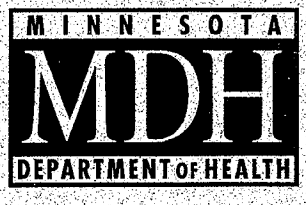
Health Provider Cooperatives:

The Status of Direct Contracting

A Report to the Minnesota Legislature

Minnesota Department of Health
Office of Rural Health & Primary Care
121 East 7th Pl, Suite 460
St Paul, MN 55101
(651) 282-3838



January 1999

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 11, 1999

Dear Interested Parties:

On behalf of the Office of Rural Health and Primary Care, Minnesota Department of Health, I am forwarding this report on the status of direct contracting between health provider cooperatives and self-insured employer plans to the Legislature. This report was required by Minnesota Statutes Section 62R.25.

The option of direct contracting for the health provider cooperatives was established through a demonstration project approved by the 1995 Legislature. Due to a variety of reasons discussed in the report, the cooperatives never engaged in direct contracting.

Sincerely,

Kelli Johnson
Acting Commissioner

121 East Seventh Place • St. Paul, MN 55101 • http://www.health.state.mn.us

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For more information, contact:

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Minnesota Department of Health
121 East 7th Place, Suite 460
St Paul, MN 55101

Phone: (651) 282-3838
Fax: (651) 297-5808

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Introduction

Section 62R.25 of the Minnesota Statutes regarding Health Care Cooperatives directs the Office of Rural Health and Primary Care, Department of Health to provide an informative report *on the status of direct contracting between health provider cooperatives and self-insured employer plans or qualified employers.* (See Appendix). This report fulfills that mandate.

History

A 1995 MinnesotaCare amendment originally authorized a demonstration project for a health provider cooperative (Quality Health Alliance) to participate in direct contracting. The 1996 Legislature authorized two additional health provider cooperatives, the Minnesota Rural Health Cooperative and Southwest Health Alliance, to be included in the demonstration. No funding was appropriated as part of this authorized demonstration.

Quality Health Alliance (QHA), formed as the state's first health care cooperative in November 1994, created a managed care delivery network to serve a nine-county area in south central Minnesota. The cooperative works with health plan companies to tailor managed care products and methods for the rural communities in the region. Its mission is to improve the health of the people in the local communities by addressing quality, access and cost efficiency issues within an integrated network. Twenty-three clinics and hospitals are members of QHA.

The Minnesota Rural Health Cooperative (MRHC), incorporated in February 1995, serves an 18-county area of southwestern Minnesota. Its values include local decision making, maintaining a high quality, effective system of health care that meets local needs, and preserving the economic and physical health of its communities. Its membership consists of more than 40 clinics and hospitals.

Both QHA and MRHC have worked toward contracts with managed care organizations, effective communication with their communities about health care issues, and providing participating providers a forum to share information. Processes to streamline health care delivery, information systems, and billing practices are additional benefits provided by these cooperatives.

Southwest Health Alliance, also incorporated in February 1995, serves the same communities as the Sioux Valley Network, headquartered in Sioux Falls, South Dakota. The network includes providers and hospitals from a 16-county area in southwestern Minnesota plus portions of northwestern Iowa and South Dakota. At the time of incorporation, its adopted principles of operation included the importance of local physician and hospital ownership, providing health care services within network communities, and working toward a partnership with local employers and community leaders.

Sections 62R.17 through 62R.24 describe the health provider cooperative regions and requirements of the demonstration project. This section of statute instructs any employer plan

contracting with the cooperatives to maintain stop loss insurance, and certain contract requirements regarding financial risk and member coverage are included. In addition, health provider cooperatives are to notify the Department of Health upon entering a contract involving the direct contracting of health services. (See Appendix).

The 1997 *Direct Contracting for Health Care Services* Report to the Legislature stated that none of the three health provider cooperatives included in this demonstration project were engaged in direct contracting for health services. The report provides an overview of direct contracting, includes potential advantages and disadvantages of participation, addresses financial solvency and risk sharing issues, and discusses recommendations for regulation of entities involved in direct contracting. The 1997 report is not included as an attachment to this report due to its size; a copy can be obtained by contacting the Minnesota Department of Health Clearinghouse at (651) 282-6314.

Current Status

As of December 31, 1998, the authorized health care provider cooperatives still are not contracting directly with self-insured plans. All carefully explored direct contracting. However, contracts for health care services with the self-insured employer groups of their regions never came to fruition.

The Office of Rural Health and Primary Care collected information from each of the health provider cooperatives in this demonstration project. Health provider cooperatives shared strong common themes regarding the process of studying direct contracting, barriers to reaching a contract, and impressions of viability.

Response from the Cooperatives

Each of the health provider cooperatives conducted a careful, thorough examination of direct contracting and its potential impact. Many board, provider, and community discussions took place in each region. They communicated and well understood the benefits and risks involved with direct contracting. However, the barriers to implementation could not be overcome.

The following barriers to direct contracting were identified:

- *Resources and start-up difficulty:* All three health provider cooperatives were still in the early stages of development when the demonstration began. Some expressed the problem of small budgets and the need for staff to focus on day to day operations. Little time or money was available to address, market and properly plan for direct contracting. Another source stated that a greater barrier was that providers were not willing or able to move beyond initial discussion stages.

- *Network development difficulty:* Key providers in each area were not enticed to join the networks. This may have been partially due to the small enrollment base of the health provider cooperatives. In theory, many providers agreed with the advantages of direct contracting in their communities. Some key providers were owned, managed or affiliated with managed care organizations and could not identify a true incentive to change practice policies and procedures.

  Also, the larger self-insured employers were contracted with health plans that offer more comprehensive networks and discounts on premiums.

- *Low enrollment:* Small enrollment for each of the health provider cooperatives also made financial risks associated with direct contracting too great. Currently, cooperative enrollees receive medical coverage through a Health Maintenance Organization (HMO) that has contracted with the health provider cooperative for its network; under this kind of arrangement, the HMO is responsible for bearing financial risk. As of December 1998, Minnesota Rural Health Cooperative's enrollment was approximately 2200; Quality Health Alliance's enrollment was approximately 4000. Southwest Health Alliance has not yet developed to the stage of enrollment.

Conclusion

Representatives of the health provider cooperatives think direct contracting is viable, pending solutions to the stated barriers. Clearly, the requirement of the cooperatives to include capitated or significant risk sharing is the most difficult for them to meet.

Section 62R.25 requires this report to "consider the effects on public policy and on health provider cooperatives of a possible requirement that health provider cooperatives using direct contracting be obligated to become community integrated service networks." Community Integrated Service Networks (CISNs) are subject to state laws and regulations governing Health Maintenance Organizations, with certain exceptions regarding governing board composition, net worth and solvency requirements, and administrative requirements.

Given that none of the health provider cooperatives are engaged in direct contracting and have not reached many of the developmental requirements of a CISN , a discussion of whether the health provider cooperatives should be required to become CISNs is not applicable at this time.

Appendix

62R.17 Provider cooperative demonstration.

(a) A health provider cooperative incorporated and having adopted bylaws before May 1, 1995, that has members who provide services in Sibley, Nicollet, Blue Earth, Brown, Watonwan, Martin, Faribault, Waseca, and LeSueur counties, may contract with a qualified employer or self-insured employer plan to provide health care services in accordance with sections 62R.17 to 62R.26.

(b) A health provider cooperative incorporated and having adopted bylaws before July 1, 1995, that has members who provide services in Big Stone, Chippewa, Cottonwood, Jackson, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, and Yellow Medicine counties, may contract with a qualified employer or self-insured employer plan to provide health care services in accordance with sections 62R.17 to 62R.26.

(c) A health provider cooperative incorporated and having adopted bylaws before March 1, 1995, that has members who provide services in Big Stone, Chippewa, Cottonwood, Jackson, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, and Yellow Medicine counties, may contract with a qualified employer or self-insured employer plan to provide health care services in accordance with sections 62R.17 to 62R.26.

(d) The health provider cooperative, the qualified employer, or the self-insured employer plan shall not, solely on account of that contract, be subject to any provision of Minnesota Statutes relating to health carriers except as provided in section 62R.21. The grant of contracting power under this section shall not be interpreted to permit or prohibit any other lawful arrangement between a health care provider and a self-insured employee welfare benefit plan or its sponsor.

HIST: 1995 c 234 art 10 s 1; 1996 c 451 art 4 s 4

62R.18 Definitions.

Subdivision 1. Application. For purposes of sections 62R.17 to 62R.26, the terms defined in this section have the meanings given.

Subd. 2. Health carrier. "Health carrier" means a health carrier as defined in section 62A.011.

Subd. 3. Plan participant. "Plan participant" means an eligible employee or retiree of a qualified employer or an eligible dependent of an employee or retired employee of a qualified employer.

Subd. 4. Qualified employer. "Qualified employer" means an employer sponsoring or maintaining a self-insured employer plan meeting the requirements of sections 62R.19 and 62R.21.

Subd. 5. Self-insured employer plan. "Self-insured employer plan" means a plan, fund, or program established or maintained by a qualified employer on or before January 1, 1995, for the purpose of providing medical, surgical, hospital, or other health care benefits to plan participants primarily on a self-insured basis. A governmental joint self-insurance plan established under chapter 471 is a self-insured employer plan for purposes of this definition.

HIST: 1995 c 234 art 10 s 2

62R.19 Stop loss requirement.

A health provider cooperative shall not contract with a qualified employer or self-insured employer plan under section 62R.17 unless the qualified employer or self-insured employer plan maintains a policy of stop loss or excess loss insurance from an insurance company licensed to do business in this state in accordance with the following:

(1) A qualified employer with more than 750 employees as defined in section 62L.02 must not maintain a policy of stop loss, excess loss, or similar coverage with an attachment point less than 120 percent of the self-insured employer plan's annual expected benefit costs;

(2) A qualified employer with 200 or more but fewer than 750 employees as defined in section 62L.02 must maintain a policy providing aggregate stop loss insurance with an annual attachment point of no less than 120 percent of the self-insured employer plan's annual expected benefit costs and providing individual stop loss coverage with a deductible of no less than $10,000; and

(3) A qualified employer with fewer than 200 employees as defined in section 62L.02 must maintain a policy meeting the requirements of section 60A.235.

HIST: 1995 c 234 art 10 s 3

62R.20 Contract requirements.

Any contract for health care services described in section 62R.17 is subject to the following requirements:

(1) The contract must be structured so that the health provider cooperative does not bear financial risk in excess of 50 percent of the self-insured employer plan's expected annual costs.

(2) The contract must not be effective prior to January 1, 1996.

(3) The contract must be limited to those services regularly provided by the cooperative or its members.

(4) The contract must obligate the qualified employer to maintain its self-insured employer plan in accordance with section 62R.21.

HIST: 1995 c 234 art 10 s 4

62R.21 Plan requirements.

The requirements described in section 62R.20, clause (4), are as follows:

(1) The plan shall not exclude any eligible employees or their dependents, both as defined in section 62L.02, from coverage offered by the employer, under this paragraph or any other health coverage, insured or self-insured, offered by the employer, on the basis of the health status or health history of the person.

(2) Contributions to the cost of the self-insured employer plan from plan participants must not be based upon the gender of the plan participant.

HIST: 1995 c 234 art 10 s 5

62R.22 Participant hold harmless.

The health provider cooperative and its members and patrons must not have recourse against the plan participants of any self-insured employer plan with which the cooperative has contracted in accordance with sections 62R.17 to 62R.26, except for collection of copayments, coinsurance, or deductibles, or for health care services rendered that are not covered by the self-insured employer plan or that are in excess of the lifetime maximum benefit limit. This requirement applies to, but is not limited to, nonpayment of the cooperative by the self-insured employer plan or qualified employer, insolvency of the qualified employer, insolvency of the health provider cooperative, or nonpayment by the cooperative to the cooperative member or patron.

HIST: 1995 c 234 art 10 s 6

62R.23 Continuation of care.

In the event of the insolvency or bankruptcy of a qualified employer, a health provider cooperative described in section 62R.17 and its members shall continue to deliver the contracted health care services to plan participants for a period of 30 days, whether or not the cooperative receives payment from the qualified employer, its estate in bankruptcy, or from the self-insured employer plan. Section 62R.22 applies to this section. Nothing in this section, however, limits the right of the cooperative to seek payment from the qualified employer, its estate, or the self-insured employer plan for services so rendered.

HIST: 1995 c 234 art 10 s 7

62R.24 Taxes and assessments.

Effective January 1, 1998, as a condition to entering a contract described in section 62R.17, a self-insured employer plan or the qualified employer must voluntarily pay the one percent premium tax imposed in section 60A.15, subdivision 1, paragraph (d), and assessments by the Minnesota Comprehensive Health Association.

HIST: 1995 c 234 art 10 s 8

62R.25 Notification of contract; report to legislature.

(a) Each health provider cooperative shall notify the office of rural health in writing upon entering a contract described in section 62R.17.

(b) The department of health, office of rural health, shall provide an information report to the MinnesotaCare finance division of the house health and human services committee and the senate health care committee no later than January 15, 1999, on the status of direct contracting between health provider cooperatives and self-insured employer plans or qualified employers in accordance with sections 62R.17 to 62R.26. The report shall consider the effects on public policy and on health provider cooperatives of a possible requirement that health provider cooperatives using direct contracting be obligated to become community integrated service networks.

HIST: 1995 c 234 art 10 s 9

62R.26 Sunset.

Sections 62R.17 to 62R.25 expire on December 31, 1999.

HIST: 1995 c 234 art 10 s 10