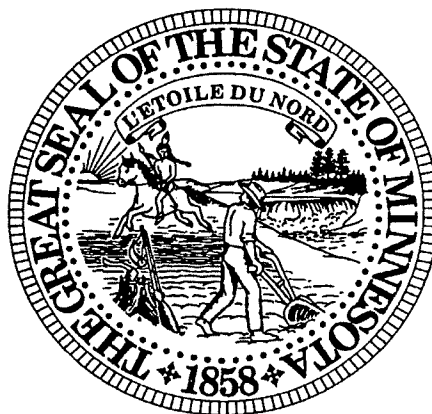

Direct Contracting for Health Care Services

Final Report to the Legislature



Department of Commerce
Department of Health

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Direct Contracting for Health Care Services

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*As required by Minnesota Statute 3.197: This report cost approximately \$6,600
to prepare including staff time, printing and mailing expenses.*

STATE OF
MINNESOTA



January 31, 1997


Dear Legislative Oversight Committee Member:


With this letter, we are transmitting to you our final report titled "Direct Contracting for Health Care Services." This report was requested by the 1996 Legislature (*Minn. Laws* (1996), Ch. 451, Sec. 3), in response to interest expressed by constituents during the session, as well as by continuing changes in the health care market.

In conducting this study, the commissioners sought input from those who would likely be affected by this new type of health care delivery system, including consumers, health plans, providers, and employers. In addition, comments on the draft report were solicited from this group. All comments from interested parties have been considered in developing this final report.

In brief, the report concludes that allowing risk-sharing direct contracting arrangements between otherwise self-insured employers and provider groups (PSOs) is feasible, and that such arrangements should be regulated by the state for the protection of consumers. The report describes the regulatory tools currently available to the commissioners, and lays out some changes the legislature may wish to consider if it determines that it is desirable to encourage the development of this type of direct contracting arrangement.

Sincerely,


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Executive Summary

The 1996 Minnesota Legislature directed the Commissioners of Commerce and Health to conduct a study and report to the Legislative Oversight Commission on health care access on:

the feasibility of allowing direct provider contracting of health care services. Included in this report shall be recommendations on the consumer protections, reserve requirements, and protections for consumers who will not have direct contracting available to them that the legislature should consider to ensure protection of persons receiving health coverage through networks allowed to conduct direct provider contracting (Minn. Laws (1996), Ch. 451, Art. 1, Sect. 3.).

This report fulfills that mandate. The following sections are included in the report: recommendations, overview of direct contracting concept, financial solvency issues, and quality assurance and access to care issues. The legislature may wish to consider these recommendations in deciding whether to permit direct contracting arrangements in the state.

I. Overview Of Direct Contracting

The health care market has been in a period of rapid and dramatic change in recent years. New service delivery systems are emerging, and public and private buyers of health care services have begun to pursue new purchasing strategies, including the consideration of direct contracting arrangements. In turn, health care providers have, in some cases, begun to create cooperatives to market their services to employers, as well as to more traditional, state-licensed health plans.

What is Direct Contracting?

Throughout this report, *direct contracting* refers only to a contract for health care services offered by a provider sponsored organization (PSO), typically to an employer, where *the PSO accepts the risk* for utilization of health care services above the anticipated level. Direct contracting could take a number of forms. For example, the contract could require the employer to pay for health care services on a fee-for-service basis, or could involve a withhold to be paid to providers if utilization remains within some limit. This is in contrast to the currently available options where employers purchase health care coverage from an insurer or from an insured health plan such as an HMO or Blue Cross/Blue Shield, or where the health care coverage is provided by a self-insured employer on a fee-for-service basis.

Although much of the discussion in this report concerns PSOs that provide a broad range of health care services, another type of organization, sometimes referred to as a limited service organization (LSO), could also be developed. LSOs might provide pharmacy services, vision services, dental services, or mental health services, for example. Because the LSO provides only one type of service, it assumes much less risk than a full-service PSO, and would likely require a different level of regulation.

Possible Advantages and Disadvantages of Direct Contracting

Direct contracting between provider groups and employers is thought to have the potential to provide several advantages for purchasers, providers, and enrollees. Observers also suggest a number of potential disadvantages, however. In addition, the interests of various groups, such as consumers and purchasers, could at times conflict, so that an advantage for one group may be seen as a disadvantage for another. Because this type of direct contracting arrangement is currently not legal in the state, many of these remain open questions. The advantages and disadvantages are discussed in more detail in the body of the report.

Possible Advantages

- May help to counter trends toward market consolidation in recent years.
- May encourage increased competition.
- May result in increased choice, as well as more information about available options in health care services, for consumers.
- May increase provider accountability and improve incentives for providers to provide cost-effective, high quality care.
- Depending on state regulation, some or all payments to PSOs may not be subject to MCHA assessments, premium taxes, mandated benefit requirements, guaranteed renewal, or other state insurance laws.

Possible Disadvantages

- Increased risk to enrollees if coverage is terminated due to provider insolvency.
- Less ability to assure that enrollees have access to an adequate level of services.
- Lack of protection for enrollees in the areas of quality control, utilization review, marketing and disclosure, and appeal rights.
- Administrative costs may be duplicated, rather than reduced.
- The provider in a direct contracting arrangement could be subject to all state insurance regulations and mandates, and the self-insured employer could lose the advantages of the ERISA preemption.
- Under a direct contracting arrangement, there may not be a contractual relationship between the enrollee and the PSO.

Current Activities in Minnesota

A 1995 MinnesotaCare® amendment specifically authorized a demonstration project of direct contracting between a specific provider cooperative and qualified employers or self-insured employer plans. The statute requires the provider cooperative to notify the Department of Health when it enters into a contract with a self-insured employer. The department is required to report by 1999 on the status of this direct contracting. Two additional pilot projects were authorized by the 1996 Legislature. All three of these provider co-ops are located in southwestern Minnesota. None of these cooperatives is currently directly contracting with employers. All are relatively new entities, and in some cases they do not yet have large enough provider groups to enable them to efficiently contract directly with employers.

The employers in the Buyers Health Care Action Group (BHCAG), a Twin Cities-based buying coalition of 24 of the state's largest self-insured employers, currently offer the network of a single large HMO, HealthPartners, to their employees. According to BHCAG representatives, by 1997 the group intends to contract with smaller groups of providers, or *care systems*, on a modified fee-for-service basis that would allow BHCAG member employers to remain self-insured. BHCAG's proposed plan will include risk adjustment; fee schedule adjustments to reflect utilization changes; requirements for quality assurance activities; and data reporting requirements.

With the increasing complexity of risk sharing mechanisms such as this one, it is increasingly difficult to determine how the risk is actually apportioned. Although BHCAG's plan clearly involves the transfer of some risk, it is difficult to determine exactly how much. The state would not hesitate to define BHCAG's program as insurance if it was felt necessary. Two factors have been taken into consideration by the commissioners in determining not to exert regulatory authority at this time, but instead to continue to monitor and evaluate this direct contracting model. First, the risk adjustment mechanism in the plan gives some assurance that care plans will not inadvertently take on more risk than they are able to cover. Second, and more importantly, the commissioners have some confidence that the BHCAG employers, due to their size and financial resources, would be able to maintain their commitment to their employees in the event of an insolvency of a care system. Similar plans operated by smaller employers would be closely scrutinized, and possibly brought under regulation, by the state.

Current National and State Activity

Direct contracting has generated considerable interest at the national level, as well as in a number of other states, including Iowa, Colorado, Georgia, and Ohio. Input from around the nation may be helpful as the legislature considers whether and how to regulate new types of health care arrangements. In addition, the National Association of Insurance Commissioners (NAIC) is currently working on a white paper on the topic of direct contracting, and has suggested that capitated provider networks be exempted from state insurance regulation only if the provider agrees to assume all or part of the risk for health care expenses or service delivery under a contract with a licensed health insurer.

Regulatory Issues

Some of the regulatory issues regarding direct contracting are, to some extent, out of the direct control of the state. Two of those issues, Employee Retirement Income Security Act (ERISA) issues and antitrust issues, are discussed in this report.

II. Financial Solvency Issues In State Regulation Of Health Plans

One of the main concerns of the state in its role as insurance regulator is consumer protection in the case of health plan insolvency. The Departments of Commerce and Health have regulatory oversight of health plans, including preventive measures to minimize the risk of insolvency and

measures to protect the consumer in case an insolvency occurs. State financial requirements of health plans are strict, because the state's goal is to have a very low risk of health plan insolvency.

Current regulatory protections against health plan insolvency include the following provisions:

Reporting and Oversight

Health plans are required to file quarterly and annual statements of financial position with the Department of Health or Commerce.

Reserve Requirements

Health plans are required to establish liability amounts in their financial statements for any incurred expenses or claims that have not yet been paid. These liability amounts are referred to as "reserves."

Capital and Surplus Requirements

In general, a health insurance company or HMO must have an initial capital and surplus of \$1.5 million and it must not fall below \$1 million. A Community Integrated Service Network (CISN) must have initial capital of \$500,000, and must increase it to \$1 million by the end of its third year of operation. A nonprofit health service plan corporation must have an initial capital and surplus of \$400,000. All of these health plans must constantly maintain a surplus that reflects their increasing liabilities.

Guaranty Association

Health insurance companies and nonprofit health service plan corporations are required to join a guaranty association. In the event that a member becomes insolvent, and that its assets are insufficient to cover its obligations to policy holders, the association will assess its members for sufficient money to meet those obligations up to a limit defined in law. Enrollees of an insolvent HMO or CISN are entitled to enroll in the Minnesota Comprehensive Health Association (MCHA is the state's high risk pool) without satisfying a pre-existing condition limitation. An additional protection is provided in *Minn. Rules* §4685.0600, which requires the HMO to continue to provide health care services for 60 days after the discontinuance of the HMO.

Risk Sharing Issues

One of the greatest challenges for the state in its mission of consumer protection is the complicated nature of risk sharing arrangements that have evolved around health care payment. Where do the risks lie in these arrangements? What are the consequences to the consumer if any of the entities involved becomes bankrupt and closes its doors? Is the consumer aware of these arrangements? The state is responsible for answering these questions if it is to fulfill its responsibility to the consumer.

The financial risk to organizations is sometimes divided into the two categories of "insurance risk" and "business risk." Insurance risks are "risks arising from the pooling of risks and the advance funding of expected average costs" (as defined in a monograph from the American

Academy of Actuaries). Business risks are risks arising from the organization's conduct of its business (i.e. how they invest their surplus). For an organization providing insurance coverage, insurance risk is a type of business risk. From the point of view of state regulation, a more important determination is which risks can severely impact the consumer.

The National Association of Insurance Commissioners is now testing a formula for "Health Organization Risk Based Capital." The intent is to use the formula to establish appropriate levels of capital needed to protect the public based on the risk that the organization assumes. The formula is intended to apply to any organization taking on health insurance risk, regardless of its structure or name. Although the formula is unlikely to be final until late in 1997, it may be useful to the state in the future in evaluating the level of risk assumed by PSOs and in establishing appropriate regulation of them.

III. Minnesota Department Of Health Oversight Of HMOs and CISNS

The onset of managed care has brought about the need for regulation of the quality and access of health care services. All HMOs, CISNs, and Preferred Provider Organizations, and most insurers and Blue Cross and Blue Shield Plans utilize one or more methods to manage the care that their enrollees or consumers receive. Some of these managed care techniques may create disincentives for health plans to provide care to enrollees. Minnesota statutes and rules address these potential disincentives by ensuring that comprehensive medical services are available and accessible and providing mechanisms for assuring the quality of care that consumers receive from their health plans.

Financial Regulation

HMOs and CISNs licensed to operate in Minnesota must meet financial solvency requirements. Each health plan must file annual and quarterly reports with the Department of Health (MDH), and in addition, the department conducts financial examinations of each HMO and CISN at least once every two years.

Quality and Accessibility

Quality Assurance

Minn. Stat. §62D and Minn. Rules §4685 define quality assurance in broad terms and include the following requirements for HMOs and CISNs:

Written quality assurance work plan. These rules require each HMO and CISN to have a written quality assurance work plan that describes the plan's quality assurance program, methods for reviewing and evaluating data related to quality of care, and ways in which the plan works to identify and correct problems related to quality.

Ongoing quality evaluation. HMOs and CISNs must conduct evaluations of quality on an ongoing basis.

Focused studies. HMOs must conduct three focused studies per year to acquire information relevant to quality of care.

Statistics. This rule requires HMOs and CISNs to compile, evaluate and report statistics, including gross utilization aggregates, operational statistics, demographic characteristics of the enrollees, disease-specific and age-specific mortality rates, and enrollment statistics.

Enrollee complaints. This rule requires HMOs and CISNs to have an internal system for handling enrollee complaints. At any time, a consumer may submit a complaint to the commissioner for investigation.

Department of Health quality assurance audits. The department conducts quality assurance audits of each HMO and CISN once every two years.

Availability and Accessibility of Services.

HMOs and CISNs must provide a full range of primary and specialty care services in a timely manner, and those services must be available within a reasonable geographic distance from the enrollees.

Contract and Rate Review

MDH reviews and approves enrollee certificates of coverage, premium rates for small employer group health plans, individual health plans, conversion health plans, and Medicare supplement health plans. In addition, MDH reviews contracts between HMOs and providers. While CISNs do not file their provider contracts with the department for review, their contracts must be in compliance with *Minn. Stat.* §62D.123, and MDH checks for compliance during audits and in response to complaints from consumers or providers.

Enforcement

An important component of the regulatory oversight of HMOs and CISNs is the authority of the commissioner of health to enforce the statutes and rules that apply to these health plans. The commissioner may take any of a number of enforcement actions against HMOs or CISNs that have been found to violate relevant statutes or rules.

The department takes enforcement actions in response to issues raised during the department's routine financial, quality assurance and market conduct audits, as well as in response to the investigation of complaints from consumers.

IV. Minnesota Department Of Commerce Oversight Of Insurance Companies And Nonprofit Health Service Plan Corporations

The Department of Commerce (DOC) regulates insurance companies, fraternal and nonprofit service plan corporations who are licensed to market health insurance to Minnesota's residents. The principal mission of the Department of Commerce is to enhance the stability and strength of these companies, enforce state laws and safeguard consumer's rights and resolve conflicts between the consumers and these companies.

Financial Regulation

Each health insurance company, fraternal and nonprofit health service plan corporation who wants to operate in Minnesota must meet certain financial requirements before it may be licensed by the Department of Commerce. When appropriate, the commissioner may authorize investigations or take administrative action to protect the policyholders.

Policy Analysis and Review

The Department of Commerce annually reviews health forms to determine whether they are in compliance with Minnesota's regulations. All rates that are to be used with these health insurance products are reviewed to determine if they are reasonable and in compliance with Minnesota's regulations. All individual rate increases must receive prior approval, before they can be implemented. (*Minn. Stat.* §62A.02).

Preferred Provider Organizations (PPO's) are indirectly regulated when they are affiliated with a licensed health insurer, who must provide summary data regarding the financial reimbursements offered to the providers, listing of a separate organization that administers the plan, name and addresses of all providers, terms of agreement with designated health care provider and records of all complaints submitted to the arrangement. Additionally, the department reviews each of these PPO arrangements to determine if the number and location of its providers are adequate (*Minn. Stat.* §72A.20, subd. 15(4)).

Multi-Employer Welfare Arrangements (MEWAs) are groups of two or more self-insured employers that jointly offer health care coverage to their employees. MEWAs are regulated under *Minn. Stat.* § 62H and *Minn. Rules* §2765. These joint self-insurance employee health plans are authorized if they comply with the excess stop loss coverage risk management or administrative services, management of funds and other statutory (*Minn. Stat.* §§62A, 62E and 72A) requirements.

Enforcement

The enforcement section responds to inquiries and complaints from enrollees. Under *Minn. Stat.* §72A, insurers must complete their investigations and inform their insureds of acceptance or denial of a claim within 30 business days after receipt of notification of the claim (*Minn. Stat.* §72A.201). If the insured is dissatisfied with the claim denial, he may appeal directly to the insurer or to the Commissioner of Commerce.

Insurers must operate under the unfair methods and unfair and deceptive acts section of the regulations of trade practices. The Commissioner of Commerce has jurisdiction to investigate unauthorized insurers and false advertising, and issue a cease or desist order if necessary.

V. Utilization Review Oversight by the Departments of Commerce and Health

The provision of appropriate and necessary medical care is a component of managed care that is commonly used by various types of health plans. Utilization review is the manner by which health plans determine whether or not certain procedures, services or benefits are medically necessary. Health plan companies that conduct utilization review procedures must do so in compliance with *Minn. Stat. §62M*, the Minnesota Utilization Review Act of 1992. The Departments of Commerce and Health are responsible for enforcing this statute for the entities that they regulate.

VI. Findings and Recommendations

Direct contracting between employers and risk-bearing provider sponsored organizations (PSOs) is clearly feasible. When a PSO assumes risk from the employer, however, we believe that the PSO may be in the business of insurance and will need to be regulated by the state to protect the consumers that they serve. While the state is obligated to protect consumers, regulation should interfere as little as possible with the operation of the market.

All types of health plans, including risk-bearing PSOs, that offer similar services should be regulated in a similar manner. Risk-bearing PSOs can be thought of as *mini care systems*, similar to HMOs and CISNs. Their regulation should be similar to current regulation of HMOs and CISNs. Limited service organizations (LSOs), those that would provide only one type of service, such as pharmacy, vision or dental services, may be regulated less extensively.

One option available to the legislature is to do nothing further with regard to risk-sharing direct contracting by provider groups, because the Departments of Commerce and Health currently have in place the statutes and rules necessary to regulate the business of insurance. Other attempts to allow new forms of service delivery in the state, including Health Care Provider Cooperatives and Community Integrated Service Networks (CISNs) have not proven useful. The legislature could choose to attempt to determine what have been the barriers to provider acceptance of these models, before embarking on new legislation.

While the commissioners do not necessarily believe that a new regulatory structure would be appropriate at this time, the following are general areas of regulation that could provide a starting point for the design of a new regulatory structure, should the legislature determine that new regulation is desirable:

Solvency

This report presents two options for regulating the solvency of risk-bearing PSOs. The legislature might choose one or the other, or PSOs could be given the choice of being regulated under whichever framework best fits their circumstances. Under each option, solvency and oversight requirements are the same after the first five years of operation.

Under one option, financial requirements would be less in early years, becoming more stringent over time. This is similar to the current solvency standards for CISNs (*Minn. Stat.* §62N). At the same time, regulatory oversight would be heavier at first but lightened in later years as the organization developed. The initial net worth requirement would be \$500,000. After five years of operation, the PSO would have to have \$1 million in net worth. LSOs would need initial capital of \$200,000, plus six months of projected revenue.

An alternate way of regulating PSOs would be to start the level of regulation at \$1 million. LSOs would be required to have initial capital of \$500,000.

Quality

- PSOs would need to meet HMO quality standards
- PSOs would not be required to file reports showing that they met the standards, but would be required to certify to the commissioner that they had done so.
- MDH would audit a random sample of PSOs annually.
- MDH would retain the authority to audit at any time.

Access

- PSOs would need to comply with nondiscrimination language in regard to both individual enrollees and employers.
- MDH\DOC would perform market conduct audits, including scrutiny of marketing materials and enrollee cards.

Complaints

- The PSO would be required to maintain 24-hour access to customer service.
- The PSO would be required to report complaints to MDH\DOC.
- Enrollees in PSOs would retain the right to complain directly to MDH\DOC.
- The PSO would be required to agree to submit to an impartial arbitration procedure in the event an enrollee complaint cannot be resolved.

Subcontracting

- Subcontracts would be limited to 10% of annual capitation fees.
- MDH\DOC would be notified of all subcontracts.
- MDH\DOC would not be required to review all subcontracts, but would retain the right to review any at any time.

Other Requirements

Other state requirements should be reviewed for applicability to a risk-sharing PSO. For example, guaranteed issue and renewability, portability, premium taxes, assessments for the high risk pool, or membership in a guaranty association may be appropriate legislative requirements for risk-bearing PSOs. Each of these requirements places some additional burden on the licensed plans. To the extent that a level playing field for all health plans is desirable, risk-sharing PSOs would need to be included in these requirements.

I. Introduction and Overview

The health care market has been in a period of rapid and dramatic change in recent years. New service delivery systems are emerging, and public and private buyers of health care services have begun to pursue new purchasing strategies, including the consideration of direct contracting arrangements. In turn, health care providers have, in some cases, begun to create cooperatives to market their services to employers, as well as to more traditional, state-licensed health plans.

To guide discussions about the role of government in this dynamic market, Governor Carlson has articulated several basic principles, including the following:

- Let the market be the primary entity to sort out the delivery of health care and the quality acceptable to customers. As regulator, government should not replace the free decisions among various stakeholders such as purchasers, care providers, and customers.
- The state should allow market creativity and flexibility among providers while assuring sound solvency standards.
- It is preferable to let the market design products through interactions among stakeholders rather than through mandated benefits.
- Let the market, operating in a competitive framework, determine prices.
- The state has a role in the protection of consumers as it relates to assuring and protecting the health of the public. The state must work with market stakeholders to determine quality standards and help assure that the market continues to meet these standards.

The 1996 Minnesota Legislature directed the Commissioners of Commerce and Health to conduct a study and report to the legislative oversight commission on health care access on:

the feasibility of allowing direct provider contracting of health care services. Included in this report shall be recommendations on the consumer protections, reserve requirements, and protections for consumers who will not have direct contracting available to them that the legislature should consider to ensure protection of persons receiving health coverage through networks allowed to conduct direct provider contracting (Laws of Minnesota 1996, Chapter 451, Article 1, Section 3.).

This report is submitted to fulfill that mandate. The report describes issues related to direct contracting arrangements, and includes recommendations on consumer protection and reserve

requirements, as well as protections for consumers who do not have access to direct contracting. The legislature may wish to consider these recommendations in discussions about legislation regarding direct contracting arrangements in Minnesota.¹

What is Direct Contracting?

Direct contracting refers to a contract for health care services offered by a provider sponsored organization (PSO), typically to an employer. Direct contracting could take a number of forms. For example, the contract could require the employer to pay for health care services on a fee-for-service basis, or could involve a withhold to be paid to providers if utilization remains within some limit.

Throughout this report direct contracting refers only to the situation where *the PSO accepts the risk* for utilization of health care services above the anticipated level. This is in contrast to the currently available options where employers purchase health care coverage from an insurer or from an insured health plan such as an HMO or Blue Cross/Blue Shield (BCBSM), or where the health care coverage is provided by a self-insured employer on a fee-for-service basis. The following examples illustrate some key differences between these various arrangements for providing employer-based health care coverage.

Example 1: A health plan provides coverage to an employer for its employees. Employees use the health care services they need, and the health plan pays for or provides those services. All insurance risk - the risk that the enrolled group needs more services, or more costly services, than anticipated - lies with the health plan. The health plan is licensed and regulated by either the Department of Commerce or the Department of Health to assure that enrollees receive the services that have been paid for.

Example 2: A self-insured employer defines a set of health care benefits it will provide for employees. Employees use health care services as necessary, and the employer pays providers on a fee-for-service basis. All of the insurance risk in this case lies with the self-insured employer. The state is not permitted to regulate self-insured employers with regard to employee benefits, because they are covered under federal ERISA (Employee Retirement Income Security Act) law. ERISA provides some protections for enrollees, and the recent Health Insurance Portability and Accountability Act of 1996 (often referred to as the "Kassebaum/Kennedy" bill) added some further protections.

Example 3: A PSO contracts directly with an employer, agreeing to provide all health

¹It is important to note that this report does not address direct contracting for Medical Assistance services. The issues involved in county direct contracting are inherently different from those involved in direct contracting for private health care coverage, and will likely require different solutions. The Department of Human Services, the Association of Minnesota Counties, and the Department of Health have committed to continue to work together to develop meaningful county participation in service purchase.

care services needed by employees in exchange for a capitated payment. All of the insurance risk lies with the provider group in this situation. If the employer is self-insured, it cannot be regulated by the state, but the provider group is regulated to the extent it is providing insurance.

A joint memo issued by the Departments of Commerce and Health in 1995 explained the state's position with regard to health care provider cooperatives assuming risk.² The commissioners stated that contracts between provider cooperatives and self-insured employers can only be on a "substantially capitated or other risk sharing basis." By sharing substantial risk, providers who would otherwise be considered competitors can avoid federal antitrust issues. The requirement for substantial risk sharing has been the policy of federal antitrust agencies for many years, and has been applied to Independent Practice Associations (IPAs) and other provider organizations, as well.

Because this risk-sharing requirement inherently involves an assumption of risk by the PSO, the relationship is considered by the state to be the business of insurance. The PSO would therefore be required to be licensed as an HMO, CISN, BCBSM plan, or indemnity insurer (Note that an exception to this requirement has been granted to several health care provider cooperatives on a pilot project basis. They are discussed further later in this report.).

Although much of the discussion in this report concerns PSOs that provide a broad range of health care services, another type of organization, sometimes referred to as a limited service organization (LSO), could also be developed. LSOs might provide pharmacy services, vision services, dental services, or mental health services, for example. Because the LSO provides only one type of service, it assumes much less risk than a full-service PSO, and would likely require a different level of regulation. These differences are discussed further later in the report.

Possible Advantages and Disadvantages of Direct Contracting

Direct contracting between provider groups and employers is thought to have the potential to provide several advantages for purchasers, providers, and enrollees. Observers also suggest a number of potential disadvantages, however. In addition, the interests of various groups, such as consumers and purchasers, could at times conflict, so that an advantage for one group may be seen as a disadvantage for another. This section provides a discussion of some of those issues. Because this type of direct contracting arrangement is currently not legal in the state, many of these remain open questions.

Possible Advantages of Direct Contracting

- **May help to counter trends toward consolidation in the health care market.** Some observers have expressed concern in recent years over the continuing trend toward fewer, larger entities dominating the health care market. Direct contracting could have the effect of

²The definition of PSOs in this report includes health care cooperatives.

allowing more, smaller entities to enter the market, especially if it proved to be popular with employers.

- **May encourage increased competition.**

To the extent that smaller provider groups enter this market, more competition will result. Because they may contract for ancillary services, even full-service PSOs may not need to have all health care services available within their organization, although they will need to have some "critical mass" in order to successfully directly contract with purchasers.

- **May result in increased choice, as well as more information about available options in health care services, for consumers.**

With a greater number of providers participating in the market, and increased competition among providers, purchasers may have more leverage to require providers to provide information about quality. Providers may also choose to compete for enrollees, in part, on the basis of offering good information on the cost and quality of the services they provide. The information will allow consumers or group purchasers to shop for health coverage based on quality as well as cost, enhancing consumers' influence in the health care market.

- **May increase provider accountability and improve incentives for providers to provide cost-effective, high quality care.**

When health care is purchased from a health plan with a broad network, individual providers may not be held accountable for the cost and quality of care they provide. Ineffective providers' experiences are blended with those of more effective providers. Any information consumers receive is likely to be on a plan-wide basis, with variations among individual providers obscured. In a direct contracting arrangement, individual providers' performance could be more easily discerned. In addition, providers competing directly in the health care market might more quickly feel the effects of providing health care inefficiently, as it could cut directly into their personal incomes.

- **Depending on state regulation, some or all payments to PSOs may not be subject to MCHA assessments, premium taxes, mandated benefit requirements, guaranteed renewal, or other state insurance laws.**

This advantage will depend on future legislation permitting direct contracting between PSOs and self-insured employers. Note that this advantage for providers and self-insured employers would be a disadvantage to the state and to regulated health plans. The state would need to impose these taxes and assessments at a higher rate if fewer enrollees were in the regulated market. Regulated health plans would therefore be at a relative disadvantage compared to PSOs that could provide similar services, but without the same regulatory burden.

Possible Disadvantages of Direct Contracting

- **Less ability to assure that enrollees have access to an adequate level of services.**

Depending upon how they are regulated, smaller provider groups may not have all necessary specialties represented within the group, or may not have broad geographic availability of all

provider types. Enrollees could face excessive waits for some types of services if inadequate numbers of providers were available.

- **Lack of protection for enrollees in the areas of quality control, utilization review, marketing and disclosure, and appeal rights.**

Enrollees in direct contracting arrangements would have less protection against receiving poor-quality health care, denials of services, or deceptive or incomplete marketing information than enrollees in insured health plans. Without the guarantee of an appeal process, enrollees in direct contracting arrangements could be left with recourse only through the courts in these cases. Statutory protections for health plan enrollees are described later in this report (note that these protections also do not extend to enrollees in self-insured plans). In order to prevent this problem, these protections could be included in enabling legislation for direct contracting.

- **Administrative costs may be duplicated, rather than reduced.**

One advantage of direct contracting arrangements is thought to be their potential to reduce administrative costs by eliminating the "middle man," i.e., the health care plan. But the functions usually performed by the plan, such as contract negotiation and administration, marketing, and claims processing, would instead have to be done by each PSO, possibly resulting in increased administrative costs.

- **Increased risk to enrollees if coverage is terminated due to provider insolvency.**

Administrators of the provider groups may be less experienced in assessing risk, and may underestimate the amount of risk and the assets required to protect against insolvency. Risk may increase because the size and assets of the provider group are likely to be relatively small, so the number of high cost cases needed to cause insolvency would also be smaller. For these reasons, some insolvencies would be likely, especially in early arrangements, and insolvencies could result in enrollees losing health care coverage, at least temporarily. A later section of this report provides a more detailed discussion of risk and solvency protections.

- **The provider in a direct contracting arrangement could be subject to all state insurance regulations and mandates, and the self-insured employer could lose the advantages of the ERISA preemption.**

ERISA issues are covered in more detail in a later section of this report. Whether the employer loses that preemption depends on the state's direct contracting enabling legislation and also on decisions made by Congress and the courts.

- **Under a direct contracting arrangement, there may not be a contractual relationship between the enrollee and the PSO.**

In an insured health plan, such as an HMO or indemnity plan, a contractual relationship exists between the plan and the enrollee, as well as between the plan and the purchaser, if different from the enrollee. That contractual relationship gives the enrollee an additional recourse directly back to the HMO or indemnity plan in the event of a disagreement between the plan and the enrollee.

Current Activities in Minnesota

A 1995 MinnesotaCare® amendment specifically authorized a demonstration project of direct contracting between a specific provider cooperative and qualified employers or self-insured employer plans. The statute requires the provider cooperative to notify the Department of Health when it enters into a contract with a self-insured employer. The department is required to report by 1999 on the status of this direct contracting. Two additional pilot projects were authorized by the 1996 Legislature. All three of these provider co-ops are located in southwestern Minnesota. They include:

Quality Health Alliance (QHA), which was the first pilot project authorized. QHA covers nine counties, and includes about 150 physicians and ten hospitals.

Minnesota Rural Health Cooperative was added to the pilot project language in 1996. This co-op covers 16 counties, and includes about 30 physicians and eight hospitals.

Southwest Minnesota Health Alliance was also added in 1996. The co-op covers ten counties, and includes about 40 physicians and 12 hospitals.

None of these cooperatives is currently directly contracting with employers. All are relatively new entities, and in some cases they do not yet have large enough provider groups to enable them to efficiently contract directly with employers.

The employers in the Buyers Health Care Action Group (BHCAG), a Twin Cities-based buying coalition of 24 of the state's largest employers, currently offer the network of a single large HMO, HealthPartners, to their employees. According to BHCAG representatives, by 1997 the group intends to contract with smaller groups of providers, or *care systems*, on a modified fee-for-service basis that would allow BHCAG member employers to remain self-insured. BHCAG's proposed plan will include risk adjustment; fee schedule adjustments to reflect utilization changes; requirements for quality assurance activities; and data reporting requirements.

With the increasing complexity of risk sharing mechanisms such as this one, it is increasingly difficult to determine how the risk is actually apportioned. Although BHCAG's plan clearly involves the transfer of some risk, it is difficult to determine exactly how much. The state would not hesitate to define BHCAG's program as insurance if it was felt necessary. Two factors have been taken into consideration by the commissioners in determining not to exert regulatory authority at this time, but instead to continue to monitor and evaluate this direct contracting model. First, the risk adjustment mechanism in the plan gives some assurance that care plans will not inadvertently take on more risk than they are able to cover. Second, and more importantly, the commissioners have some confidence that the BHCAG employers, due to their size and financial resources, would be able to maintain their commitment to their employees in the event of an insolvency of a care system. Similar plans operated by smaller employers would be closely scrutinized, and possibly brought under regulation, by the state.

Current National and State Activity

Direct contracting has generated considerable interest at the national level, as well as in a number of other states. This section presents information about developments at these levels. Input from around the nation may be helpful as the legislature considers whether and how to regulate new types of health care arrangements.

National Organizations

Direct contracting has begun to be discussed at the national level, by such groups as the National Association of Insurance Commissioners (NAIC) and the Group Health Association of America (GHAA). The NAIC is currently working on a white paper on the topic of direct contracting; and has suggested that capitated provider networks be exempted from state insurance regulation only if the provider agrees to assume all or part of the risk for health care expenses or service delivery under a contract with a licensed health insurer.

GHAA conducted a 50-state survey of regulators' attitudes toward licensure of PSOs. The survey showed that most states prohibit PSO assumption of substantial risk. However, regulators in 25 states said they had no policy to require licensure of PSOs that assume limited risk (less than 110 percent of a predetermined annual budget). Regulators in only nine states had no such policy even if the PHO assumes full financial risk. GHAA suggested that the erratic nature of PHO regulation from one state to another suggested the need to address the adequacy of consumer protections and the fairness of the competitive environment.

Other States

A number of states have addressed some issues related to direct contracting in the last couple of years. Some that are relevant to Minnesota's situation are presented here.

Iowa: A 1994 statute created Organized Delivery Systems (ODS), an organization that is responsible for delivering or arranging to deliver the full range of health care services offered under a standard benefit plan. An ODS is required to assume risk and is subject to solvency standards. The ODS is accountable for cost, quality, and access. It establishes its own service area, criteria for including providers, and complaint procedures.

The ODS is required to give to the state agency provider utilization data, as well as information on measures of quality, access, member satisfaction, membership and utilization, finance, and management. Solvency requirements are spelled out in great detail, and include a requirement for unencumbered funds equal to \$1 million or 3 times average monthly claims. Iowa has an antitrust exception process that allows ODSs and other groups to apply for a "Certificate of Public Advantage." The procedures include due process requirements, a public process, and supervision after approval.

Colorado: The 1994 Colorado General Assembly mandated a study of the need to license or regulate provider networks or providers individually. The state's Commissioner of Insurance established an Advisory Committee, which issued a report and recommendations. The recommendations included:

- A network is not in the business of insurance if it contracts with an insurer. The commissioner should define "capitated contract" and "risk-sharing agreement."
- A provider network could certify that it is not in the business of insurance provided that:
 - it is entering risk-sharing contracts only with insurers or with networks that are certified,
 - the network is entering risk-sharing contracts only under policies issued by insurers, and
 - the agreement is only for those services the network is authorized and able to provide or arrange. The network may not indemnify a carrier for services covered under a contract between them. The carrier retains the right to review and approve any network subcontracts for agreed to services. The state agency should not be required to review all agreements between carriers and networks, but should retain the right to do so. In lieu, the agency should increase consumer protections in the areas of access and quality of care.
- All carrier-network risk-sharing contracts should be required to have a "consumer hold harmless" clause.
- Networks that directly assume responsibility from a consumer (individual, group, or employer) for delivery of a wide array of services, on a prepaid basis, should continue to be required to be licensed as a carrier (HMO, BCBSM, insurer).
- The state should have a dynamic set of capital requirements that recognize the service and indemnity arrangements and risk of the plan.
- Networks that enter into limited service contracts (e.g. dentistry services, vision care, radiology) should be regulated the same as other carriers, except that regulations should recognize and vary requirements based on the amount, level, and degree of risk, in at least the areas of capital requirements, trust deposits, reporting requirements, and accounting rules. Financial requirements should be proportional to risk.
- Risk-based capital requirements should apply to all types of carriers. NAIC guidelines should be used if found to be appropriate.

Georgia: The Georgia Commissioner of Insurance issued an opinion regarding Physician-Hospital Organizations in September 1995. The commissioner's opinion stated that if a provider enters into an arrangement with an individual, employer, or other group, such that the provider assumes all or part of the risk for health care cost or delivery, that provider is engaged in the business of insurance and must be licensed. These arrangements may include capitation, risk corridors, withhold, or pooling.

Ohio: An Ohio Department of Insurance initiative, the Uniform Managed Care Regulation bill, was introduced in 1996. The bill would create Health Insuring Corporations (HICs) to replace all other health plan regulation. Risk-assuming HICs would be required to obtain a Certificate of Authority from the Department of Insurance. Non-risk-bearing entities would only be required to register with the department. The bill included three categories of HIC: Basic, Supplemental, and Both. For all three, assets would be required to be 110 percent or more of

liabilities. Net worth requirements would vary by type. The bill would create a streamlined regulatory process, but would add specific requirements for contract provisions, utilization review and quality assurance standards, access, and complaint procedures.

Illinois: The Illinois Insurance Department has issued a bulletin stating that PSOs contracting with self-insured employers will not be regulated by the department because there is no contractual obligation of the PSO to the employees.

Regulatory Issues

Some of the regulatory issues regarding direct contracting are, to some extent, out of the direct control of the state. Two of those are addressed here: Employee Retirement Income Security Act (ERISA) issues and antitrust issues.

ERISA Issues

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law regulating employee benefit plans. ERISA contains a very broad preemption clause, which provides that ERISA "supersedes any and all state laws insofar as they may now or hereafter relate to" employee benefit plans (29 U.S.C. 1144(a)).³ Therefore, state laws that "relate to" ERISA plans are preempted unless they fall within the "insurance saving clause." The insurance saving clause provides that ERISA will not preempt those state laws that involve the traditional state regulation of insurance, banking, or securities (29 U.S.C. 1144(b)(2)(A)). Regulation of insurance, however, is restricted by the final part of the ERISA analysis, which states that if a law has the effect of "deeming" an employee benefit plan to be an insurer, that law cannot be saved from the preemption (29 U.S.C. 1144 (b)(2)(B)).

Case law does not predict with any certainty how the court would interpret an attempt to regulate provider groups that contract directly with self-insured employers. This is an evolving area, both in terms of the case law, and in how direct contracting arrangements would actually be implemented, and it is not clear what position the federal government will take on this issue.

Antitrust Issues

The Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) jointly share authority over antitrust matters, including those concerning health care entities. Antitrust issues are of concern to groups of hospital and non-hospital providers that wish to form networks to market their services. Although the federal agencies have jurisdiction in these matters, states may also bring antitrust charges.

In October, 1995 the DOJ resolved its first two antitrust cases against physician-hospital organizations (PHOs). The DOJ offered the PHOs two permissible methods of operation: the messenger model, in which an agent acts as a messenger between each provider individually and

³Political subdivisions, such as counties or cities, are not exempt from state regulation under ERISA, however.

the purchaser; and a restructuring of ownership into "Qualified Managed Care Plans" (QMCP). A QMCP is defined as an organization whose members share substantial financial risk, and whose membership comprises no more than 20 percent of the physicians in the relevant market if the network is exclusive, or 30 percent if the network is nonexclusive. In their Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, the two departments laid out these percentages as "safe harbors" for provider networks - that is, at this level of participation, the agencies would generally not challenge the networks.⁴ The agencies noted that, to qualify for these safety zones, the providers participating in the network must share substantial financial risk, for example under capitation or a substantial withhold.

For networks that fall outside of the safe harbors, the agencies have stated that they will apply a "rule of reason" analysis, that is, the network will not be viewed as *per se* illegal, assuming that the network is not likely to merely restrict competition and decrease output. In performing the analysis, the agencies will consider whether the network could raise prices above competitive levels or prevent the formation of other networks and whether the network would likely result in efficiencies that would benefit consumers.

In those areas of Minnesota where providers are relatively scarce and competition is already limited, networks may very well need to include more than 20 or 30 percent of the providers in a given market. The state has had an antitrust exception process in statute (*Minn. Stat.* 62J.2911 through 62J.2921) since 1993. The stated purpose of the statute is "to create an opportunity for the state to review proposed arrangements and to substitute regulation for competition when an arrangement is likely to result in lower costs, or greater access or quality, than would otherwise occur in the marketplace." To date, the state has only been asked for, and has granted, one such antitrust exception. More may be requested, however, as provider groups in more rural areas of the state contemplate forming groups for the purpose of direct contracting. In determining whether to grant an antitrust exception, the statute directs the commissioner to consider essentially the same factors that the federal agencies would consider in a rule of reason analysis. The statute requires that cost savings to providers, health carriers, group purchasers, or others, be considered relevant only to the extent that they will be passed on to consumers.

⁴Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, Issued by the U. S. Department of Justice and the Federal Trade Commission, September 27, 1994.

II. Financial Solvency Issues in State Regulation of Health Plans

The Federal McCarran-Ferguson Act reserves to the states authority for regulating most insurance transactions. One of the main concerns of the state in its role as insurance regulator is consumer protection in the case of health plan insolvency. The Departments of Commerce and Health have regulatory oversight of health plans, including preventive measures to minimize the risk of insolvency and measures to protect the consumer in case an insolvency occurs. State financial requirements of health plans are strict, because the state's goal is to have a very low risk of health plan insolvency.

Risk to Consumers of Health Plan Insolvency

There is a great risk to consumers when a health plan that covers them becomes insolvent. The Minnesotan as a consumer of health care has different needs than as a consumer of most other goods and services. This is due to three aspects of health care: (1) the prepaid nature of most health care, (2) the ongoing relationship with a health care provider, and (3) the urgency of many health care treatments.

We can compare the bankruptcy of a health plan with the bankruptcy of a hardware store. If your local hardware store closes its doors, you can find another hardware store. Rarely would the hardware store owe you any money. If the health plan closes its doors, you are likely to have already paid premiums to the company for some future period of coverage, and also you have lost the guarantee of lifetime coverage from that plan. You may be able to sue the plan, but any payment would likely come too late to help with your immediate needs.

Also, you may have an ongoing relationship with your doctor. If you must switch coverage to another health plan, you may also have to switch to a new doctor. Obviously, this may impact the quality of medical care that you receive.

In the case of a health plan insolvency, finding new coverage for the patients is extremely urgent. A delay in treatment due to questions about source of payment may have significant impact on the patient's health, even if he does not have a life-threatening illness. There may be no help coming from the health plan, and so the state must step in to answer phones, organize records, and identify sources of replacement coverage. The health plan should have resources to back their reserves, but there is also a cost involved in gaining prompt access to that money and paying it out appropriately.

Current Regulatory Protections Against Insolvency

The regulatory protections for Minnesotans against insolvency depend on who pays directly for their health care. The possible payers consist of the following:

- 1) The patient himself, for those who do not have insurance. Those who do not have insurance must rely on state programs after they have exhausted their own resources.
- 2) An employer who offers a self-insured health benefit plan. Those covered by self-insured employee benefit plans must rely on Federal oversight of those plans, because Federal law prohibits the state from regulating such plans. For more information, see the section above on "ERISA Issues."
- 3) A health policy purchased by an individual, an employer, or an association. Those who are

covered by individual or group health policies are protected by various mechanisms set up by state law and enforced by the Departments of Health and Commerce. See the next section for more detail.

4) The state or Federal government, for whom solvency is not a significant concern.

Reporting and Oversight

Health plans are required to file quarterly and annual statements of financial position with the Department of Health or Commerce. Those statements contain detailed information in a prescribed format about the health plan's income, expenses, and claim payments for the year. They also contain information about the health plan's assets, liabilities, and the capital remaining after the value of the liabilities is subtracted from the value of the assets. In addition, the statements contain other background information about the health plan, to enhance understanding of the financial information and to provide early warnings of pending financial problems.

Reserve Requirements

Health plans are required to establish liability amounts in their financial statements for any incurred expenses or claims that have not yet been paid. These liability amounts are referred to as "reserves." They should not be confused with the assets that are held by the health plan or be viewed as profits. They must have these amounts certified by a qualified actuary every year, and must have an independent actuary certify them every three years.

Capital and Surplus Requirements

In general, a health insurance company or HMO must have an initial capital and surplus of \$1.5 million and it must not fall below \$1 million. A CISN must have initial capital of \$500,000, and must increase it to \$1 million by the end of its third year of operation. A nonprofit health service plan corporation must have an initial capital and surplus of \$400,000. More detail about this requirement for insurance companies can be found in *Minn. Stat.* §60A.07, Subd. 5(a); for HMOs and CISNs in *Minn. Stat.* §62D.042; and for nonprofit health service plan corporations in *Minn. Stat.* §62C.09.

On an ongoing basis, the capitalization levels of health plans are reviewed by the financial examiners at the Departments of Commerce and Health. These levels rise from the initial levels as the volume of business rises. The review is authorized by *Minn. Stat.* §§60A.60 to 60A.696, and is based on risk-based capital formulas developed by the National Association of State Insurance Commissioners.

Guaranty Association

Health insurance companies and nonprofit health service plan corporations are required to join a guaranty association. They are automatically members of the Life and Health Insurance Guaranty Association as required by *Minn. Stat.* § 61B.20, subd. 13. In the event that a member becomes insolvent, and that its assets are insufficient to cover its obligations to policyholders, the association will assess its members for sufficient money to meet those obligations up to a limit defined in law. The amount of assessment is credited against the members' premium taxes.

HMOs are not required to be members of any such association. However, *Minn. Stat.* §62D.181 requires that the enrollees of an insolvent HMO be entitled to enroll in the Minnesota Comprehensive Health Association (MCHA is the state's high risk pool) without satisfying a pre-existing condition limitation. MCHA is financed through premiums paid by enrollees and by an assessment on health insurers, HMOs, CISNs and nonprofit health service plan corporations. An

additional protection is provided in *Minn. Rules* §4685.0600, which requires the HMO to continue to provide health care services for 60 days after the discontinuance of the HMO.

Consumer Protection Against Insolvency of PSOs

This section discusses some issues relating to consumer protection against insolvency of PSOs. Consumer protection with regard to health care provider network access and quality is addressed elsewhere in this report.

If the state decides to allow PSOs to accept insurance risk, the state has a responsibility for consumer protection against PSO insolvency. However, states have a responsibility not to impose excessive or unnecessary regulation upon entities that may provide innovative products for consumers. The following goals should be reviewed when considering the structure of solvency regulation of PSOs:

- Regulation should protect the consumer from becoming responsible for large medical bills or for finding alternative coverage. Regulation should include a requirement for consumer “hold harmless” clauses to help ensure that PSOs rather than the state provide for protection of the consumer.
- Regulation should provide a level playing field. All entities who are providing the same or similar products should be subject to the same or similar standards.
- Regulation should go no farther than necessary. Regulation should not hold back innovation in the market, except when necessary to protect the consumer. PSOs and other health care risk takers should not incur unnecessary expenses for compliance, and the state should not incur unnecessary expenses of oversight.

In order to achieve the above goals, it makes sense to review the current solvency-related requirements on health plans, which are described briefly above. These requirements have been developed and tested over many years. Each requirement should be reviewed for its necessity in regulating PSOs. It may also be appropriate to revise some of the requirements for both health plans and PSOs.

Risk Sharing Issues

This section of the report discusses the following issues: (1) the current regulatory constraints on risk sharing, (2) different types of risk sharing, and (3) the NAIC’s draft formula for “Health Organization Risk Based Capital.”

One of the greatest challenges for the state in its mission of consumer protection is the complicated nature of risk sharing arrangements that have evolved around health care payment. For example, the following example is not far-fetched in today’s market:

Say that a self-insured employer purchases the following coverages: (1) medical coverage under a PPO with a fee schedule, where the PPO pays a bonus to providers who experience low utilization, (2) aggregate stop loss coverage for claims over 120% of expected, (3) specific stop loss coverage for any claim over \$10,000 per year per person, (4) capitated vision coverage from a retail chain of

opticians, and (5) a capitated exclusive network for mental health treatment, where the network carries stop-loss insurance to cover its risk of high claim levels. In this example, the terms used have the following meanings:

A *PPO* is a Preferred Provider Organization, a network of providers. Usually the network offers discounts to the employer in exchange for exclusive use of the network by employees. The employer offers better reimbursement to employees who use the network.

A *Fee Schedule* is a list of medical procedures and the amount to be charged to the employer for each procedure that is performed.

A *Bonus* is a payment to a medical care provider based on the financial experience of a PPO.

Utilization is the frequency of use of medical procedures.

Aggregate Stop Loss is an arrangement in which an insurance company will reimburse an employer for employee medical claims after the employer has paid a certain dollar amount.

The *Expected Claims* are the average claims that can be actuarially projected for a certain population for a certain period.

Specific Stop Loss is an arrangement in which an insurance company will reimburse an employer for medical claims for a particular employee after the employer has paid a certain dollar amount of that employee's claims.

Capitated refers to an arrangement in which a medical care provider agrees to provide certain services for a certain period in exchange for a fixed dollar amount.

Where do the risks lie in these arrangements? What are the consequences to the consumer if any of the entities involved becomes bankrupt and closes its doors? Is the consumer aware of these arrangements? The state is responsible for answering these questions if it is to fulfill its responsibility to the consumer.

The employees are taking the risk for copayments and non-covered services, and the employer is taking the rest of the risk up to the levels where the licensed insurer steps in to cover the excess. The PPO is not taking any insurance risk, and the rest of the risk is assumed by licensed health plans. The stop loss insurance and capitated arrangements must currently be provided by entities that are licensed to assume insurance risk.

If the employer becomes bankrupt, the consequences to the consumer's health coverage can be severe. However, the ERISA preemption prevents the state from imposing any protections on self-funded employee benefit plans.

If the PPO becomes bankrupt, the fee-for-service basis of its contract with the employer means that there is not a significant risk to the consumer. There is just the inconvenience of finding a new provider.

If any of the licensed entities involved become bankrupt, they have been subject to the state requirements discussed above which would reduce the likelihood of an insolvency and mitigate the impact if one should occur. However, if the PPO is replaced by an unregulated PSO that accepts capitation, the employees are exposed to significant risk.

Types of Risk Sharing

In examining and analyzing the degree of financial risk involved in paying for health care, an important regulatory consideration is that only one of the involved parties has personal risk—that is the consumer of medical care, the patient. The main goal of state regulation is to protect that person. Other entities have a financial risk, the worst consequence of which is the insolvency of an organization. In reviewing the necessary regulation for different types of risk sharing arrangements, it is necessary to determine the possible impact on the consumer if any of the entities fails to live up to its promises.

The financial risk to organizations is sometimes divided into the two categories of “insurance risk” and “business risk.” Insurance risks are “risks arising from the pooling of risks and the advance funding of expected average costs.” (as defined in a monograph from the American Academy of Actuaries). Business risks are risks arising from the organization’s conduct of its business. For an organization providing insurance coverage, insurance risk is a type of business risk. From the point of view of state regulation, a more important determination is which risks can severely impact the consumer.

An organization that provides insurance cannot segregate its “insurance risk” from its “business risk.” Poor conduct of its business affairs may have a severe impact on the consumer. For example, the Department of Commerce reviews the investments made by insurance companies. Although investment policy is a business decision that does not relate directly to the promises made in insurance contracts, it has a significant indirect impact. If the insurance company makes bad investments, it may not be able to fulfill its promises to the consumer.

Another distinction that is sometimes attempted is that between “service risk” and “insurance risk.” For example, although a PSO is contracting to pay provider salaries, rent, maintenance, and all other costs involved in *providing* medical services, it is not contracting to pay cash to providers of medical services outside of the PSO. Although this may somewhat reduce the risk to the consumer, because to some extent the PSO can ask its own providers to continue providing services for lower reimbursement, the reduction in risk is not significant. Also, PSOs may be contracting for some services that are not directly available from member providers, such as organ transplants, pharmacy, chiropractic care, and mental health benefits. These providers would likely be unwilling to provide services at reduced payment levels.

The simplest type of insurance risk sharing is the coinsurance or percentage sharing of financial risk. For example, a health plan contract may specify that the health plan is responsible for 80 percent of medical care costs, and the consumer is responsible for the other 20 percent. Similarly, a health plan may reinsure 50 percent of its coverage with a reinsurer. The reinsurer is responsible for exactly 50 percent of the health care cost. In most such arrangements, each entity assuming responsibility for a percentage of the cost is clearly assuming insurance risk.

Another type of risk sharing that can be fairly easily defined is “layered risk.” This concept can be understood from the common insurance provision of a deductible. The consumer is responsible for

the first layer of cost, up to the deductible, such as \$500 per year, and the health plan is responsible for cost (or a percentage of cost) above that level. The concept of a "specific stop loss" is another example of layered risk. This is where an employer is responsible for each employee's medical cost up to the stop loss limit, such as \$10,000 per year, and the stop loss insurer is responsible for cost (or a percentage of cost) above that level. In general, with layered risk the average cost per dollar of coverage is less for a higher layer, but the variability of cost is much greater.

One aspect of risk that is important but often overlooked is timing. For example, health plans are required to guarantee renewability of their policies, and to offer individual conversion policies to employees who lose eligibility for group coverage. The risk assumed by the group insurer lasts for the lifetimes of the employees. On the other hand, some employers pay for their employees' health coverage on a cash flow basis, not setting aside any money for claims that will be submitted in the future. In practice, these employers are taking on a more limited risk. If the employer goes out of business, it is the employees who will pay for any unfunded care.

Another type of risk is backup risk or guarantees. In this case, the risk is not split as in the types of risk above, it is actually joint risk between different entities. For example, an HMO may contract with a large PSO to provide a broad range of medical care for a fixed monthly per member capitation. The PSO has taken on 100 percent of the risk. However, the HMO remains at risk and is responsible for the services if the PSO does not provide them. In employer self-insured coverage, the employer may shift the risk to a PSO. If the PSO does not provide the coverage, presumably the employer may pay again for their employees' care from another entity. Although federal ERISA law imposes fiduciary responsibility upon self-insured employers, they may not be in a position to pay twice for health care, given the lack of Federal requirements for reserves and pre-funding of employee health plans.

Risk Based Capital

The National Association of Insurance Commissioners is now testing a formula for "Health Organization Risk Based Capital." The intent is to use the formula to establish appropriate levels of capital needed to protect the public. The formula is intended to apply to any organization taking on health insurance risk, regardless of its structure or name. This would be a revision of the risk-based capital formula that currently is in effect for insurance companies. The formula is based on the expected statistical fluctuations in results from different types of coverage. It is designed to assist in establishing a level playing field among risk-bearing entities. Although the formula is unlikely to be final until late in 1997, it may be useful to the state in the future in evaluating the level of risk assumed by PSOs and in establishing appropriate regulation of them.

III. Minnesota Department of Health Oversight of HMOs and CISNs

The Minnesota Department of Health (MDH) is the state agency that regulates HMOs and CISNs by enforcing applicable laws and rules. The Commissioner of Health issues certificates of authority to HMOs and licenses to CISNs that meet the requirements of the statutes and rules. After an HMO receives a certificate of authority or a CISN receives a license, the health plans must file certain information with the commissioner on a regular basis, and the commissioner performs audits and investigations of the plans. Each of these activities is designed to protect the HMO and CISN enrollees.

Financial Regulation

HMOs and CISNs licensed to operate in Minnesota must meet the financial solvency requirements mentioned earlier in this report, which are designed to ensure that health plan companies are strong enough financially to be able to pay claims and provide services to enrollees. Each of these health plans must file the following information with the Department of Health:

- An annual report that includes a financial statement, enrollment figures, certain wage and salary information, etc. (Minnesota Statutes §62D.08)
- Quarterly reports with similar financial and enrollment information (Minnesota Rules 4685.1980)

In addition to these reports, the department conducts financial examinations of each HMO and CISN at least once every two years. The department analyzes the financial information obtained from the reports and audits to determine compliance with relevant statutes and rules, which are designed to ensure the financial solvency of HMOs and CISNs.

Quality and Accessibility

The onset of managed care has brought about the need for regulation of the quality and accessibility of health care services. All HMOs, CISNs, and Preferred Provider Organizations, and most insurers and Blue Cross and Blue Shield Plans, utilize one or more method to manage the care that their enrollees or consumers receive. Examples of managed care techniques include limited provider networks, prior authorization of services, provider credentialing, "gatekeeping" by primary care physicians, capitated payments to providers, and an emphasis on primary care/prevention.

Some of these managed care techniques may create disincentives for health plans to provide care to enrollees. Minnesota statutes and rules address these potential disincentives by ensuring that comprehensive medical services are available and accessible and providing mechanisms for assuring the quality of care that consumers receive from their health plans.

This section of the report will focus on the current quality assurance, access and availability portions of the Minnesota statutes and rules that apply to HMOs and CISNs. The recommendation section of this report will discuss whether or not these or similar standards should be applied to risk-bearing PSOs.

Quality Assurance

Minn. Stat. §62D and *Minn. Rules* §4685 define quality assurance in broad terms and include the following requirements for HMOs and CISNs:

- **Written quality assurance work plan (*Minn. Rules* §§4685.1100 and 4685.1110)**

These rules require each HMO and CISN to have a written quality assurance work plan that describes the plan's quality assurance program, methods for reviewing and evaluating data related to quality of care, and ways in which the plan works to identify and correct problems related to quality. The department reviews and approves the work plan when the HMO or CISN applies for its certificate or license. HMOs then file the report on an annual basis. While CISNs do not have to file the work plan with the department, they must have a written plan, and the department reviews the plan during quality assurance audits (discussed below).

The work plan must explain in detail how the HMO or CISN monitors and implements the plan. The rules require the health plans to evaluate enrollee complaints that are related to quality of care, analyze utilization review data on a quarterly basis, and conduct an ongoing evaluation of the health plans's medical records.

The health plan's governing board is ultimately responsible for the quality assurance activities of the health plan, and a physician must advise, oversee and be actively involved in the implementation of the quality assurance program. The governing board must oversee an evaluation of the quality assurance plan on an annual basis.

- **Ongoing quality evaluation (*Minn. Rules* §§4685.1115 and 4685.1120)**

HMOs and CISNs must conduct evaluations of quality on an ongoing basis. Those evaluations must address both clinical and organizational components of the health plan that may affect quality of care for enrollees. The rules require health plans to identify the existence of actual or potential quality problems or identify opportunities for improving care. When an HMO or CISN identifies a problem, it must develop and implement a corrective action plan to address the problem and then evaluate the effectiveness of that plan.

- **Focused studies (*Minn. Rules* §4685.1125)**

HMOs must conduct three focused studies per year to acquire information relevant to quality of care. The topics for study must be based on areas of high volume; areas of high risk; areas where problems are expected or where they have occurred in the past; areas that can be corrected or where prevention may have an impact; areas that have potential for adverse health outcomes; or, areas where complaints have occurred. The health plans are required to implement corrective actions for any problems that they identify in the focused studies.

- **Statistics (*Minn. Rules* §4685.1200)**

This rule requires HMOs and CISNs to compile, evaluate and report statistics, including gross utilization aggregates, operational statistics, demographic characteristics of the enrollees, disease-specific and age-specific mortality rates, and enrollment statistics.

- **Enrollee complaints (*Minn. Rules §4685.1700*)**

This rule requires HMOs and CISNs to have an internal system for handling enrollee complaints. Health plans must notify enrollees within 30 days of receiving a written complaint of its decision and the reasons for it. If the health plan's decision is adverse to the complainant, the enrollee has the right to appeal the decision.

At any time, a consumer may submit a complaint to the commissioner for investigation. After an investigation, MDH reaches a decision in favor of either the consumer or the health plan. The commissioner has the authority to order the HMO or CISN to resolve the situation in favor of the complainant. In 1995, MDH received 661 formal complaints about HMOs or CISNs. Approximately 50 percent of those complaints were resolved in favor of the complainants, and the other 50 percent were resolved in favor of the health plans.

MDH receives and investigates a wide variety of complaints from HMO and CISN enrollees, including complaints related to quality of care, access to services and billing problems. The most common types of complaints concern gaining referrals to specialists and/or providers outside of the health plan's network, premium rates, and disputes over medical necessity of procedures or services. MDH reviews complaint data to look for particular areas of concern and follows up on those concerns during quality assurance audits, which are discussed below.

In addition to the complaint procedures within the health plans and with MDH, all HMOs and CISNs must agree to utilize alternative dispute resolution processes at the request of a complainant.

- **Department of Health quality assurance audits (*Minn. Stat. § 62D.14*)**

The department conducts quality assurance audits of each HMO and CISN once every two years. The purpose of the audits is to ensure that the health plans are meeting the requirements of the quality assurance rules statutes and rules. If the department identifies deficiencies in the health plan's quality assurance plan, the HMO or CISN must develop a plan for correcting those deficiencies. The department ensures that the plans for correction are implemented. The department has the authority to impose fines in cases where a health plan violates a relevant statute or rule.

Availability and Accessibility of Services

Minn. Rules §4685.1010 addresses the availability and accessibility of services for HMOs and CISNs. This rule requires HMOs and CISNs to provide the full range of primary and specialty care services in a timely manner and to provide the services within a reasonable geographic distance from the enrollees.

MDH assures that HMOs and CISNs meet these requirements when the health plans apply for their certificates of authority or licenses. The department conducts follow-up checks for compliance with these rules during audits of the health plans and investigates consumer complaints regarding these issues. In addition, HMOs or CISNs that want to expand their approved service areas must prove that they meet all of the availability and access rules in that proposed expansion area before they are approved to operate there.

The following briefly describes the availability and access requirements in the HMO rules:

- **Basic services (*Minn. Rules §4685.1010, subp. 2., 3., 4, and 6.*)**

This rule requires HMOs and CISNs to make available appropriate and sufficient personnel, resources and equipment to meet the needs of the enrollees in their service areas in a timely manner. Health plans must provide the comprehensive primary care services, hospital, and specialty care services, including mental health and substance abuse services, on a 24 hours per day, seven days per week basis.

The maximum travel distance to primary care providers is 30 miles or 30 minutes, and for specialty care providers, the maximum is 60 miles or 60 minutes. The rules allow HMOs and CISNs to request an exception to these distance requirements in areas of the state where there are no providers. If there are providers in the area, but the health plan does not have a contract with those providers, the department would not grant an exception to the rules.

HMOs and CISNs must also make emergency care available to all enrollees. The rules also describe how health plans determine whether care is reimbursable as emergency care.

- **Continuity of care in case of contract termination (*Minn. Rules §4685.1010, Subp. 8*)**

HMOs and CISNs must have written plans providing for continuity of care in the event of contract termination between the health plan and any of its contracted providers. The written plans are meant to ensure that all enrollees receive adequate notice of provider terminations and that enrollees with special medical needs will have their needs met.

Contract and Rate Review

The department reviews contracts between health plans and providers as well as enrollee certificates of coverage in order to protect enrollee rights.

- **Review of enrollee certificates of coverage (*Minn. Stat. §62D.07*)**

The department must approve any certificate of coverage before the HMO or CISN issues it to enrollees in order to see that the health plan is providing enrollees with all of the benefits required by law. The certificates must provide clear descriptions of all benefits to which the enrollees are entitled, any exclusions or limitations on services, the total amount of copayments, and the health plan's method of resolving complaints. In addition, the certificates must include the "Important Consumer Information and Enrollee Bill of Rights" language that is found in *Minn. Stat. § 62D.123, Subd. 5 (c)*. This statute also requires HMOs and CISNs to grant a 31-day grace period for payment of premiums for individual contracts, and the certificates must clearly state how enrollees can terminate their coverage.

- **Review of premium rates (*Minn. Stat. §§62L.08, 62L.23; 62A.23; 62A.021; 62J.04; 62A.65, subd. 3.; 62A.31, subd. 1.; and 62A.36, subd. 1.*)**

HMOs and CISNs file premium rates for group coverage in annual statements with the Department of Health. Premiums for small employer group health plans, individual health plans, conversion health plans, and Medicare supplement health plans must be submitted to and approved by the Department of Health prior to implementation.

- **Review of provider contracts (*Minn. Stat. § 62D.123*)**

MDH reviews contracts between HMOs and providers. While CISNs do not file their provider

contracts with the department for review, their contracts must be in compliance with *Minn. Stat.* §62D.123, and MDH checks for compliance during audits and in response to complaints from consumers or providers. When reviewing provider contracts, MDH looks for the following three items:

1. That the provider agrees not to bill enrollees in any case, except for copayments or for uncovered services;
2. That the provider agrees to participate and cooperate with the HMOs' or CISNs' quality assurance program, dispute resolution procedure, and utilization review program; and,
3. That the provider will give the HMO or CISN at least 120 days' advance notice of the termination of its contract with the health plan.

The department approves HMO contracts that meet these requirements and disapproves those that do not meet the requirements.

Enforcement

An important component of the regulatory oversight of HMOs and CISNs is the authority of the Commissioner of Health to enforce the statutes and rules that apply to these health plans. The commissioner may take any of the following enforcement actions against HMOs or CISNs that have been found to violate relevant statutes or rules:

- Deny, suspend, or revoke a certificate of authority (HMOs) or a license (CISNs) (Minnesota Statutes §62D.16)
- Issue administrative penalties (Minnesota Statutes §62D.17)
- Issue cease and desist orders (Minnesota Statutes §62D.17)
- Order plans of correction (Minnesota Statutes §62D.17)
- Conduct regular and special examinations (Minnesota Statutes §62D.14)
- Conduct a rehabilitation or liquidation of an HMO or CISN (Minnesota Statutes §62D.18)

The department takes enforcement actions in response to issues raised during the department's routine financial, quality assurance and market conduct audits, as well as in response to the investigation of complaints from consumers.

IV. Minnesota Department of Commerce Oversight of Insurance Companies and Nonprofit Health Service Plan Corporations

The Department of Commerce regulates over 900 insurance companies, fraternal and nonprofit service plan corporations who are licensed to market health insurance to Minnesota's residents. Of these companies, 33 are domiciled in Minnesota with assets totaling over \$90 billion dollars. The principal mission of the Department of Commerce is to enhance the stability and strength of these companies, enforce state laws and safeguard consumer's rights and resolve conflicts between the consumers and these companies.

Financial Regulation

Each health insurance company, fraternal and nonprofit health service plan corporation that wants to operate in Minnesota must meet certain financial requirements before it can be licensed by the Department of Commerce. Depending on the type of company, (stock, mutual, fraternal or nonprofit) certain amount of capital and surplus must be maintained by each entity. For example, a mutual company must have an initial surplus amount of \$1.5 million dollars and thereafter constantly maintain a surplus that reflects its liabilities. (*Minn. Stat.* §60A.07).

After the company is licensed, it must provide the department with an annual statement, which describes in detail its assets, liabilities, investments, profit and losses on each type of insurance product it markets, reinsurance ceded or held, etc.. Additionally, each company must file a quarterly statement, providing a summary of its financial stability. This information is reviewed by the department's actuaries, CPAs and analysts to evaluate the financial status of the company. Every three years, field examiners visit each of these entities to conduct an on-site review of its financial stability, accuracy of its financial reports and claim processing. When appropriate, the commissioner may authorize additional investigations or take administrative action to protect the policyholders.

Policy Analysis and Review

The Department of Commerce annually receives over 1,600 health forms that must be reviewed to determine whether they are in compliance with Minnesota's regulations. These forms must comply with *Minn. Stat.* §§60A, 62A, 62C, 62E, 62H, 62J, 62L, 62Q, 64B, 72A, Minnesota Rules or other department regulations, depending on the type of health policy submitted. All rates that are to be used with these health insurance products are reviewed to determine if they are reasonable and in compliance with Minnesota's regulations. All individual rate increases must receive prior approval, before they can be implemented (*Minn. Stat.* § 62A.02).

Preferred Provider Organizations (PPO's) are indirectly regulated when they are affiliated with a licensed health insurer. The insurer must file a report with the commissioner each August, providing summary data regarding the financial reimbursements offered to the providers, listing of a separate organization that administers the plan, name and addresses of all providers, terms of agreement with designated health care provider and records of all complaints submitted to the arrangement. Additionally the department review each of these PPO arrangements to determine if the number and location of its providers are adequate (*Minn. Stat.* 72A.20, subd. 15(4)).

Multi-Employer Welfare Arrangements (MEWAs) are groups of two or more self-insured employers that jointly offer health care coverage to their employees. MEWAs are regulated under

Minn. Stat. §62H and Minn. Rules §2765. These joint self-insurance employee health plans are authorized if they comply with the excess stop loss coverage risk management or administrative services, management of funds and other statutory (*Minn. Stat. §§62A, 62E and 72A*) requirements.

Enforcement

Each year the enforcement section responds to approximately 60,000 inquiries and complaints. Some complaints are resolved by the division staff within a short time, however, approximately 7,300 complaints per year are referred to enforcement personnel for formal investigation. Additionally, an enforcement person can be sent anywhere in the country to the home offices of insurers to investigate their entire operations for possible violations of Minnesota's regulations. During the past fiscal year, there were 1,102 health insurance complaints, which resulted in \$476,081 being recovered by the enforcement division.

Under chapter *Minn. Stat. §72A's* unfair settlement practices section, each insurer must complete its investigation and inform the insured of acceptance or denial of a claim within 30 business days after receipt of notification of the claim (*Minn. Stat. §72A.201*). If the insured is dissatisfied with the claim denial, he may appeal directly to the insurer or to the Commissioner of Commerce.

Under the unfair methods and unfair and deceptive acts section (*Minn. Stat. §72A.19*) of the regulations of trade practices (*Minn. Stat. §72A.20*) misrepresentation and false advertising of policy contracts, defamation, coercion and intimidation, false financial statements and entries, discrimination, rebates, unfair service, failure to return premiums, improper business practices, nonsupport of underwriting standards, improper cancellation and nonrenewals, not providing group loss experience, not retaining records, not providing reasonable and adequate premiums, designing a network of providers to discourage enrollment, having incentives to deny services or issuing unsuitable insurance products are unfair methods of competition or unfair or deceptive acts or practices in the business of insurance.

The Commissioner of Commerce has jurisdiction under *Minn. Stat. §72A.33 to 72A.39* to investigate unauthorized insurers and false advertising and, if need be, to issue a cease and desist order. It is unlawful for any company to enter into contract of insurance as an insurer or to transact insurance business in this state without a Certificate of Authority from the Commissioner of Commerce. The commissioner may issue an injunction against unauthorized insurers if any company has violating these provisions.

Under the Minnesota Fair Information Reporting Act (*Minn. Stat. §72A.49 - .505*) all applicants and policyholders are to be informed how personal information is to be collected and accessed, methods of correcting this personal information, and reasons for adverse underwriting decisions.

The commissioner has the authority to examine and investigate the affairs of every person engaged in the business of insurance in this state in order to determine whether that person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by law (*Minn. Stat. §72A.21*).

V. Utilization Review Oversight

The provision of only medical care considered appropriate and necessary is a component of managed care that is commonly used by various types of health plans. Utilization review is the manner by which health plans determine whether or not certain procedures, services or benefits are medically necessary. Health plan companies that conduct utilization review procedures must do so in compliance with *Minn. Stat. §62M*, the Minnesota Utilization Review Act of 1992. The Departments of Commerce and Health are responsible for enforcing this statute for the entities that they regulate.

Utilization review is defined as “the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending physician, for the purpose of determining the medical necessity of the review or admission.” (*Minn. Stat. §62M.02, subd. 20.*) The Utilization Review Act includes the following:

- standards for utilization review performance;
- procedures for making utilization determinations;
- procedures for consumers to appeal decisions to deny services;
- requirements to ensure that utilization review staff are properly trained, qualified and supervised;
- a prohibition on the denial of services based on financial incentives.

VI. Conclusions and Recommendations

This report presents the following conclusions for legislative consideration:

1. Allowing risk-sharing direct contract arrangements between PSOs and employers is clearly feasible.
2. However, based upon available information, we believe that direct contracting between PSOs and employers, where the PSO assumes risk, is the business of insurance and will need to be regulated by the state to protect the public.
3. A key, but as yet unresolved, question is at what level of risk-sharing the state should impose regulation. It remains to be clarified whether a PSO that assumes any amount of risk will be considered to be in the business of insurance, or whether there is some threshold level of risk-sharing that will not require regulation.
4. Some risk-sharing PSOs can be thought of as *mini care systems*, similar to HMOs and CISNs. Their regulation should therefore be based on, though not necessarily identical to, current regulation of HMOs and CISNs. Limited service organizations may be regulated less extensively.

Risk-sharing PSOs could be regulated in various ways. One option available to the legislature is to do nothing further with regard to risk-sharing direct contracting by PSOs, because the Departments of Commerce and Health currently have in place the statutes and rules necessary to regulate the business of insurance. Other attempts to allow new forms of service delivery in the state, including Health Care Provider Cooperatives and Community Integrated Service Networks have not attracted a great deal of interest from the provider community. The legislature could choose to attempt to determine what the barriers to provider acceptance of these models has been before embarking on new legislation.

Consistent with Governor Carlson's principles for government regulation of the health care market, detailed earlier in this report, these assumptions should be made in designing any new regulatory framework:

- To the extent possible, health plans should be able to operate on a "level playing field." That is, organizations that offer similar services should be regulated similarly. The recommendations included here would regulate PSOs similarly to other licensed health plans.
- The primary goal of state regulation is the protection of consumers.
- Regulation should interfere as little as possible with the operation of the market.

Regulation of PSOs should be on the same general areas as regulation of other types of health plans. While the commissioners do not necessarily believe that a new regulatory structure would be appropriate at this time, the following are areas that could be considered should the legislature determine that new regulation is desirable.

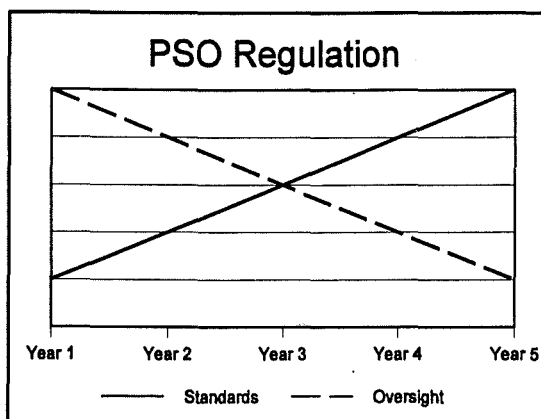
Solvency

Capital requirements should be reviewed based on the magnitude of the potential consequences to consumers of an insolvency. The National Association of Insurance Commissioners' Health Organization Risk Based Capital formula may be useful in this context, when it has been finalized. If a reduced level of capital requirement is appropriate for certain risk-taking PSOs, the same reduced level should apply to any health plan, such as a CISN or HMO, that assumes the same level of risk.

In meeting its mandate to protect consumers, government may rely on financial requirements to ensure that only PSOs with adequate financial wherewithal can enter the market, or may substitute close scrutiny and assistance for emerging PSOs to ensure that those that enter the market continue to meet their obligations to enrollees. This report presents two options for regulating solvency of risk-sharing PSOs. The Legislature might choose one or the other, or PSOs could be given the choice of being regulated under whichever framework best fit their circumstances. Under either scenario, solvency and oversight requirements are the same after the first five years the PSO operates.

Phased-In Solvency Requirements

Under one possible regulatory scheme, financial requirements would be less in early years, becoming more stringent over time. This is similar to current solvency regulation of CISNs (*Minn.*



Stat. §62N). At the same time, regulatory oversight would be heavier at first, but lightened in later years as the organization developed a "track record" of high quality care and financial solvency. As shown in this diagram, standards for capitalization start at a low level in the first year, but increase in each subsequent year. At the same time, state oversight, in the form of financial auditing and frequency of reporting, would be greater in the first year, gradually declining in later years.

This design would have the advantage of reduced requirements for PSOs in their start-up phases, allowing smaller, less-capitalized organizations the opportunity to enter the market. At the same time, the state would have

the ability to protect consumers through increased oversight during the earliest, most risky years of the PSO's operation. Under phased-in solvency regulation, these standards would apply:

- PSOs would be required to have initial capital of \$500,000. This would increase to \$1 million within 5 years.
- PSOs would be required to have initial capital of \$200,000 plus six months of projected revenue.
- PSOs would file quarterly financial reports in their first three years of operation, reduced to annual reports after that.
- The state agency would retain the authority to audit the PSO at any time.

Level Solvency Regulation

A second way to regulate PSOs would be to start at the level of regulation that would be in place at the end of the phase-in period described above, and continue at that level. Using this method, PSOs

would have the same financial requirements and would face the same level of regulatory scrutiny throughout the years they were in operation. For PSOs that are capable of establishing initial capital of \$1 million, this method would have the advantage of not imposing the burden of close oversight and frequent reporting in the first years. Under level regulation, these standards would apply:

- PSOs would be required to have initial capital of \$1,000,000 and comply with current Minnesota risk-based capital requirements (described in section II, above), moving to full implementation of new risk-based capital standards when they are adopted in Minnesota.
- LSOs would be required to have initial capital of \$500,000, with the same requirement to comply with risk-based capital requirements as described for PSOs.
- PSOs would file annual financial reports.
- The state agency would retain the authority to audit the PSO at any time.

Quality

Quality requirements for PSOs should be reviewed in the context of risk to the consumer. It would be difficult to justify lesser standards of quality for enrollees in PSOs than for enrollees in other types of health plans. If it is determined that some quality standards are unnecessary, or unnecessarily stringent, the legislature may want to review those requirements for other health plans, as well.

- PSOs would need to meet HMO quality standards.
- PSOs would not be required to file reports showing that they met the standards, but would be required to certify to the commissioner that they had done so.
- MDH would audit a random sample of PSOs annually.
- MDH would retain the authority to audit on an ongoing basis.

Access

An important aspect of health plan regulation is the assurance of adequate access to services. Access refers both to geographic access - reasonable travel times to services - and access to a full range of health care services. As with quality, it would be difficult to justify the assurance of less access to health care for PSO enrollees than what is available to enrollees in other types of health plan. In determining how to regulate PSOs, the legislature may wish to consider which, if any, access requirements for health plans should be reconsidered.

- PSOs would need to comply with nondiscrimination language in regard to both individual enrollees and employers.
- MDH/DOC would perform market conduct audits, including scrutiny of marketing materials and enrollee cards.

Complaints

An adequate complaint system for enrollees is an important part of state oversight of HMOs and CISNs. Because PSOs will include many of the same incentives to minimize costs of providing patient care, enrollee access to a complaint system both within the PSO and at MDH is necessary.

- The PSO would be required to maintain 24-hour access to customer service.
- The PSO would be required to report complaints to MDH/DOC.
- Enrollees in PSOs retain the right to complain directly to MDH/DOC.
- The PSO must agree to submit to an impartial arbitration procedure in the event an enrollee complaint cannot be resolved.

Subcontracting

Smaller PSOs will likely have more need to subcontract for some services. The state would have some concern if subcontracting reached a very high level, because the PSO has reduced ability to assure that services provided under subcontract are continued in the event the PSO experiences financial difficulty. The PSO would also have less ability to monitor the quality of care provided by subcontractors than to monitor care provided by member-providers.

- Subcontracts should be limited to 10 percent of annual capitation fees.
- MDH\DOC should be notified of all subcontracts.
- MDH\DOC is not required to review all subcontracts, but retains the right to review any at any time.

Other Requirements

Other state requirements should be reviewed for applicability to a risk-taking PSO. For example, guaranteed issue and renewability, portability, premium taxes, assessments for the high risk pool, or membership in a guaranty association may be appropriate legislative requirements for risk-bearing PSOs. Each of these requirements places some additional burden on the licensed plans. To the extent that a level playing field for all health plans is desirable, risk-sharing PSOs would need to be included in these requirements.



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