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STUDY OF HEALTH CARE MANAGEMENT COMPANIES

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Pursuant to 1992 Laws, Chapter 549, Article 1, Section 17

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Executive Summary

Administration of health services has been the fastest growing segment of the health care market during the past eleven years. In order to slow the rate of growth in health care spending, attention must be given to control of administrative and management costs as well as direct health care delivery segments of the market. Health care management companies, as defined in the Report, are a complex portion of health care delivery, and their corporate business and profits derive from negotiated contracts with health plans such as health maintenance organizations and self-insured employers to provide a wide variety of administrative and management services. To the extent that health care management companies contribute to the costs of health care, any direct or indirect controls of these costs may slow health care spending in Minnesota.

The Minnesota Health Care Commission's recommendations include several proposals which may in part reduce administrative costs and will affect health care management companies. This Report recommends, as part of these efforts to reduce administrative and management costs, that health care management companies:

- Adopt and use standard, uniform claim forms;
- Make use of electronic claims processing;
- Participate in the data collection efforts established in the 1992 MinnesotaCare Act;
- Comply with appropriate reporting requirements to report expenses/revenues as part of the overall data collection of health care expenditures in Minnesota.

Regulation of Health Care Management Companies

Among the provisions of Laws of Minnesota (1992), Chapter 549, as passed by the Minnesota Legislature in April 1992 was a requirement in Article I, Section 17 for the commissioners of commerce and health to study and to make recommendations to the legislature regarding the regulation of "health care management companies"(hereafter, HCMCs). The law requires the report to include:

(1) the definition of a for-profit, and non-profit health care management company;
(2) the scope and appropriateness of regulation of for-profit health care management companies, and of non-profit health care management companies;
(3) the extent to which cost containment and expenditure targets can be attained or realized through regulation of health care management companies; and
(4) the relationship between health care management companies and health care providers, health care plans, health care technology entities, and other components of the health care system.

Section 1:
Introduction

Much of the discussion on the rising costs of health care on a state or national level is attributed to administrative costs. One large segment of administrative costs is incurred through health care management companies (hereafter HCMC), both non-profit and for-profit. These management companies, as defined in Section 2, may sell health care related business products and services in addition to providing administrative and management services through contracts to other stakeholders in the health care delivery system. Administrative costs of health care are included in direct payments from public programs, third party payers (insurance companies, health maintenance organizations) and in individual out-of-pocket payments made to physicians, hospitals, clinics, and other groups which provide care. Hospitals and clinics likewise incur administrative costs associated with processing of claims for services driven by requirements of health plans, insurers, and the federal government. For example, the Mayo Clinic has 70 full-time employees dealing with 2,400 different insurers and government agencies[1].

Table One

National Health Care Expenditures 1980-1991 (Billions of Current Dollars)

Spending Type	1980	1991	% Change
Total	$249	$756	203.6%
Hospitals	102	286	180.4
Physician services	42	148	252.4
Dentist services	14	37	164.3
Other professional services	9	35	288.9
Drugs	20	52	160.0
Nursing Homes	20	61	205.0
Program administration	12	54	350.0

A U. S. Department of Commerce study on national health care expenditures indicated that "program administration", i.e., administrative and management costs, increased by 350% between 1980 and 1991[2] (Table 1). This is a greater percentage of change than any of the other types of health care spending in the national economy (e.g., hospital expenditures, drugs, nursing home costs).

In addition, there are similar Minnesota data which support the premise that health care administration is growing faster than any other type of health care spending. The attached chart, Table 2, is from the HMO Annual Report database that shows a 502% increase in administrative costs between 1980 and 1992. (See Table 2).

Nationally, total health care costs in 1992 were estimated to account for 14% of the nation's gross

Table Two

State of Minnesota HMO Expenditures 1980-91

(Per HMO member month)

Expense Category	1980	1991	% Change
Total	$33.44	$122.43	366%
Inpatient	$10.35	$32.81	317%
Outpatient	$19.76	$73.92	373%
Administrative	$3.14	$15.78	502%
HMO Enrollment	451,105	1,193,80	

(Some totals do not tie due to rounding of numbers.)

domestic product; this percentage of spending is expected to rise. There is great debate about directions for constraining the rising cost of health care while simultaneously increasing access to health care to the uninsured or underinsured. A key issue in the economy and in health care is whether or not reductions in administrative/ management expenses--if they can indeed be identified, could be used to expand health care benefits. The purview of this study and recommendations focus on HCMCs in connection with administrative costs because the business of these entities is to use their expertise to manage, for a fee, segments of the health care delivery system. We look to the possibilities for regulation, cost containment and expenditure targets in Minnesota as they exist at this time and particularly in light of the MinnesotaCare Act of 1992, the establishment of the Minnesota Health Care Commission and its plans to reduce costs and expand health care coverage. The charge to the Commission includes its own study and recommendations on the rate and growth of health care spending in general; however, its scope does not specifically address cost containment through regulation of HCMCs.

The MinnesotaCare Act of 1992 established the Minnesota Health Care Commission with the charge of developing recommendations to slow the growth of health care expenditures by 10% per year over the next five years. A major component of the Commission's recommendations is the formation of Integrated Service Networks (ISNs) which would be subject to limits on aggregate revenues and monitoring of expenditures. Those providers not affiliated with ISNs would be subject to extensive regulations on their price and utilization. The net result of these recommendations will be extensive safeguards to control the overall costs of health services in Minnesota.

One set of significant proposals in the Minnesota Health Care Commission's report deals with controlling the administrative costs of health services. Administrative costs will be reduced through the following:

- Adoption of uniform billing and claims forms and electronic data transfer
- Competition and incentives for health plan and provider efficiency
- Public commitments by Minnesota providers to meet cost containment goals
- The collection and analysis of data on administrative costs

Through these recommendations, it is anticipated that there will be strong safeguards against HCMCs contributing excessively to increasing health care costs. For HCMCs which contract with hospitals, physician groups or other providers, there will be strong incentives to assure that these providers' overall charges are in line with overall expenditure limits. Likewise, ISNs will be forced to develop and maintain contracts with HCMCs which allow the ISNs to stay within their overall budget cap.

Finally, while state agencies presently have some regulatory powers over the HCMCs which provide administrative and other services connected with health care delivery, regulation may be either precluded or greatly limited by federal laws preempting state authority, with particular reference to the Employee Retirement Income Security Act of 1974 (ERISA)[3], discussed further in Section 4.

Section 2: Definition
Health Care Management Company

For purposes of this report, HCMC is defined as "a for-profit or non-profit entity authorized to conduct business in this state, or under contract with another entity in this state, which provides management, administrative and other services related to health care delivery to another group for remuneration."

These may include transaction related services, benefits management services, selling and marketing services and regulatory compliance services including but not limited to:

- claims administration including payments, premium collection and claim review;
- prospective, concurrent or retrospective utilization review and case management;
- consultative services on health care benefit packages;
- topical research on health care issues;
- marketing, advertising or enrollment services;
- development of criteria, guidelines or algorithms for use in health benefit plans;
- quality assurance activities including research on utilization data, outcomes data, and other elements of quality improvement/quality assurance which are required by a government entity or by private insurers, unions or self- insured plans;
- staffing and resources to process enrollment information requests, complaint and appeal procedures;
- provider contracting;
- development of employee assistance programs for employer group plans;
- services involving establishment of preferred provider networks;
- sale or lease of computer programs for use in claims determinations, billing, accounts, utilization data or quality assurance/improvement research, and data processing; and
- legal and actuarial services.

Section 3:
Characteristics of Health Care Management Companies

This section will describe some of the types of services which are provided in administering or managing health care systems in this state. We also will use three examples of entities which fit under the definition of health care management companies to give a better understanding of the scope and breadth of the service types. It will also refer to other services and products of HCMCs provided in this state, regionally, or nationally, which are not typically administrative/management services products.

A. ADMINISTRATIVE/MANAGEMENT

Administrative costs for various sectors of the national health system (insurance and health plans, hospitals, nursing homes, physicians and clinics, firms and consumers/customers) can be divided into four basic areas[4]:

1. transaction-related
2. benefits management
3. selling/marketing
4. regulatory compliance

TRANSACTION-RELATED

Transaction-related costs include all costs connected with the submission and payment of claims, admitting and billing costs (for health care providers), tracking employee status in health coverage by employers, and submission of claims by consumers and individuals.

BENEFITS MANAGEMENT

Benefits management includes such diverse areas as statistical analyses, quality assurance, plan design, management of appeals by enrollees for coverage of services, and, for providers such as hospitals, physicians and nursing homes, and management information systems.

SELLING/MARKETING

Selling and marketing costs include underwriting, risk management, premium design, advertising, strategic planning and search costs for consumers (including employers) and individuals seeking health care coverage.

REGULATORY COMPLIANCE

Regulatory compliance includes, for example, payment of state premium taxes and compliance with statutory reserve and licensing requirements, filing of health plan descriptions, certificates of coverage and enrollment information, and administration of mandated state and federal benefits and continued coverage laws.

The Health Care Financing Administration has estimated that administrative costs for health care insurers, both public and private insurers, were approximately $38.2 billion nationwide for 1991. Of this, $28.2 billion represented costs to administer private insurance and $10 billion for public programs such as Medicare and Medicaid.

The following two tables illustrate administrative/management costs as percent of incurred claims in the private sector (Table 2A) and for public insurance (Table 2B):[5]

Table Two A

Private Health Plans Expenses as Percentage of Incurred Claims

	*Group Size**		
Function	*Individual*	*100*	*Over 10,000*
Commissions	8.4%	4.3%	3.0%
Sales, marketing, c ontract and legal work, underwriting, screening for adverse selection, client interaction, billing, accounting and data reports, personnel, accounting and facilities	12.5	4.8	0.7
Risk and profit	8.5	5.5	1.1
Claims administration	9.3	4.3	3.0
Regulatory costs (net of premium taxes and interest credit	1.3	0.9	0.6
Total	40.0	18.0	5.5

Table Two B

Public Insurance Expenses as Percentage of Incurred Claims

Function	***Medicare***	***Medicaid***
Commissions	low*	low*
Sales, marketing, c ontract and legal work, underwriting, screening for adverse selection, client interaction, billing, accounting and data reports, personnel, accounting and facilities	not available	not available
Risk and profit	not available	0.0%
Claims administration	1.5%	not available
Regulatory costs (net of premium taxes and interest credit	0.0**	0.0
Total	2.1	5.1

* Some expenses are incurred within Medicaid to enroll potentially eligible individuals. Medicare carriers incur some costs to receive designation as a fiscal intermediary.

** Does not include an estimated $294 million (fiscal year 1992) in direct costs within the Health Care Financing Administration (HCFA). Breakouts of Medicare totals are $1,457 billion in total expenses for Medicare contractors (Part A), $1.065 billion for claims processing, and $324 million for payment safeguards and $68 million in productivity investments. 75% of Medicare Part A and 42% of Part B claims are submitted electronically.

It should be noted that the data on private and public administrative expenditures are not directly comparable. Federal and state administrative costs may include many components (such as costs of certifying providers, determining program eligibility for Medicare and Medicaid, providing oversight through contracted peer review organizations and investigation of possible fraud and abuse by health care providers) which are not found in private insurance coverage. These costs are not included in estimates of public administration expenses.

Some costs of processing Medicare and Medicaid claims are lower than the private market possibly because standardized claim forms are currently in place and electronic billing is more highly developed and utilized than in the private sector. There are several other distinctions which make a comparison of administrative costs of private and public insurance difficult.

On the other hand, the costs of benefits management and regulatory compliance are greater in public programs than private programs. Commonly available comparisions of the two types of administrative costs do not include the federal/state regulatory costs and the substantial costs by providers to comply with the myriad of government requirements.

The above breakdown of administrative expenses also may not entirely reflect the differences and realities of administrative/management expenses of the various private sector entities. Factors such as the complexity and scope of administrative services, the experience and size of entities providing services, the size of enrollee base (employers, individuals) and in what setting they occur and who pays for the expenses make exact percentages difficult to assess. For example, health maintenance organizations in Minnesota incur a variety of administrative expenses (e.g, marketing the product, carrying out utilization review and quality improvement activities), which may be done by the health maintenance organization's staff or contracted out to a health care management company for a management fee. Health maintenance organization costs also vary from traditional indemnity insurance administrative costs since a health maintenance organization may act as both insurer and provider of health care. Insurance companies marketing health insurance incur costs of determining and paying claims; in this instance, the "costs" are a part of their profit margins. The large variation in administrative costs for the private sector is explained by the variation in scope of services provided to the individual consumer or commercial buyer, the number of enrollees serviced, and the substantial economies of scale which may exist for large and more "mature" companies providing management and administrative services.

Finally, hospitals and clinics incur administrative costs driven by the demands of submitting myriad claim forms, records and documentation to other parties such as Medicare's fiscal intermediaries, insurance companies, health maintenance organizations or the third party administrators who manage self-insured employer plans. Provider administrative expenses are costs of production, not activities which generate profits as is the case for management companies who provide these services for a fee.

B. OTHER ACTIVITIES OF HEALTH CARE MANAGEMENT COMPANIES

Many entities doing business in Minnesota provide other health care services and health care products in addition to providing administrative and management services. We have selected three entities to demonstrate the wide variety of types of HCMCs and the broad scope of activities they conduct. They are Employee Benefit Plans Inc. (EBP), an investor-owned corporation based in Minnesota, Healthspan, a non-profit corporation organized in Minnesota, and United HealthCare Corporation (UHC), another investor-owned corporation based in Minnesota. Limited information is available and is dependent upon voluntary reporting or required financial filings for investor-owned companies. These are examples of companies which provide a variety of health care products and are not inclusive of all HCMCs doing a portion of business in Minnesota. They are only intended to illustrate the wide variety of HCMC's involved in health care delivery.

1. Employee Benefit Plans (EBP) is an "integrated managed care company dedicated to helping America's employers control the cost of providing health care benefits to their work force" according to EBP's 1992 annual report. A Delaware corporation based in Minnesota, EBP provides health plan services to employers with self-funded employee benefit plans as an alternative to traditional indemnity health insurance or health maintenance organizations. Services include underwriting of stoploss insurance, claims payment and other administrative services including utilization review. EBP is licensed in Minnesota as a third party administrator (TPA) and must comply with the state statutes and rules of the Department of Commerce (see next section). The Department of Health has no regulatory authority over this corporation or its services, nor are figures available as to how many of the 626,300 employees (2,772 employer customers) covered nationwide are Minnesotans or how much revenue was generated in Minnesota. Revenues nationwide in 1992 were $218,648,000.

2. Healthspan, a non-profit corporation organized in Minnesota, was formed as a result of the merger of HealthOne Corporation and Lifespan and is a health care provider (hospitals, skilled nursing facilities, preferred provider organizations for employers with self-funded employee benefit plans such as the corporation itself) as well as a provider of management/administrative services and other diversified services in Minnesota, Michigan, South Dakota and Iowa. Healthspan owns ten Minnesota hospitals and is affiliated or provides management services to 9 more, some of which are located in other states. It has outright ownership or management control over 2600 licensed acute care beds in Minnesota hospitals, making it the second largest secular non-profit health care system in the United States. It provides management services for hospitals, long term care facilities, affiliated medical groups, and also operates diversified businesses such as medical transportation and home medical equipment. According to information provided by Healthspan, it is the largest health care delivery system in Minnesota with 17,000 professional, technical and support staff as well as responsibility for ownership and management of health facilities. Total revenues of the former separate entities in 1991 were $1.03 billion[6] . Present state regulation includes licensure for hospitals, health care profession-

als, ambulance services and nursing homes, as well as compliance with the state Department of Revenue regarding unrelated business income.

3. United HealthCare Corporation (UHC), an investor-owned corporation based in Minnesota, provides a variety of health industry services to clients in all fifty states and Puerto Rico, including ownership of for-profit health maintenance organizations in other states. Total enrollment in its owned and managed health plans nationwide was 1,380,000 persons at the time its annual report was issued in 1991. UHC provides comprehensive management services for two health maintenance organizations in Minnesota, Medica Primary and Medica Choice, including mental health and chemical dependency management services through a subsidiary corporation. Over 500,000[7] Minnesotans are enrolled in either the two HMOs or in self-funded employer plan groups managed by UHC for Medica. Less than 10% of the corporation's total revenues are attributed to business done in Minnesota for Medica. Its specialty managed care services in other areas include Diversified Pharmaceutical Services (a prescription drug management program), United Behavioral Systems (providing mental health and chemical dependencies services), a transplant center network, employee assistance programs and utilization management programs. UHC had national enrollments of 14,111,000 for these services during this period. UHC's major source of revenue nationally is from its owned for-profit health plans in other states ($664,806,000 of total revenues of $847,130,000 in 1991).

   The state has no direct regulatory authority over UHC except licensure as a third party administrator for employers with self-funded employee benefit plans , which is the purview of the Department of Commerce (see Section 4, present state regulatory authority).

Table 3 (next page) is a chart showing the services offered by these companies and the state regulatory authority.

Table 3: Selected businesses/services of three health care management companies and present state regulatory authority, if any. All references are to Minnesota Statutes only, and regulation references are to licensing and compliance with statutes and rules relating to the entity.

State Regulatory Authority			
Service/business	*Healthspan*	*United HealthCare*	*Employee Benefits Plan*
Hospital ownership	X - M.S. Chap. 144 (Health)		
Hospital management	X		
Nursing home ownership or management	X - M.S. Chap. 144A (Health)		
Preferred Provider Organization	X - M.S. Chap. 72A (Commerce)		
Home/Hospice Care/Management	X - M.S. Chap. 144A (Health)		
Medical Equipment	X		
Ambulance Services	X - M.S. Chap. 144 (Health)		
3rd party administrator for employer self-funded plans		X - Chap. M.S. 79A (Commerce)	X - same
Employee Assistance Services		X	
Organ Transplant Management		X	
Workers Compensation Case Management		X - M.S. Chap. 79A (Commerce)	
HMO Management Services		X	
HMO ownership (other states)		X	
Benefit Plan Design (self-funded employers)			X
Mental Health/Chemical Dependency Management		M.S. Chap. 245 M.S. Chap. 148 (Human Services)	X
Underwriting of stop/loss insurance			X - M.S. Chap. 72A (Commerce)

Healthspan is a non-profit corporation doing business in Minnesota and several other states.
United HealthCare is an investor-owned corporation doing business in all fifty states and Puerto Rico.
Employee Benefits Plan is an investor-owned corporation doing business nationally.

Section 4:
Present State Regulatory Authority of Health Care Management Companies

This section will briefly describe some, but not all, of the present authority over HCMCs, health maintenance organizations and third party administrators. Regulation related to licensing, permits, or Department of Revenue tax requirements are not included here. Part A describes the authority of the Department of Health with respect to health maintenance organizations and contracted management entities and Part B describes the authority of the Department of Commerce. Part C briefly describes the federal preemption from state regulation imposed by the Employee Retirement Income Security Act of 1974.

A. DEPARTMENT OF HEALTH

The Department of Health has limited regulatory authority over HCMCs which provide administrative, management and other services, including those which are reimbursed by the state's health maintenance organizations (HMOs).

Minn. Stat. 62D (1992) empowers the Department of Health to regulate the state's health maintenance organizations (HMOs), which, since they themselves may contract with provider physicians, hospitals and other health care facilities, are types of "health care management companies". Although all HMOs in Minnesota are non-profit by statute, several contract with separate for-profit management companies (some of which are "major participating entities" under the statute governing HMOs) to provide a variety of administrative services. In 1992, six of ten of the HMOs in Minnesota had management contracts with for-profit companies. These for-profit companies are United HealthCare Corporation, NWNL Management Company, Mayo Management Company, and American MedCenters Inc. (d.b.a. AEtna Health Benefits Inc.). The management contracts between a HCMC and an HMO may be scrutinized by the Department, and financial audits on an HMO and its contract provisions with a HCMC may be carried out to obtain needed financial information. Any fines, deficiencies or directives for corrective action plans are directed to the HMO. Table 4 (next page) shows HMOs by name, enrollment, management company, and for-profit or non-profit status of management company.

For those HMOs which contract with another entity to provide management services, HCMCs may be considered "major participating entities" as defined in Minn. Stat. 62D.02 subd. 13 (1992). A major participating entity (hereafter, MPE, used here rather than HCMC) is one which receives as compensation for services a sum greater than 30% of the HMO gross annual revenue or an entity providing administrative, financial or management services to the HMO if the total payment for all services provided by the participating entity exceeds 3% of the gross revenue of the HMO. HCMCs as "major participating entities" which provide services to HMOs come under the latter definition.

Table 4

HMO Enrollment in Minnesota			
HMO	*Enrollment 12/31/91*	*Management Company*	*Management Company Type*
Blue Plus	69,844	BCBS/MN	Non-profit
Central MN GHP	16,712	Self-managed	Non-profit
First Plan HMO	9,232	Self-managed	Non-profit
GHI/GroupCare	294,969	Self-managed	Non-profit
Mayo Health Plan	4,144	Mayo Mgmt. Co.	For-profit
MedCenters	258,839	AEtna Health Plans*	For-profit
Medica Choice & Primary	481,015	United HealthCare	For-profit
Metropolitan Health Plan	28,712	Self-managed	Local Government
NWNL Health Network	19,586	NWNL Mgmt. Co.	For-profit
UCare MN	10,709	University Affiliated Family Physicians	Non-profit
Total Enrollment	1,193,802		

* Recently merged with Group Health. A portion of the 1993 administrative services are done by the new GHI/MedCenter holding company directly.
NOTE: All Minnesota HMO corporations are nonprofit corporations or local government utilities. Management companies may be any type of corporation.

The Department of Health has statutory authority to examine the affairs of HMOs and their contracts/agreements with major participating entities. This includes inspection of an MPE's financial statements kept in the ordinary course of business as well as an examination of a MPE to ensure that an HMO has not incurred "unreasonable expenses", that is, any expense of any nature which is unreasonably high in relation to the value of the service or goods provided. The rationale for an "unreasonable expense" review is to safeguard the non-profit status of an HMO and to ensure that payments for services result in corresponding benefits to the organization (HMO) and its enrollees. Consideration is to be given to whether officers and trustees of an HMO have acted in good faith and in the best interest of the HMO in negotiating management agreements and in paying for the contracted services. In addition, an HMO must annually file, within 120 days of the anniversary of the implementation of a contract with a MPE, a document setting out the actual expenses incurred by the MPE in performing the contract in the preceding year as well as the revenues received by the entity from the HMO. Subsequent amendments to an original contract between a MPE, or a new contract for management services, must be filed with the Commissioner and may not be implemented until approved.

The Department has the authority to assess fines against HMOs and has done so in the past for deficiencies in management contracts. A substantial fine was assessed against an HMO and deposited in the general fund for violation of the management contract and failure of the HMO board to administer the contract in a manner which would minimize costs to the HMO. A finding of defi-

ciencies may be accompanied by a request for a corrective action plan, or for affirmative actions to correct a deficiency. In the instance cited above, a recommendation that the HMO retain an internal auditor to review management contract payments led to a substantial repayment from a MPE to the HMO.

Management contracts may involve a set percentage of HMO revenues or a fixed fee per HMO enrollee as payment for management services. Any payment of fees must take into consideration the size of the management entity (a very large and well-run organization may mean savings from the viewpoint of economies of scale and efficiency), the number of enrollees in the HMO, and the scope of the services provided to the HMO. There is not, in the national health care industry, a benchmark or uniform set of guidelines on costs (revenues to a MPE) which are "reasonable" or "unreasonable."

The Department reviews management contracts using the most current data, including anticipated fees compared to prior years' management fees, areas of management services supplied to the HMO and prior management contracts. Fees are reviewed and compared to state and national data.

Finally, those MPEs (HCMCs) which provide services to HMOs in Minnesota may be corporations which provide similar management services or other for-profit businesses in the health care industry in other states. None of the for-profit major participating providers (HCMCs) which provide services to the non-profit HMOs in Minnesota do business exclusively in this state.

B. DEPARTMENT OF COMMERCE

HCMCs, in and of themselves, are neither presently defined as a specific commercial entity nor licensed by the state of Minnesota. The definition could, however, include a licensed third party administrator (TPA) or a licensed insurance company marketing and providing administrative services. The Department of Commerce licenses and regulates all insurance companies which operate in Minnesota. At any time and for any reason related to the enforcement of insurance law or for financial solvency, the Commerce Commissioner may examine the affairs and conditions of any foreign or domestic insurance company engaged in health insurance; this also includes Blue Cross Blue Shield of Minnesota, a non-profit health service plan corporation licensed and regulated under Minn. Stat. 62C.

TPAs are not insurance companies selling health insurance in the state but are health care management companies, under the definition, cited above, which provide health care related services to employers with self-funded employee benefit plans subject to federal ERISA statutes and regulations. Under Minnesota Statute 60A.23, subd. 8, "no vendor of risk management services or entity administering a self-insurance or insurance plan may transact this business in this state unless it is licensed to do so by the commissioner" (of Commerce). A "vendor of risk management services" means an entity providing, for compensation, actuarial, financial management, accounting, legal or other services for the purpose of designing and establishing a self-insurance or an insurance plan for

an employer. "Administering a self-insurance or insurance plan" means (i) processing, reviewing or paying claims, (ii) establishing or operating funds or accounts, or (iii) otherwise providing necessary administrative services in connection with the operation of a self-insurance or insurance plan.

The license may be granted only when the commissioner (of Commerce) is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. At the present time, there are 167 entities which are licensed as third party administrators. Of the total, 128 provide services for the type of insurance encompassing accident, health, medical, hospital care, sickness, disability and dental care. The services provided by these entities can include any combination of the following: accounting services/record retention, actuarial services, claims administration, general administration, insurance, legal services, loss control and safety, rehabilitation, and risk management and analysis. Proof of coverage under a fidelity bond for all persons involved in making claim payments, and all officers of the company, is required to be submitted. The amount of fidelity bond required depends on whether or not the administrator commingles funds of either its fiduciary account or claims paying account.

Licenses are normally granted for a two-year period. At the time of application renewal, the entity is required to submit financial statements for the two most recent years. In the case of a renewal, the most recent year is required to have been audited. In addition to the financial statement requirement, the entity must complete an application indicating the types of insurance they wish to continue servicing and the type of services provided. The key employee/subcontractor must be specified and a resume on that specified individual must be included. If the applicant intends to provide workers' compensation and other liability claims adjusting, a resume detailing the experience of the supervisor who shall possess at least three years' experience adjusting claims in the area of services to be provided must be included. Furthermore, a copy of the license of the adjuster responsible for workers' compensation or other liability claims, if applicable, must be provided since the administrator or its subcontractor must have at least one adjuster licensed under Minnesota Statute 72B. The information is then reviewed by designated Commerce department personnel to insure that the applicant is in compliance with these statutory requirements. Once this determination has been made, a license will be granted or denied.

C. FEDERAL REGULATION THROUGH ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) allows self-funded employer health benefit plans to develop individual packages for employees which need not comply with state mandated benefits set out in health insurance and health maintenance organization statutes or pay premium taxes. The U. S. Department of Labor oversees employer compliance with statutes and federal regulations related to these employer-funded plans.

As noted above, Minnesota does require licensure and compliance with statutes and rules by third party administrators which provide administrative and management services to self-funded employer

sponsored benefit plans. This is the extent of regulatory authority the state presently has with reference to ERISA self-funded employer plans.

In 1991 approximately 1.3 million Minnesotans received their health care through their employer via an ERISA plan[8], and figures on total payments and administrative costs for these self-insured plans are unavailable except for voluntary reporting and information found in required federal filings for investor-owned corporations. Approximately 1.2 million Minnesotans were enrolled in health maintenance organizations during that period.

Section 5:
Recommendations

Following are our recommendations to the legislature regarding Article I, Section 17 of the MinnesotaCare legislation.

(1) The definition of a for-profit, and non-profit health care management company:

We recommend the definition of a health care management company as set out in Section 2 as follows:

> For purposes of this report, a health care management company (hereafter, HCMC) is defined as "a for-profit or non-profit entity authorized to conduct business in this state, or under contract with another entity in this state, which provides management, administrative and other services related to health care delivery."
>
> These include transaction related services, benefits management services, selling and marketing services and regulatory compliance services including but not limited to:
>
> - Claims administration including payments, premium collection and claim review
> - Prospective, concurrent or retrospective utilization review and case management
> - Consultative services on health care benefit packages;
> - Topical research on health care issues;
> - Marketing, advertising or enrollment services;
> - Development of criteria, guidelines or algorithms for use in health benefit plans;
> - Quality assurance activities including research on utilization data, outcomes data, and other elements of quality improvement/quality assurance activities which are required by a government entity or by private insurers, union or self-insured plans;
> - Staffing and resources to process enrollment information requests, complaint and appeal procedures;
> - Contracting services for health care providers
> - Development of employee assistance programs for employer group plans;
> - Services involving establishment of preferred provider networks;
> - Sale or lease of computer programs for use in claims determination, billing, accounts, utilization data or quality assurance/improvement research;
> - Data processing;
> - Legal and accounting services.

(2) The scope and appropriateness of regulation of for-profit health care management companies, and of non-profit health care management companies;

We recommend controlling rising administrative costs attributable in part to the business of HCMCs to be handled within the overall context of the recommendations of the Minnesota Health Care Commission. The combination of incentives for competition, extensive data reporting and accountability for meeting overall expenditures will enable overall health care costs including the costs of HCMCs to be controlled.

In accordance with this overall recommendation, we propose specifically the following items relating to the costs of HCMCs:

a. We recommend that all HCMCs contracting with Minnesota providers and health plans use standardized claims and billing forms.

b. We recommend that all HCMCs participate in the data collection effort established in the 1992 MinnesotaCare Act and delineated by the Minnesota Health Care Commission.

c. We recommend that the appropriate reporting requirements be established for HCMCs to report expenses/revenues as part of the overall data collection of health care expenditures.

d. We recommend and encourage the use of electronic claims processing as proposed by the Administrative Uniformity Committee to the Minnesota Health Care Commission.

(3) The extent to which cost containment and expenditure targets can be attained or realized through regulation of health care management companies;

The overall target for the recommendations of the Minnesota Health Care Commission is to slow the growth in health care expenditures by 10% over the next five years. It is the consensus of the Commission that all of the proposals for cost containment taken together will enable this target to be met.

As a result, we recommend that no additional regulation of HCMCs be instituted, above and beyond the recommendations of the Minnesota Health Care Commission. The involvement of HCMCs in the data reporting and the overall expenditure limits of health care providers will assure their contribution to meeting the overall health expenditure target.

(4) The relationship between health care management companies and health care providers, health care plans, health care technology entities, and other components of the health care system:

We recognize that the relationship between HCMCs and health care providers, health plans, health care technology entities and other components of the health care system to be extremely complex.

For those organizations which organize their services as an Integrated Service Network, as proposed by the Minnesota Health Care Commission, there will be overall accountability for controlling health expenditures without "micromanaging" the internal operations within the ISN. As a result, as much flexibility as possible should be given to ISNs in their dealings with HCMCs.

For providers who do not participate in an ISN, stringent price and volume limits will be imposed on individual services. Those providers will be responsible for determining the extent to which their relationships with HCMCs enable them to operate efficiently within the price and volume limits.

The recommendations of the Minnesota Health Care Commission will need to be carefully monitored in future years to assure that the health expenditure targets are adequately met. One component of these evaluations should be the role of HCMCs in their services for health care providers and health plans.

Section 6:
Endnotes

1 The New York Times, January 24, 1993, p.1.

2 Sources: U.S. Department of Commerce, U.S. Industrial Outlook, 1991, (U.S. Government Printing Office), Chapter 44: H.C. Lazenby and S.W. Letsch, "National Health Expenditures, 1989, Health Care Financing Review 12, no. 12 (Winter 1990): 1-26.

3 29 U.S.C. §1144 (1974).

4 Kenneth E. Thorpe, "Inside the Black Box of Administrative Costs", Health Affairs (Summer 1992): 41-55.

5 Congressional Research Service, Insuring the uninsured: Options and Analysis (October 1988); and U.S. House of Representatives, Committee on Ways and Means, Overview of Entitlement Programs, 1991 Green Book (Washington, D.C.: U.S. GPO, 1991).

6 CityBusiness, May 22, 1992, p.14.

7 Reported in the summer, 1992 issue of "Living Smarter", a Medica publication sent to enrollees in Medica Primary and Medica Choice.

8 Figure supplied by the Health Care Analysis Program, Minnesota Department of Health.