the primary HMO regulatory agency, with Commerce providing support in financial matters. Health also stated its support for a reorganization of regulatory authority for managed care "so that all financial and corporate issues are reviewed by the Department of Commerce and all health care benefit and provider issues are reviewed by the Department of Health."

Conclusions

There is general agreement in these reports that regulation should make use of the expertise of both departments. They recommend that Commerce should regulate financial matters and Health should regulate health care access and quality. The key problems are in defining those terms in respect to specific functions and making the difficult choices where some functions are not neatly in one category or the other, or are so inherently bound up with related functions that splitting them would create significant practical difficulties.

CONSENSUS PLAN

The legislative directive for this study built on the efforts of the past several years. It additionally specified that certain functions now with Health would be transferred under a new configuration of regulatory authority.

Objective

The directive for the study provides that the departments will examine the level and type of HMO regulation that is appropriate for each department, and prepare a consensus plan to transfer authority over the financial aspects of regulation to Commerce, while retaining the authority of Health over the health care quality aspects of HMO regulation.

Process

In the first part of the study, Management Analysis interviewed about 40 persons, including management and staff from both departments, legislators, HMO executives, representatives of the Minnesota Insurance Federation, and others knowledgeable about the topics and history of the study issues. Management Analysis also reviewed the reports of related studies and other documentation from both departments and elsewhere concerning the history and development of these issues.

Based on the information gathered in interviews and review of documents, Management Analysis facilitated several discussions with representatives of the two departments toward development of a consensus plan. As a result of the meetings, a consensus plan was developed that in essence would transfer to the Department of Commerce those aspects of HMO regulation that relate to financial monitoring and solvency, including rehabilitation and liquidation.

Both departments worked to develop this consensus plan. Neither department, however, supports implementation of this option. The departments regard split regulatory authority as inefficient, and have noted that joint regulation can create obstacles such as consumer confusion and higher administrative costs. They believe, however, that the consensus plan set forth in this report is crafted to minimize these difficulties.

Chief problems encountered in developing the plan

Administration of regulatory program

The difficulties in resolving the issues of a division of regulatory authority come from a number of sources. One key difficulty has to do with separating some regulatory functions into financial and health care dimensions when they are essentially indivisible or divisible only with great practical difficulty. Discussions with department personnel and others familiar with the issues confirmed that separating financial and health care quality for many regulatory functions involved great difficulties.

Two options for reconfiguration that had been previously developed — based on the Regulatory Reform Commission report scheme and the

scheme from H.F. 431 — presented difficulties in practice that the many participants in this study said would be extremely difficult to develop to finality. For many of the functions of regulation, the financial aspects were inherently bound up with the health care aspects. The result of an attempt to split them would be duplication, practical problems for the HMOs in knowing whom to deal with on specific issues, and unclear lines of authority and final responsibility for various parts of regulation. In addition, although it might have been possible to clearly define specific duties for each department, it would also imply a degree of cooperation and coordination that may be unattainable.

From interviews it was noted that the HMO industry would have additional concerns about a reconfiguration of regulatory responsibilities. The concerns center on the potential for duplicative filings, other administrative inefficiencies, and inconsistent requirements, among others.

Additionally, the two departments have very different "world views" with respect to regulation of health care plans. The financial focus of Commerce and health care focus of Health have resulted in very different regulatory orientations and skills of staff. The difficulty is that regulation of managed care plans, including HMO products, probably requires both sets of skills and world views to be effective. For both departments, changes in the marketplace for both indemnity products (which have taken on elements of managed care) and HMOs (with combination products), among other issues, have necessitated their becoming equipped to deal with unfamiliar issues (solvency and other financial issues in Health and quality of care issues in Commerce). In both cases, statutory changes have been implemented to deal with these evolutions of the marketplace.

Health care reform

The consensus plan should be considered in the context of actions taking place under the MinnesotaCare law, including efforts of the Minnesota Health Care Commission. Some work of the commission to date (*Cost Containment Plan*, preliminary draft) suggests that major restructuring of the health delivery system may be needed to contain costs. Implementation of integrated service networks, for example, would have unclear implications for regulation of health plans. The extent and nature of regulatory changes that might be required have not been defined by the commission. Clearly, however, the resolution of regulatory issues under MinnesotaCare is related to that of the regulatory issues in this study.

Criteria for plan selection

Based on the findings from interviews and review of previous studies of related issues, it was judged that a scheme for reconfiguration of HMO regulatory authority should attempt to meet these criteria:

- Promote accountability. The respective responsibilities of both regulators should be defined so that it is clear who is accountable for decisions and actions for each regulatory function.

- Encourage efficiency. There should be minimal need — or at least less need than under other options — for the two departments to have to carry out extensive coordination efforts for decisions and actions.

- Promote consistent regulation. The preferred option would promote consistency of application of statutes among the health plans.

- Consider severability of functions. To the extent practical, avoid splitting regulatory functions that are inherently and inextricably a combination of financial and health quality issues. If, for a particular function, the financial and quality characteristics cannot be separated, then functions should be assigned to one agency, with mechanisms to manage the areas where expertise is undeveloped and coordination is required with the other agency. For assignment of the functions to one or the other agency, strengths and weaknesses in the ability to carry out the functions should be considered. In general, functions should reside with other functions that are most related.

- Match regulatory requirements to expertise and resources. The skills and resources to conduct regulation in financial matters, quality assurance, complaints, market conduct, and other areas should be placed with the department best suited and experienced in each area. Where regulators would rely on a support system of related expertise for functions, the regulatory authority should be placed to make this easier to accomplish.

- Minimize duplicative efforts. Two agencies should not, except as it is unavoidable, be developing duplicative expertise.

- Promote industry ease of compliance. HMOs should not have to deal with a confusing scheme of regulation where a simpler configuration would promote and ease compliance. Unnecessary complexity and duplication should be avoided.

- Ensure that authority goes with responsibility. Authority to carry out responsibilities should accompany transfers of responsibilities. Each agency should have the regulatory power it needs to accomplish its responsibilities.

- Clarify final authority over regulatory functions. Potential inconsistent or conflicting determinations between two agencies should be avoided whenever possible by specifying a final authority for each regulatory activity.

- Take account of major changes in the marketplace and government actions. The preferred option would fit a revised configuration of HMO regulation with larger issues and trends in health care reform. With rapid changes taking place in managing, providing and ensuring health care, any regulatory solution should be flexible enough to adapt to future needs for regulation of the industry.

It seems clear that no reconfiguration of HMO regulation can completely accommodate all the criteria. The consensus plan, as well as the current configuration of authority and others that have been proposed, involves tradeoffs among these considerations. Under the terms of the statutory directive, the consensus plan appears to make reasonable tradeoffs among these considerations.

Rationale for the consensus plan

The consensus plan has been put together based on the lessons of past efforts to create a reconfiguration of regulatory responsibilities for HMOs. Specific decisions about the functions to transfer to Commerce had these considerations as their underlying rationale:

- The reconfiguration of responsibilities meets the statutory directive. In the consensus plan, the regulatory functions proposed for transfer

are financial. They represent the aspects of regulation that concern financial monitoring of HMOs and solvency-related matters. They exclude functions that concern health quality and access issues as their major focus.

- The regulatory functions proposed for transfer in the consensus plan are "severable." That is, under the consensus plan, the separation of financial functions from health care quality functions could be more practically made than with other reconfiguration options that were considered.

- To a great extent, the consensus plan avoids many of the practical difficulties that had been encountered in defining the reconfiguration of functions under H.F. 431 and the Regulatory Reform Commission report. The plan is able to achieve this by creating more specificity than the commission scheme and sought to define more precisely the purely financial functions than with the H.F. 431 reconfiguration.

- The proposed reconfiguration is agreeable to both departments as the basis for a consensus plan to meet the statutory directive. As previously noted, however, it does not necessarily represent either department's preferred option for regulation.

- The specific duties and personnel connected to the functions could be more easily determined than with the other options considered.

- It appears that the consensus plan would require less difficult interdepartmental coordination than would the other options considered.

- Role definition for particular functions should be clearer under the consensus plan than under other options considered.

- Duplication of functions would be reduced under the consensus plan, insofar as the functions traditionally done by each department would reside in each such department for HMOs (financial matters for Commerce and health care matters for Health).

- Areas of responsibilities were defined to minimize the duplication of effort that might be required by industry and to specify areas of responsibility that are well defined and understandable. Although additional efforts might be needed to minimize any negative impacts on industry, the consensus plan seeks to minimize potential impacts.

Reconfiguration under the consensus plan

Under the consensus plan, the functions transferred to the Department of Commerce are those related to financial monitoring and solvency regulation, including rehabilitation and liquidation.

Major functions that remain with Health under the consensus plan include quality assurance, complaints, and review of contracts and agreements. Health retains responsibility for all matters not specifically transferred to Commerce under this plan.

The intention of the consensus plan is to create distinct areas of regulatory responsibility to the extent possible. With each area of responsibility, the powers of enforcement necessary to carry them out are transferred along with the duties. The joint exercise of enforcement powers does not create duplicative authority, but authority

within the respective areas of assigned responsibility. Health retains final responsibility for the issuance and revocation of the certificate of authority.

Table 4 provides details of the consensus plan. The sections of statutes affected are noted, with descriptions of the transfers of responsibilities or the joint responsibilities assumed for each function in the statutes.

Table 4. Redistribution of regulatory responsibilities under the consensus plan

Authority in statute	Statutory reference	Responsibility with Health	Responsibility with Commerce	Footnote reference
Establishment of HMOs	62D.03	●	●	1
Issuance of certificate of authority	62D.04	●	●	
Protection in the event of insolvency	62D.041		●	2
Net worth and working capital requirements	62D.042		●	3
Guaranteeing organizations	62D.043		●	4
Admitted assets	62D.044		●	5
Investment restrictions	62D.045		●	6
Powers of health maintenance organizations	62D.05	●	●	7

[1] M.S. 62D.03-.04 establish the required contents of the application for certificate of authority. In the consensus plan, certain responsibilities for application review are transferred to Commerce that relate to review of financial matters. The major responsibilities for review of applications are divided as follows:

Health — Review of provider agreements and other contracts and agreements, provider networks, service areas, evidences of coverage, corporate governance, marketing, and quality assurance (programs and statistics, utilization, and quality, availability, and accessibility of the health care services).

Commerce — Financial reviews including determinations of net worth, working capital, and deposit requirements; and review of the required demonstration of financial responsibility.

Applications are made to the commissioner of health. The forms are prescribed by the commissioner of health, except that financial forms are prescribed by the commissioner of commerce. All matters not specifically designated as the responsibility of the commissioner of commerce remain the responsibility of the commissioner of health, and the determination of jurisdiction, in the event of uncertainty, and within the guidelines of the consensus plan, resides with the commissioner of health. Health will provide Commerce with all application information to carry out Commerce's responsibilities. The certificate of authority is issued by the commissioner of health, who must have received notice from the commissioner of commerce that the reviews within Commerce's jurisdiction are complete and the results are satisfactory for issuance of the certificate. Commerce and Health may make requests directly to HMOs for information to complete their reviews.

[2] Matters that concern HMO solvency are transferred to the Department of Commerce. Included in this section of statutes are requirements for deposits under various circumstances.

[3] Regulation of these financial matters is transferred to the Department of Commerce. This section sets the requirements for HMO net worth and working capital, and includes creation of plans of correction for financial solvency.

[4] The authority to regulate matters that concern the guaranteeing organizations is transferred to the Department of Commerce. Commerce would approve agreements guaranteeing HMOs' net worth requirements.

[5] These financial matters are transferred to Commerce.

[6] The regulation of investments is transferred to Commerce, including the related matters under this section.

[7] This section describes powers of HMOs upon obtaining a certificate of authority. These powers are in areas regulated by both agencies under the consensus plan. In Subd. 6(a), the authority to determine the adequacy of surplus funds and to require additional surplus in conjunction with supplemental benefits is transferred to Commerce. Pursuant to this transfer, the commissioner of commerce would have rule-making powers granted in Subd. 6(b), and any existing rules of the Department of Health on these matters would be reviewed and new rules instituted as required.

Authority in statute	Statutory reference	Responsibility with Health	Responsibility with Commerce	Footnote reference
Governing body	62D.06	●		[8]
Evidence of coverage	62D.07	●		
Annual report	62D.08	●	●	[9]
Information to enrollees	62D.09	●		
Provisions applicable to all health plans	62D.10-62D.106	●		[10]
Complaint system	62D.11	●		
Prohibited practices	62D.12	●		[11]
Required replacement coverage	62D.121	●		
Mediation	62D.122	●		
Provider contracts	62D.123	●		
Powers of insurers and nonprofit health service plans	62D.13	●	●	[12]
Examinations	62D.14	●	●	[13]

[8] This section requires that an HMO's governing body must be 40 percent consumers. Matters of corporate governance are dealt with in other sections of Chapter 62D.

[9] This section requires submission of a variety of information annually and when there are changes to information in the certificate of authority. Both departments have authority for review of portions of this information under the consensus plan. The annual report and all other filings will continue to be filed with the commissioner of health. Commerce will receive copies of all documents filed with Health. The regulatory reviews of the two departments follow the configuration described earlier with respect to the certificate of authority. Financial information is reviewed by the Department of Commerce. Forms will be prescribed by both departments in their respective areas of responsibility. Either commissioner may directly request additional information deemed necessary for their reviews. Similarly, fines and other sanctions for late filing can be imposed by each department in its areas of responsibility.

[10] These several sections relate to provisions of health plans including terms of open enrollments, continuation and conversion privileges, minimum benefits, second opinions, required out-of-area conversion, spouse and children coverage, and dependent coverage. They concern matters that remain within the jurisdiction of Health under the consensus plan.

[11] The section on prohibited practices relates to regulation of advertising and solicitations, trade practices, cancellation of enrollee coverage, conditions for reimbursement of enrollees, and nonrecourse against enrollees by providers or HMOs for amounts in excess of co-payments, discrimination in enrollment, authorized expenses, earnings devoted to nonprofit purposes, and other provisions with respect to enrollees and providers. Under the consensus plan, Health retains jurisdiction over these matters. Health may seek the advice of Commerce on these matters or contract with Commerce to have this review, or some of it, done in conjunction with financial examinations.

[12] These organizations are authorized to provide the types of coverage to HMOs described in M.S. 62D.05, Subd. 3, which may fall under the jurisdiction of either agency.

[13] The authority to conduct examinations of HMOs is given to both departments in their areas of assigned responsibilities.

Authority in statute	Statutory reference	Responsibility with Health	Responsibility with Commerce	Footnote reference
Suspension or revocation of certificate of authority	62D.15	●	●	[14]
Denial, suspension, and revocation; administrative procedures	62D.16	●	●	
Penalties and enforcement	62D.17	●	●	[15]
Rehabilitation and liquidation of health maintenance organizations	62D.18		●	[16]
Insolvency; MCHA alternative coverage	62D.181		●	[17]
Liabilities	62D.182	●		
Unreasonable expenses	62D.19	●		
Rules	62D.20	●	●	[18]
Fees	62D.21	●	●	[19]
Renewal fee	62D.211	●	●	[20]
Statutory construction and relationship to other laws	62D.22	●	●	[21]
Authority to contract	62D.24	●	●	[22]
Demonstration projects	62D.30	●		

[14] M.S. 62D.15-.16. Only the commissioner of health can revoke or suspend the certificate of authority of an HMO, and the commissioner must consider the recommendations of the commissioner of commerce with respect to financial matters within Commerce's purview in doing so. If the commissioner of commerce believes that such action should be taken, he will provide recommendations and supporting evidence to the commissioner of health.

[15] The authority to levy penalties, issue cease and desist orders, hold hearings, or take other administrative actions is given to both departments in their respective areas of responsibilities. However, each department must consult with the other department before taking any such action.

[16] The commissioner of commerce may apply to a court for an order of rehabilitation or liquidation of an HMO. The rehabilitation or liquidation will be supervised by the Department of Commerce. Commerce will have all the powers in 62D.18 to carry out the rehabilitation or liquidation. The commissioner of commerce will seek and utilize the advice and assistance of the commissioner of health in executing this function.

[17] This section defines the rights of enrollees of HMOs in insolvency to obtain coverage from Minnesota Comprehensive Health Association.

[18] Both Health and Commerce have rule-making authority to carry out their respective responsibilities.

[19] The departments will split the fees for filings in an equitable manner to be determined.

[20] The departments will determine an equitable split of the fees for renewal of the certificates of authority.

[21] Subd. 10 will provide that both commissioners have access to data or information necessary to conduct their reviews of an HMO.

[22] Under the consensus plan, both commissioners have power to contract to carry out their responsibilities under Chapter 62D.

Notes on the consensus plan

It is important to note that any reconfiguration of regulatory authority between the departments will likely increase the need for coordination of functions. To this end, and if the legislature decides to split authority, it is recommended that the departments create a small interagency working group that will identify the issues requiring coordination under this plan and a workplan for dealing with the issues. This would be most useful if the parties would specify more precisely the areas that will require coordination, and the nature of the desired coordination, and assign responsibilities and an expected timetable for efforts to achieve the coordination.

Also advisable under the consensus plan would be a cross-agency team to conduct examinations. The interagency working group and the examinations team should promote greater coordination between departments and help to minimize difficulties that may be experienced with the division of regulatory responsibilities in the examinations process and in other functions of regulation.

APPENDIX

Blue Cross and Blue Shield

Blue Cross and Blue Shield is organized as a nonprofit health services plan (Minnesota Statutes, Chapter 62C), and is the largest health plan company in the state. Blue Cross and Blue Shield also operates an HMO, a for-profit third-party administrator for self-insured plans, and an insurance company. It also serves as fiscal intermediary for Medicare in Minnesota, and network manager and claims processor for the Minnesota Comprehensive Health Association.

Self-insured health plans

A self-insured plan provides health coverage as an employee fringe benefit that is provided directly by the employer rather than directly by an insurer, health service plan corporation, or health maintenance organization. Under self-insurance, companies pay for ordinary employee medical expenses out of operating funds, instead of buying health insurance.

State regulation of self-insured plans is limited by the Employee Retirement Income Security Act of 1974 (ERISA), which preempts state laws that "relate to" employee welfare benefit plans, except state laws that regulate the "business of insurance." Federal courts have interpreted this as prohibiting state regulation of self-insured health plans. As a result, these plans are essentially not subject to state regulation that applies to other health plans.

Self-insurance plans are administered by third-party administrators, employers, or others. Blue Cross and Blue Shield is the state's largest administrator of self-insured plans. Many insurance companies also administer these plans as a major part of their business. ERISA does not prohibit regulation of administrators performing certain services for self-insured plans. The Commerce Department licenses self-insurance plan administrators.

Nationally, self-insurance of health care by employers has been a major and growing force. A 1991 survey of 2,409 employers by Foster Higgins, a benefits consulting firm, found that 65 percent had self-insured health plans, up from 46 percent in 1986. Foster Higgins also found that "22 percent of businesses that offered health benefits and had fewer than 100 employees were self-insured in 1991, compared to 8 percent in 1988."

The number of Minnesota companies that self-insure all or part of their employee health plans is large and growing. In a survey conducted by the Office of the Legislative Auditor for a February 1988 report, *Health Plan Regulation*, about 75 percent of large Minnesota firms reported that they self-insured all or part of their employee health plan. Nearly one-fourth of all Minnesota employees were then covered by a self-insured plan. The Citizens League, in its *Managed Care Report 1992*, noted, "Enrollment in HMOs and other insured plans has leveled off in recent years, but there has been a significant increase in self-funded plan enrollment." For 1991, enrollment was about 750,000. The number of employees seen as needed for a self-funded plan has dropped steadily; currently, groups as small as 50 employees are becoming self-insured.

Employers who self-insure have great flexibility in designing benefits packages because they are not subject to state laws that regulate commercial insurance carriers. Self-insuring has other advantages, including exemption from state mandated benefits, taxes and surcharges, and other regulations, and no requirement to contribute to the state's risk pool.

Because they are unregulated, self-insured plans can carry special risks for employees. For example, if a self-insured company goes out of business, employees could be left to pay their own health bills. Additionally, the recent McGann case (McGann v. H & H Music Co.) established that, based on ERISA, a self-insured employer can revoke coverage to avoid paying the medical bills of an employee.

Minnesota Comprehensive Health Association

The Minnesota Comprehensive Health Association (MCHA) provides health insurance to people who are turned down for coverage in the private insurance market. Health care coverage access problems often are experienced by small employers who have a "high-risk" group member or by individuals who exceed the lifetime maximums of their benefit contracts. MCHA is the largest high-risk pool in the United States. Currently more than 32,000 people are enrolled in MCHA.

MCHA has incurred substantial deficits in recent years. The losses are recovered through an assessment against HMOs, Blue Cross and Blue Shield, and insurance companies. In February 1992, an assessment of $25 million was made. ERISA precludes an assessment against self-insured plans, thereby insulating them from the costs associated with insuring "high-risk" individuals.

Preferred provider organizations

Preferred provider organization plans involve a selective contracting arrangement whereby insurers or self-insured entities contract with individual providers or an organized provider network for the provision of health care services.

Several HMOs have developed PPOs to offer to employers who operate self-insured programs. They include Medica, Group Health, MedCenters, and NWNL Health Network. The largest PPO is Blue Cross and Blue Shield, with more than 1 million enrollees. Other PPOs are Aetna PPO, Prudential Plus and PruNetwork, Select Care (LifeSpan hospitals), Preferred One (HealthOne, Fairview and North Memorial hospitals), and Ethix-Midwest (investor-owned).

MinnesotaCare (formerly HealthRight)

The stated intent of MinnesotaCare is to "lay a new foundation for the delivery and financing of health care in Minnesota . . . ." The legislation contemplates major changes in the way health care is delivered and paid for, and would affect the type and level of regulation required in the new environment. The law assumes that the new health plans will incorporate the cost-containment features of managed care plans. The plan provides for a commission (Minnesota Health Care Commission) to deal with cost-containment issues, with a goal to reduce the growth rate of health costs by 10 percent annually.

The law allows providers to seek federal and state antitrust immunity for shared service arrangements, such as integrated service networks, by applying to the commissioner of health and meeting criteria that are to be established.

Integrated service networks

The Minnesota Health Care Commission, created to deal with the issues of MinnesotaCare, is considering establishment of integrated service networks (ISNs) that would be networks of HMOs, insurers, hospitals, and providers. It is expected that most, if not all, managed care plans in the Twin Cities area would quickly qualify as ISNs. The commission's draft report released Jan. 21, 1993, briefly referenced certain regulatory matters. The report said that:

> All ISNs will operate with the same regulatory requirements regardless of whether an ISN was formed by an HMO, an insurer, a provider, or a purchaser. Regulations will avoid micromanaging administration of the networks. While ISNs will be required to satisfy basic criteria demonstrating their ability to be responsible for a continuum of care and costs for a defined population, they will have flexibility to define their own structure. Each ISN will be required to demonstrate their ability to bear the financial risk for providing defined services to a defined population. ISNs will be required to satisfy standards for the quality of the health services provided through its network and will be required to provide data on patient revenues, expenditures, and quality.

A new non-ISN regulatory scheme would also be created under the commission plan for providers and purchasers who are not part of an ISN. This would be a regulated "all-payer" system whereby multiple payers would utilize a single payment scheme. The system would be designed to encourage participation in ISNs. Quality measures would be developed for non-ISN care to monitor the impact of regulation and quality of care. "The non-ISN system will be designed to control costs. Overall expenditures on care that occurs outside an ISN will be limited in a manner that is consistent with the legislative mandates and the growth limits established by the commissioner of health," according to the commission.

Employer purchasing coalitions

The Business Health Care Action Group, a major purchasing coalition of 14 of the Twin Cities' largest employers (Bemis, Cargill, Carlson Cos., Ceridian, Dayton Hudson, FirstBank System, General Mills, Honeywell, IDS, Norwest, Pillsbury, Rosemount, Supervalu and Tennant), selected GroupCare Consortium as its provider. GroupCare includes Group Health, MedCenters, Mayo Clinic, and Park Nicollet Medical Center, which joined forces to offer health plans to both insured and self-insured employers.

Another Minnesota employer purchasing organization is the Employers Association Health Care Purchasers Coalition, which serves small employers. The plan selected Prudential Insurance Co. as its provider. Currently there are up to 500 company-members of the coalition, and 70 companies have signed up for the new health plan that begins in January 1993.

Managed competition

Although considerable attention is focused on Minnesota legislation, developments at the national level are also noteworthy. These efforts also contemplate fundamental restructuring of the health care system. For example, the National Leadership Coalition for Health Care Reform — consisting of businesses in many industries, public and private-sector unions, consumer and nonprofit groups, and associations of health care providers — recently published a report that recommends comprehensive reform of the health care system to address issues of cost, access, and quality.

At the federal level, considerable discussion of reform has focused on the concept of "managed

competition." The basic idea of managed competition is to create large health-insurance purchasing networks and to require health care providers — including HMOs, insurance companies, doctors, hospitals, and others — to compete on price and quality to win their health care business.

Other features of such a program could require employers to provide a standard benefits package to employees, permit unemployed people to purchase coverage through these networks, guarantee coverage to the uninsured, and limit tax deductibility for employee health benefits. Another proposal that could be added is a national health care board that would set a limit on national health spending. As the theory of this approach goes, it would keep the health system largely private and bring innovation and competition to health care. Managed competition has never been tried in any country.

Regulatory Reform Commission plan for division of regulatory responsibilities

In order to show what the Regulatory Reform Commission's plan for division of regulatory responsibilities would mean for HMO regulation, Table A1 overlays the commission's list of functions on the HMO statutes. This is necessarily an imprecise exercise. However, the table illustrates where responsibilities were assigned and identifies areas where detail and specificity are lacking. In most instances, where the commission plan was silent, the project team did not try to surmise where the responsibilities would be assigned. It is possible, however, that the report authors would be able to better complete the assignment of responsibilities. In the right column of the table, an asterisk signifies that it is not clear from reading the commission's plan which agency would be responsible for these activities, or how the responsibilities would be divided or shared.

Table A1. Redistribution of regulatory responsibilities under Regulatory Reform Commission proposal

Authority in statute	Statutory reference	Responsibility with Health	Responsibility with Commerce	Footnote reference
Establishment of HMOs	62D.03	●	●	[1]
Issuance of certificate of authority	62D.04	●		
Protection in the event of insolvency	62D.041		●	
Net worth and working capital requirements	62D.042		●	
Guaranteeing organizations	62D.043		●	
Admitted assets	62D.044		●	
Investment restrictions	62D.045		●	
Powers of health maintenance organizations	62D.05	●	●	
Governing body	62D.06			*
Evidence of coverage	62D.07			*
Annual report	62D.08			*
Information to enrollees	62D.09			*

[1] M.S. 62D.03-.04. The Regulatory Reform Commission plan assigned responsibility for issuing the certificate of authority to Health and is unclear about Commerce's role. Commerce would be the "licensing agency." Responsibilities that are financial, solvency, or corporate in nature are given to Commerce. Matters of quality, access, and medical issues are with Health.

Authority in statute	Statutory reference	Responsibility with Health	Responsibility with Commerce	Footnote reference
Provisions applicable to all health plans	62D.10-62D.106			*
Complaint system	62D.11	●	●	[2]
Prohibited practices	62D.12			*
Required replacement coverage	62D.121			*
Mediation	62D.122			*
Provider contracts	62D.123	●		
Powers of insurers and nonprofit health service plans	62D.13			*
Examinations	62D.14			*
Suspension or revocation of certificate of authority	62D.15	●		[3]
Denial, suspension, and revocation; administrative procedures	62D.16	●		
Penalties and enforcement	62D.17			*
Rehabilitation and liquidation of health maintenance organizations	62D.18		●	
Liabilities	62D.182			*
Unreasonable expenses	62D.19	●	●	[4]
Rules	62D.20	●		
Fees	62D.21			*
Renewal fee	62D.211	●		
Statutory construction and relationship to other laws	62D.22			*
Authority to contract	62D.24			*
Demonstration projects	62D.30			*

[2] The plan gives Health responsibility for complaints relating to questions of medical necessity, experimental technology, urgently needed services, and access to services. Commerce would deal with complaints for indemnity plans.

[3] M.S. 62D.15-.16. Health has power with respect to the certificates of authority. It is not clear what role Commerce would have on these issues.

[4] Apparently both departments would have authority under this section, as Health would use it for provider agreements, for example, and Commerce would use the authority for management contracts.

H.F. 431 plan for division of regulatory responsibilities

A proposed reconfiguration of regulatory responsibilities between the Department of Health and the Department of Commerce was proposed in H.F. 431 during the 1992 legislative session.

Table A2 shows how the responsibilities would have been redistributed between the departments under this bill.

TABLE A2. Redistribution of regulatory responsibilities under H.F. 431 (1992 legislative session)

Authority in statute	Statutory reference	Responsibility with Health	Responsibility with Commerce	Footnote reference
Establishment of HMOs	62D.03	●	●	[1]
Issuance of certificate of authority	62D.04	●	●	
Protection in the event of insolvency	62D.041		●	
Net worth and working capital requirements	62D.042		●	
Guaranteeing organizations	62D.043		●	
Admitted assets	62D.044		●	
Investment restrictions	62D.045		●	
Powers of health maintenance organizations	62D.05		●	
Governing body	62D.06		●	

[1] M.S. 62D.03-.04 establish the required contents of the application for certificate of authority. H.F. 431 provides for a single certificate of authority. An application must be filed with both commissioners, who review it for matters within their respective jurisdictions. One certificate is issued jointly, but each commissioner has the authority to deny certification if the application does not meet standards. The major responsibilities for review of applications are as follows:

Health — Reviews of capabilities of HMO to ensure availability and accessibility of health care services; quality assurance programs and statistics on costs of operations, utilization, and quality, availability, and accessibility of services; evidences of coverage.

Commerce — Determinations of net worth, working capital, and deposit requirements; insolvency plan; marketing; arrangements for stop-loss, reinsurance, and insolvency coverage; provider agreements; evidence of coverage; management contracts; determinations of unreasonable expenses; corporate governance.

Authority in statute	Statutory reference	Responsibility with Health	Responsibility with Commerce	Footnote reference
Evidence of coverage	62D.07	●	●	2
Annual report	62D.08	●	●	3
Information to enrollees	62D.09		●	
Provisions applicable to all health plans	62D.10-62D.106		●	
Complaint system	62D.11		●	4
Allocation of complaints	62D.112	●	●	5
Prohibited practices	62D.12		●	
Required replacement coverage	62D.121	●	●	6
Mediation	62D.122	●		7
Provider contracts	62D.123		●	
Powers of insurers and nonprofit health service plans	62D.13		●	
Examinations	62D.14	●	●	8
Suspension or revocation of certificate of authority	62D.15	●	●	9
Denial, suspension, and revocation; administrative procedures	62D.16	●	●	10

[2] Evidences of coverage must be submitted to both agencies. Both have the authority to enforce the law regarding evidences of coverage, with authority given to Commerce over "important consumer information," the "enrollee bill of rights," and the complaint system. Health has power in 62D.15(a)(1) to revoke or suspend a certificate of authority for noncompliance under this section.

[3] The annual report is submitted to both agencies for review in their respective areas of jurisdiction.

[4] Overall authority for the complaint system is given to the Department of Commerce.

[5] This is a new section for allocating complaints between the departments. All complaints go first to Commerce, which handles complaints under its jurisdiction. Complaints regarding the quality of care, experimental treatments, or medical necessity questions, are referred to Health. Complaints of a mixed nature are handled at the discretion of the Department of Commerce.

[6] The functions related to replacement coverage reside with Commerce, except that Health may issue a plan to correct an insufficiency of providers in a geographical service area.

[7] Health retains the authority to order or participate in mediation to resolve disputes between providers of health care services and HMOs if the dispute threatens to prevent renewal or maintenance of contracts for services.

[8] Both agencies are required to examine the affairs of HMOs at least every three years.

[9] Both agencies are given the authority to suspend or revoke a certificate of authority for matters within their respective jurisdictions.

[10] This section requires notice to be given and a hearing to be held by whichever agency decides to take action.

Authority in statute	Statutory reference	Responsibility with Health	Responsibility with Commerce	Footnote reference
Penalties and enforcement	62D.17	●	●	[11]
Rehabilitation and liquidation of health maintenance organizations	62D.18		●	[12]
Insolvency; MCHA alternative coverage	62D.181		●	
Liabilities	62D.182		●	
Unreasonable expenses	62D.19		●	
Rules	62D.20	●	●	[13]
Authority, disagreement	62D.201		●	[14]
Fees	62D.21	●	●	[15]
Renewal fee	62D.211	●	●	
Statutory construction and relationship to other laws	62D.22	●	●	[16]
Authority to contract	62D.24	●	●	[17]
Demonstration projects	62D.30	●	●	

[11] Both agencies have powers within their respective areas of responsibility to fine HMOs, conduct hearings, issue cease and desist orders, and obtain injunctive relief.

[12] Authority for the rehabilitation and liquidation of HMOs is transferred to the Department of Commerce. Health can only recommend actions concerning matters of the availability of and access to health care services.

[13] Rule-making power is given to both agencies within their respective areas of responsibility. The two commissioners are directed to coordinate this authority to prevent duplication and eliminate conflicting requirements. Rules may be issued jointly or separately.

[14] This new section gives final authority to the commissioner of commerce to determine which agency has jurisdiction over matters where jurisdiction is in dispute.

[15] Both agencies can assess fees for their activities, but the annual certificate of authority renewal fee is to be split evenly between them.

[16] Either agency may contract with any qualified person to make recommendations concerning determinations of the agency.

[17] Demonstration projects must be jointly reviewed and administered.

BIBLIOGRAPHY

Aspen Systems Corp., for the U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Prepaid Health Care, *A Report to the Governor on State Regulation of Health Maintenance Organizations*, 11th ed., 1989.

Baumgarten, Allan, and Vanderwall, Kathleen, "A New Framework for State Regulation of Managed Care Health Plans," presented to the 116th annual meeting, American Public Health Association, Nov. 15, 1988, Boston.

Citizens League, *Managed Care Review 1992*, 708 S. Third St., Suite 500, Minneapolis.

Consumer Reports, "Wasted Health Care Dollars," July 1992.

Corporate Report Minnesota, "Power in Numbers: How businesses are ganging up to control health care costs," November 1992.

Fortune, "Yes, the Market Can Curb Health Costs," Dec. 28, 1992, Pp. 84-88.

House File 431, 1992 legislative session.

InterStudy, *From HMO Movement to Managed Care Industry: The Future of HMOs in a Volatile Health Care Market*, June 1988.

Journal of Insurance Regulation, "Evolution and Impact of State HMO Regulation," Fall 1991, Pp. 110-128.

Laws 1992, Chapter 549, "HealthRight Law."

Minnesota Commission on Health Plan Regulatory Reform, *Final Report*, April 1989.

Minnesota Department of Health, *Health Maintenance Organizations, 1991 HMO Operations in Minnesota*, April 1992.

Minnesota Health Care Access Commission, *Final Report to the Legislature*, January 1991.

National Association of Insurance Commissioners, HMO Model Act.

New England Journal of Medicine, "Comprehensive Health Care Reform and Managed Competition," Vol. 327, No. 21, Nov. 19, 1992, P. 1525.

Office of the Legislative Auditor, Program Evaluation Division, *Health Plan Regulation*, February 1988.

St. Paul Pioneer Press, "Lawsuit that challenged hospital tax is dismissed," Dec. 18, 1992, P. 2B.

Wall Street Journal, "Health Insurance After McGann," Nov. 11, 1992, P. A14.

Wall Street Journal, "New Concept for Health Care Wins Support," Nov. 2, 1992, P. B1.

Wall Street Journal, "Self-Insurance of Health Plans Benefits Firms," Nov. 11, 1992, P. B1.