Health Economics Program

Issue Paper
February 1998

MinnesotaCare Interim Growth Limits Changed to Cost Containment Goals

An integral component of the 1993 MinnesotaCare legislation was to begin efforts to reduce the rate of growth of health care expenditures in the state of Minnesota. Annual limits on the growth rate of health care spending were established under the MinnesotaCare law of 1993, and applied to both health care providers and payers. Several statutory changes were made during the 1997 legislative session that affect the growth limits. This fact sheet outlines the key changes made and how they impact providers and payers.

Changes to Growth Limit Statute

The 1997 Minnesota Legislature made several statutory changes relating to the growth limit statute. ***First, the revenue limit placed on health care providers was repealed.*** This means that hospitals, doctors, and other health care professionals are no longer subject to limits on their increase in revenue or fees from one year to the next.

Second, the growth limits on expenditures by health plan companies have been changed to cost containment goals. While health plan companies are still encouraged to limit their annual increases in health care expenditures, these efforts are now voluntary. The enforcement provisions of the original law have been repealed.

The third important change provides an exemption from premium taxes for certain companies meeting the cost containment goals. The amendment to *Minnesota Statutes* section 60A.15 applies to health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations. Any of these companies meeting the cost containment goal for 1996 are exempt from paying premium taxes between April 1, 1997 and March 30, 1998. Those companies meeting the cost containment goal for 1997 are exempt from paying premium taxes during the period April 1, 1998 to March 30, 1999.

The Premium Tax Exemption Should Be Reflected in Premium Rates

Health maintenance organizations, community integrated service networks, and nonprofit health service plan corporations that are exempt from the one percent premium tax will be presumed to reduce their premium rates to reflect the savings generated by the exemption. Therefore, health plan companies filing individual or small group policy rates with the Departments of Health or Commerce must demonstrate that the exemption savings are being used to reduce premium rates for these policies. The ratio of savings reflected in these premiums to total savings should be equivalent to the ratio of business generated by individual and small employer policies to the company's total business. Health plan companies desiring more information regarding this requirement should review Administrative Bulletin #97-1, issued jointly by the Departments of Health and Commerce.

Cost Containment Goals Finalized

The cost containment goals are computed using the same methodology as had been used for the growth

limits. Each year's goal is based on separating the general trend in inflation from the medical trend. This methodology is referred to as the "CPI+X%" methodology. The X percent is set in the law and the CPI is allowed to vary from year to year. The CPI-U regional index for all items was used to characterize the general inflation component of the growth rate. The resulting goals reflect a 10% reduction in projected health care spending from 1994 through 1998, as mandated by law. The cost containment goals for the growth in health care expenditures are as follows:

Year	CPI-U + X%	Cost Goal
1994	2.9% + **6.5**%	**9.4%**
1995	2.9% + **5.3**%	**8.2%**
1996	3.1% + **4.3**%	**7.4%**
1997	3.1% + **3.4**%	**6.5%**
1998	2.4% + **2.6**%	**5.0%**

Current law contains no provision for setting cost containment goals beyond calendar year 1998.

Which Entities Are Subject to Cost Containment Goals?

All health plan companies are expected to make efforts to achieve the cost containment goals. This includes insurance companies, nonprofit health service plans and health maintenance organizations. Affiliated health plan companies may elect to meet an aggregate cost containment goal.

As mentioned above, the health care provider revenue limits found in *Minnesota Statutes* section 62J.042 have been repealed. They have not been replaced by cost containment goals.

Reporting Requirements Not Changed

Despite the statutory changes relating to the former growth limits, the MinnesotaCare reporting requirements have not changed. Hospitals will still submit annual revenue and expense data as part of the Health Care Cost Information System (HCCIS) report. Physician clinics must report their patient encounters, patient revenue, and cost allocation on an annual survey.

Health plan companies must complete an annual survey that includes information on health care expenditures, enrollees, and revenues. Health plans that formerly made adjustments to their expenditure data using a methodology approved by the Department of Health may continue to do so. Health plans and health care providers must complete the surveys and submit them to the Commissioner of Health by May 1 for data from the preceding calendar year. As before, the data provided on the surveys is non-public and will not be released in a manner that identifies individual health plans.

The data collected on the annual surveys of health plan companies provide valuable information about Minnesota's health care market to legislators and the general public. The information is used to estimate state health care revenues and expenditures, as well as to track trends in enrollment and expenditures for HMOs, commercial insurers, and public programs. For recent information on these trends, see *Minnesota Health Care Expenditures and Trends*, Issue Brief 14, published in September 1997 by the Health Economics

The Health Economics Program conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy.

For more information, contact the Health Economics Program at (651) 282-6367. This issue brief, as well as other Health Economics Program publications, can be found on our website at: http://www.health.state.mn.us/divs/hpsc/hep/hepintro.htm

Minnesota Department of Health
Health Economics Program
121 East Seventh Place, P.O. Box 64975
St. Paul, MN 55101
(651) 282-6367