Health Plan Regulation

February 1988

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Program Evaluation Division

The Program Evaluation Division was established by the Legislature in 1975 as a center for management and policy research within the Office of the Legislative Auditor. The division's mission, as set forth in statute, is to determine the degree to which activities and programs entered into or funded by the state are accomplishing their goals and objectives and utilizing resources efficiently. Reports published by the division describe state programs, analyze management problems, evaluate outcomes, and recommend alternative means of reaching program goals. A list of past reports appears at the end of this document.

Topics for study are approved by the Legislative Audit Commission (LAC), a 16-member bipartisan oversight committee. The division's reports, however, are solely the responsibility of the Legislative Auditor and his staff. Findings, conclusions, and recommendations do not necessarily reflect the views of the LAC or any of its members.

The Office of the Legislative Auditor also includes a Financial Audit Division, which is responsible for auditing state financial activities.

Professional Staff

James Nobles, *Legislative Auditor*

Roger Brooks, *Deputy Legislative Auditor*

Joel Alter
Allan Baumgarten
Edward Burek
David Chein
Mary Guerriero
Marilyn Jackson-Beeck
Daniel Jacobson
Elliot Long
Kathleen Vanderwall
Jo Vos
Tom Walstrom
John Yunker

Support Staff

Jean Barnhill
Linda Bond
Mary Moser

Health Plan Regulation

February 1988

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Veterans Service Building, Saint Paul, Minnesota 55155 • 612/296-4708

STATE OF MINNESOTA
OFFICE OF THE LEGISLATIVE AUDITOR
VETERANS SERVICE BUILDING, ST. PAUL, MN 55155 • 612/296-4708
JAMES R. NOBLES, LEGISLATIVE AUDITOR

February 24, 1988

Representative Phillip J. Riveness, Chairman
Legislative Audit Commission

Dear Representative Riveness:

In May 1987 the Legislative Audit Commission directed the Program Evaluation Division to evaluate health plan regulation in Minnesota. There was concern that the state's regulatory structure had evolved in ways that might harm competition and leave consumers without adequate protection.

The evaluation studied the impact of state regulation on various types of health plans and examined options for changes to the regulatory system.

The report concludes that health plan regulation in Minnesota needs reform. While health plans have become more and more alike, state laws treat them differently and introduce important influences in the marketplace. The report recommends a new framework for state regulation and identifies steps that will ensure better consumer protection.

We received the full cooperation of the Departments of Health and Commerce which share reponsibility for monitoring health plans in Minnesota.

This report was researched and written by Allan Baumgarten (project manager) and Kathleen Vanderwall.

Sincerely yours,

James R. Nobles
Legislative Auditor

Roger A. Brooks
Deputy Legislative Auditor
for Program Evaluation

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

HEALTH PLAN REGULATION

Executive Summary

Minnesota, like other states, has established a regulatory scheme for health plans that treats these plans as distinctly different from one another. Thus, health maintenance organizations (HMOs) are regulated differently from traditional health insurers, and Blue Cross/Blue Shield plans are under a third set of state rules.

Historic distinctions between types of health plans are still the basis for state regulation.

As we show in this report, these plans, which are competing for the same business, have grown increasingly similar to one another. Furthermore, the difference between nonprofit and for-profit health providers is no longer clear. Yet these distinctions remain the basis for how Minnesota regulates health plans.

In May 1987, the Legislative Audit Commission directed the Program Evaluation Division to analyze how Minnesota regulates health plans. In our study, we asked:

- **Has Minnesota's regulation of health plans kept up with changes in the marketplace? How should the state regulate health plans?**
- **What role, if any, should the state play in regulating self-insured health plans?**
- **How have the Departments of Health and Commerce carried out their regulatory duties? Is the division of responsibilities between the two departments appropriate?**

CHANGES IN THE HEALTH MARKETPLACE

Minnesota is a leader among the states in the development and growth of new health care plans. The figure on the next page shows the categories of health plans analyzed in this report.

Before 1965, most Americans received health care coverage from two sources: *non-profit health service plans*, popularly known as Blue Cross or Blue Shield plans, and *accident and health insurance* offered by life insurance companies. These plans generally paid for treatment of illness from a virtually unlimited choice of licensed providers.

Health maintenance organizations (HMOs) were first organized in the 1930s and have grown rapidly in the past ten years. They are prepaid health plans offering comprehensive care, including preventive care, from a limited number of providers, in exchange for a fixed premium. These plans attempt to reduce costs by substituting outpatient care for hospitalization, and by reducing the number and length of hospital stays. HMO enrollment in the United States grew from 5.3 million in 142 plans in 1974 to 28.6 million members in 662 HMOs in 1987.

- **Enrollment in Minnesota HMOs has increased even faster. By June 1987, nearly 1.2 million Minnesotans were enrolled in 12 HMOs.**

One in four Minnesotans is enrolled in an HMO.

Some employers have chosen to *self-insure* their employee health plans, paying claims out of operating funds or specially designated trust funds. Under federal law, self-insured health plans are generally exempt from state regulation and taxation.

Based on a survey of 435 Minnesota employers, we found:

- **Half of the employees in firms of 500 or more employees are covered by self-insured plans, and one-fourth are enrolled in HMOs.**

- **40 percent of the employees in small firms (fewer than 50 employees) have no health coverage through their employer; most of the rest are covered by accident and health insurance.**

The distinctions between different types of health plans have blurred in recent years. Plans have become similar in three ways.

- **Insurers and Blue Cross/Blue Shield plans have developed HMO "look-alikes," such as the Aware plans, which provide comprehensive care with smaller charges and less paperwork for the enrollee.**

In response, HMOs promoted *combination plans*, in which enrollees can choose either full coverage from their HMO doctors or reduced coverage

- ***Nonprofit Health Service Plans*** **are sponsored by Blue Cross/Blue Shield and cover health care costs on a fee-for-service basis.**
- ***Accident and Health Insurance*** **indemnifies enrollees against losses resulting from illness and accident by paying the resulting health care expenses.**
- ***Health Maintenance Organizations*** **are prepaid plans providing comprehensive care to enrollees.**
- ***Combination Plans*** **provide a choice of full HMO coverage or indemnity coverage from a non-HMO provider.**
- ***Self-insured Plans*** **are used by employers to assume the risk of their employees' health care costs.**
- ***Preferred Provider Arrangements*** **are used by insurance companies and self-insuring employers to contract with a limited group of physicians and hospitals who accept discounted fees in exchange for more patients.**

Types of Health Plans

Characteristics	Physicians Health Plan	Blue Cross & Blue Shield	Mutually Preferred
Type	Health Maintenance Organization Combination Plan	Health Service Plan	Accident & Health Preferred Provider
Basic, Regulating Statute	Minn. Stat. Chap. 62D	Minn. Stat. Chap. 62C	Minn. Stat. Chap. 62A
Physician Services From Participating Provider	Paid in full	Paid in full	Paid in full
Physician Services Outside Network	80% of eligible expense, after member's annual deductible has been satisfied	80% of allowed amount, after member's annual deductible has been satisfied	80% of allowed amount, after member's annual deductible has been satisfied
Preventive Care From Participating Provider	Paid in full	Paid in full	Paid in full
Physician Payment	Fee schedule	Fee schedule	Fee schedule
Paperwork for Patient	None when using participating provider	None when using participating provider	None when using participating provider

NOTE: Plan design options allow employer to select a different level of coverage.

Comparison of Health Plans

from a provider of choice outside the HMO. The figure above shows how different types of plans, though regulated differently, may provide similar benefits. Second:

- **Insurers, government, and employers now "manage" health care by adopting the cost-containment measures associated with HMOs: contracting directly with providers, reviewing providers' practices, and intervening in the patient-provider relationship.**

Insurers and others seek to "manage" health care.

For example, most employers responding to our survey said that their accident and health insurance plans require a second opinion prior to surgery. Third:

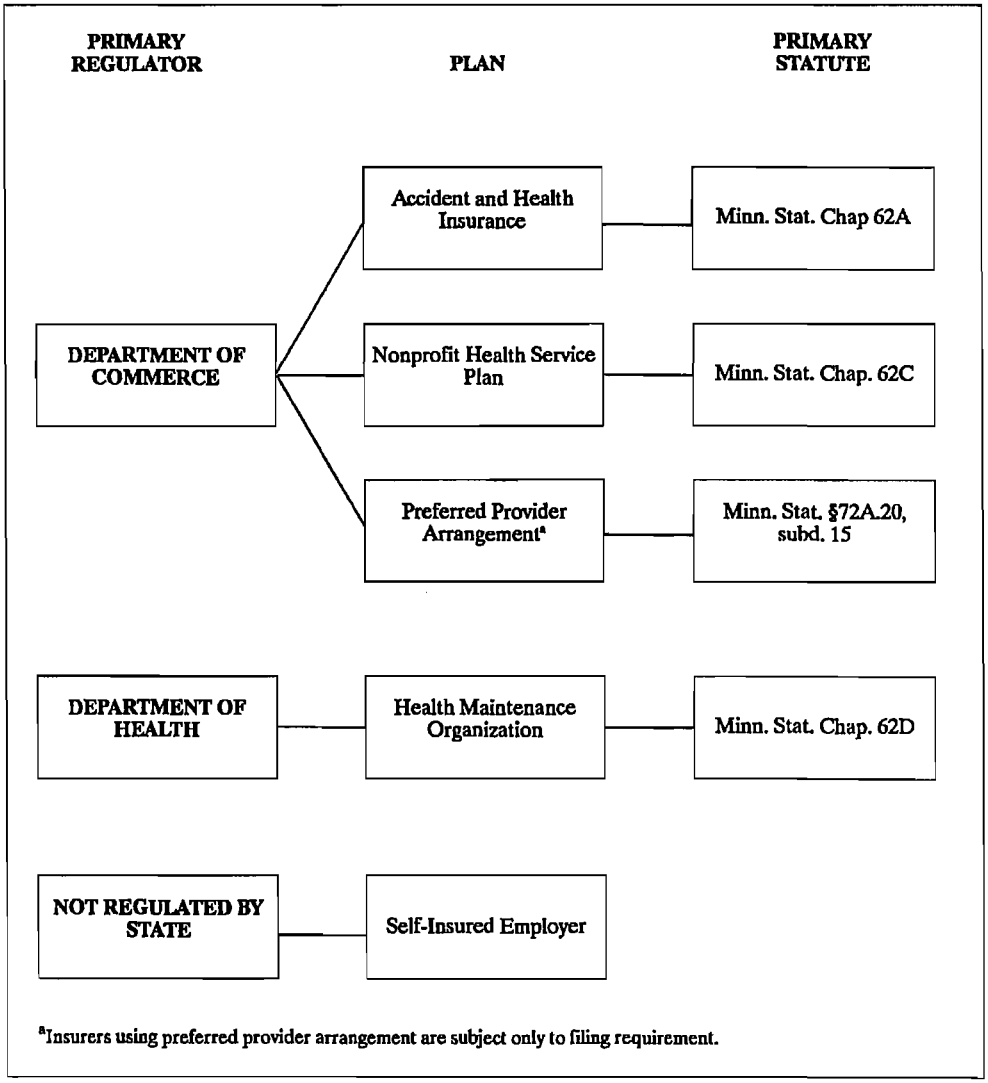
- **Health service plans and accident and health insurance have become more like HMOs because they share certain financial risks with providers.**

These plans may withhold a portion of fees or require a provider to absorb the costs of services that the plan found were not "medically necessary." Health service plans may also pay providers on a capitation basis, putting them at risk for an enrollee's care costs.

STATE REGULATION OF HEALTH PLANS

While distinctions between types of health plans have faded, state regulation has not kept up with those changes. The "uneven playing field" of state regulation described in this report impairs competition between different types of plans.

Regulation is divided between the Departments of Commerce and Health.



Who Regulates Health Benefit Plans?

"Level Playing Field" Issues

We reviewed state regulation of health plans to see how different plans are treated and to determine whether differences impair competition. We concluded:

- **There are significant differences in how the state regulates different types of plans.**

For example:

- **Plans are treated differently with regard to state-mandated benefits and providers.**

In one respect, *HMOs* have a competitive advantage, because they are not required to guarantee access to nonphysician providers, such as chiropractors. *Accident and health insurers* and *health service plans*, on the other hand, are required to ensure access to nonphysician providers. However, HMOs must provide comprehensive services, while other plans have more flexibility in plan design. Some other examples of differential regulation are:

Plans are treated differently in several ways.

- **Ability to limit providers and enrollees:** *HMOs* and *PPOs* have significant flexibility to select providers to participate in their plans. But, *accident and health insurers* may not discriminate against any licensed provider, and a *health service plan* must include any licensed provider willing to accept the plan's terms. On the other hand, *HMOs* have less flexibility than other plans to discriminate against potential enrollees, since they must open enrollment to groups once a year and accept group members without health screening.

- **Financial requirements:** *HMOs* are not subject to review of premium rates, while *health service plans* and *accident and health insurers* are. Requirements for start-up capital and ongoing reserves are much less stringent for *HMOs* than for *insurers* and *health service plans.*

- **Taxation:** *Accident and health insurers* pay Minnesota's two percent premium tax. *HMOs* and *health service plans*, as nonprofit organizations, and *self-insured* firms do not pay the premium tax. Furthermore, *accident and health insurers* are subject to state income tax if their liability exceeds their premium tax liability. *HMOs* are exempt from the income tax, while *Blue Cross/Blue Shield* recently became subject to state and federal taxes.

- **Minnesota Comprehensive Health Association:** All plans, except *self-insured plans,* are now required to be contributing members of the Minnesota Comprehensive Health Association (MCHA), which provides health coverage to Minnesotans who cannot secure coverage elsewhere.

- **Quality assurance:** Under state and federal law, *HMOs* face unique requirements for developing systems of quality assurance and for maintaining mechanisms to receive and handle complaints from enrollees. No other type of plan faces such requirements.

Nonprofit and For-profit Plans

Minnesota is the only state which limits HMO operations to non-profit organizations. Despite this requirement:

- **The distinction between for-profit and nonprofit organizations has become blurred because many Minnesota HMOs are managed by or affiliated with for-profit entities.**

Many Minnesota HMOs have adapted to the nonprofit requirement by contracting with for-profit management companies. They pay a fee which has ranged up to 15 percent of premium revenue. Physicians Health Plan and MedCenters Health Plan, the two largest HMOs in the state, are managed by for-profit companies owned by national HMO companies. Blue Cross/Blue Shield, which by law is also required to be nonprofit, has three subsidiaries that are for-profit operations.

Many Minnesota HMOs are managed by for-profit companies.

- **Besides payment of management fees, other arrangements have been used to move money from certain HMOs to affiliated companies or persons.**

Self-insurance

A growing number of firms in Minnesota self-insure all or part of their employee health plans. Based on responses to our employer survey, we estimate that:

- **About 75 percent of large firms self-insure at least one health plan. Nearly one-fourth of all Minnesota employees are covered by a self-insured plan.**

- **Most enrollees in self-insured plans receive benefits similar to those mandated by state law for enrollees in other plans, although smaller firms were less likely to offer mandated benefits.**

Attempts by states, including Minnesota, to regulate self-insured plans have had limited success. Our review of consumer complaints received by the Department of Commerce from members of self-insured plans did not disclose any major problems with self-insured plans.

Conclusions and Recommendations

Health plans in Minnesota, competing for the same business, have become more and more alike, yet they are regulated differently. We conclude:

- **Differential regulation of health plans impairs competition in several ways.**

First, regulations like the premium tax give a clear competitive edge to certain types of plans. Second, it is economically inefficient when, in order to compete or to evade state regulations, health plans establish management organizations or parallel subsidiaries and plans. These complex structures make effective state oversight even more difficult. Finally, when health plans find that it is advantageous and a competitive necessity to steer employers toward self-insured plans, the state's opportunity for useful regulation virtually disappears.

We recommend:

- **The Legislature and state agencies should clarify the purposes of state health plan regulation and specify which roles are important for the state to play.**

In our view, the state has an important role to play in two areas:

- *Disclosure:* **The state should determine if a plan clearly discloses which services are not covered and what the consumer's obligations are.**

- *Financial solvency:* **The state should monitor the financial condition of the plan to see if it has adequate resources to provide the coverage that enrollees pay for.**

In short, we think the state's role should be to see that consumers understand the coverage they get and get the coverage they bargain for.

To correct the problem of plans regulated differently, we recommend:

- **In general, the state should seek to make health plans compete on the same terms. Where differential regulations create serious impediments to competition, they should be modified.**

State regulation should be based on how plans seek to manage care.

Health plans are best distinguished not by a superficial label but by how they attempt to manage health care. In this respect, three issues are important:

- *Risk:* **How widely does the plan distribute risk among payors, providers, enrollees, and employers?**

- *Provider autonomy:* **To what extent does the plan intervene in the provider-patient relationship through techniques such as utilization review, pre-authorization reviews, and provider practice standards?**

- *Access:* **To what extent does the plan limit free choice of providers? To what extent does the plan limit enrollment?**

The more extensively a plan does these things, the greater the state's interest should be in regulating the plan. For example, if the plan limits a patient's access to a provider of choice, the state might impose quality assurance or

complaint resolution requirements for that plan. Some rules would be applied uniformly, such as standards for disclosure to consumers of their rights and the limitations of the plans.

In our view,

- **The Legislature should create a uniform body of regulation for "managed health care plans," including the range of plans discussed in this report.**

We conclude that the state's requirement that HMOs be nonprofit organizations has become counterproductive. We recommend:

- **The Legislature should amend state law to allow HMOs to organize as they see fit, whether as nonprofit or for-profit entities.**

For-profit HMOs should be permitted in Minnesota.

For-profit firms, whether national or Minnesota-based, are a source of outside capital that the state should not exclude. We do not expect that this will result in a swarm of new national HMO firms descending on the state. (Two national firms, United Health Care and Partners National Health Plans, already operate HMOs with 72 percent of HMO enrollment in Minnesota.) Neither do we expect that existing HMOs will immediately seek to convert to for-profit status, given the costs of such conversions.

SOLVENCY OF HMOs

Minnesota, like other states, set relatively low requirements for start-up capital and reserves for HMOs to help new HMOs enter the market and because HMOs shift some risk to providers. After a rash of insolvencies last year, many states were reexamining those requirements. In 1987, two Minnesota HMOs, More HMO Plan and Health Partners, were declared insolvent and are being liquidated.

Under standards adopted in 1984, a new HMO must make a deposit of $100,000 in a restricted account and have at least 60 days worth of working capital. However, the law makes an exception for any HMO with sufficient net worth and an adequate history of generating income. In 1987,

- **Only four HMOs, including the two now being liquidated, actually maintained a deposit.**

We reviewed the activities of the Department of Health in monitoring the solvency of HMOs. We concluded:

- **The Department of Health is not adequately equipped to monitor the finances of HMOs.**

The department currently has one analyst responsible for financial monitoring, and he has other duties as well. The department has moved slowly to add

new staff for that function. Problems resulting from the More and Health Partners insolvencies demonstrate the need for closer financial monitoring of HMOs.

- **Although the final outcome is not clear, the worst case is that providers and enrollees of the two HMOs may suffer losses of nearly $2.3 million.**

Using 1986 annual reports, we analyzed HMOs' financial condition. We found that many are not financially strong.

- **Five HMOs had current liabilities in excess of their current assets; the trend during 1986 was negative for all but four HMOs.**

- **Nine HMOs were highly leveraged, and their debt was more than three times the amount of their equity.**

- **Working capital and reserves were very thin for most of the HMOs.**

Increased oversight of HMOs' financial condition is needed.

Based on our review of the HMO insolvencies and the financial strength of the other HMOs, we concluded that state regulation of the solvency of HMOs should be strengthened. Specifically,

- **The Legislature should increase start-up capital, ongoing reserves, and restricted deposit requirements for HMOs.**

- **The Department of Commerce should be given responsibility to monitor the financial integrity of HMOs.**

The Department of Commerce should develop and implement an "early warning" system to identify problems with HMOs through a combination of broader and more frequent reporting and periodic and special examinations.

ROLE OF STATE AGENCIES

Two agencies share responsibility for regulation of health plans in Minnesota. The Department of Commerce regulates accident and health insurance and health service plans. However, Minnesota is one of only nine states where the state insurance department is *not* the primary regulator of health maintenance organizations. In 1973, the Legislature gave that responsibility to the Department of Health. Self-insured plans are largely unregulated by state agencies.

Department of Health

The Department of Health has had a small staff to perform broad responsibilities.

After ten years with only one or two persons assigned to HMO regulation, the Department of Health will have 15 or 16 persons in that unit by the end of the 1988-89 biennium. The department saw that the lack of staff up to now was a serious obstacle to carrying out its broad duties and requested additional resources in 1987. For example, it is supposed to conduct examinations of all HMOs on a three-year cycle, reviewing their finances and the quality of services provided. However, we found that:

- **The department has completed only three such reviews, and those have generally lacked focus and have paid excessive attention to paperwork issues.**

Relatively little attention was given to an independent review of the financial condition of the HMO or of the major providers and other entities under contract with the HMO. Department staff have also conducted special financial reviews of other HMOs.

The Department of Health reviews the quality assurance plans of each HMO and has begun some promising initiatives in this area. By law, HMO enrollees can bring complaints about HMOs to the department, but the statute does not say what the department should do. Based on a review of 292 complaint files closed by the department in 1987, we concluded:

- **The department appears to have acted largely as a clearinghouse, noting complaints and passing them along to HMOs.**

Only about 15 percent of all cases showed evidence of independent follow-up efforts by the department beyond sending out form letters to the HMO.

Department of Commerce

Regulation of health plans by the Department of Commerce is carried out through several different sections which monitor solvency, review filings, and handle consumer complaints. Analysts in the Department of Commerce have developed a body of standards for reviewing certain provisions of health insurance policies, such as "loss ratios" and the use of cost containment techniques. However,

- **The department has not adopted these standards in rule through the Administrative Procedure Act.**

The department needs to clarify its review standards for certain plans and to improve its review of provider contracts.

Cooperation

The record of cooperation between the two agencies has been mixed. The departments jointly review HMO combination plans and exchange information about preferred provider arrangement filings. However, joint efforts to draft administrative rules for PPOs did not succeed, partly because the two agencies could not agree on key issues.

We also observed a fundamental difference in the approach taken by the two agencies. The Department of Commerce, particularly in recent years, sees its primary regulatory role as consumer advocacy, and it is not reluctant to take a public, adverse stance with insurers and others. We view the Department of Health as a more cautious regulator of health plans, interpreting its role as shaping future health care policy and markets. The Department of Health disagrees with this characterization, and feels that it is an assertive and vigorous regulator.

Regulation of HMOs and other managed health care plans should be unified in the Department of Commerce.

With limited resources, the Department of Health has done much of what the Legislature asked it to do in 1973: provide a conducive regulatory atmosphere that would allow the state to see if the "HMO experiment" would succeed. The department's staff has performed in a professional manner, and this goal has been accomplished. However, the state needs to view all health plans, including HMOs, as systems of financing health care, and to regulate similar health plans consistently. One agency, with expertise in monitoring the financial integrity of health plans and in protecting consumers, should regulate all managed health care plans. Thus, we recommend:

- **The Legislature should transfer most regulatory responsibilities for HMOs to the Department of Commerce.**

Although the Department of Health has only recently become actively involved in the area of quality assurance, it is the logical and best qualified agency to perform this function. We recommend:

- **The Department of Health should assume responsibility for quality assurance activities for all managed health care plans.**

INTRODUCTION

In recent years, the health plan marketplace in Minnesota has changed dramatically. For example, health maintenance organizations (HMOs), once an experiment, now provide prepaid health benefits to one in four Minnesota *consumers*. *Payors*, including government and insurance companies, insist on greater influence over patterns of medical practice. Hospitals and other medical *providers* have reorganized and consolidated their operations, and now contract directly with large employers or with insurers to use their facilities and affiliated doctors as preferred providers. Many employers, who along with government are the primary *purchasers* of health care, now assume risk for their employees' health care costs and ask providers and insurers for detailed information on those costs.

Legislators and others have asked whether state regulation of health plans has kept up with changes in the marketplace. They have also been concerned by recent developments involving the solvency of health plans and access to those plans in rural areas of the state.

We were asked by the Legislative Audit Commission to study Minnesota's regulation of health plans and determine if changes were needed. In our study, we asked:

- **Has Minnesota's approach to health plan regulation kept up with changes in the marketplace? How should the state regulate health plans?**

- **What role, if any, should the state play in regulating self-funded health plans?**

- **How have the Departments of Health and Commerce carried out their regulatory duties, and where should those duties be located in state government?**

To answer these questions, we gathered and analyzed data on different health plans, evaluated the activities of the state Departments of Health and Commerce, and analyzed documents received by those departments. We surveyed a sample of employers in the state to find out what health plans they offer, and we interviewed researchers and consumers, and representatives of providers and health plans.

During our study, we found that traditional distinctions have become blurred. The difference between nonprofit and for-profit health providers is no longer clear, and neither is the distinction between plans offered by insurers and by health maintenance organizations. Yet these distinctions still control the way Minnesota regulates health plans.

Chapter 1 of this report reviews national developments in the health care marketplace, while Chapter 2 provides additional information on Minnesota trends in health care and results from our survey of employers. Chapter 3 compares how the state regulates different health plans and analyzes whether the current regulatory framework fosters competition in the marketplace. The financial solvency of HMOs, an increasingly important regulatory issue, is addressed in Chapter 4. Our analysis of the perceived trend of Minnesota employers to self-insure their health plans and the role the state might play in regulating those plans is presented in Chapter 5. Finally, Chapter 6 reviews the activities of the Departments of Health and Commerce and addresses the question of where regulatory authority should be located in state government.

BACKGROUND

Chapter 1

In 1983, an estimated 192 million Americans had health care insurance of some type, provided through employment, government programs, or at their own expense. In this chapter, we review the development of health plans in the United States during the last 50 years and explain the different types of plans. Figure 1.1 provides a short description of each type.

TRADITIONAL TYPES OF HEALTH PLANS

States authorized Blue Cross plans in the 1930s and 1940s.

Widely available health insurance is a recent development in the United States. In the late 1930s and 1940s, states authorized the creation of *non-profit hospital service plans*, known by the name "Blue Cross." These plans covered the cost of surgery and hospitalization. Non-profit service plans for outpatient care of illness--"Blue Shield" plans--soon followed in most of the states. Both plans were provider sponsored, which meant that physicians effectively controlled both the delivery and financing of health care.

In the years following World War II, there was explosive growth in the number of Americans covered by *accident and health insurance* offered by for-profit insurers. These plans are often called *indemnity plans* because they indemnify subscribers against loss by paying for services received from a provider of the subscriber's choice. Between 1945 and 1960, the number of people covered by hospital insurance and

- *Nonprofit Health Service Plans* are sponsored by Blue Cross/Blue Shield and cover health care costs on a fee-for-service basis.
- *Accident and Health Insurance* indemnifies enrollees against losses resulting from illness and accident by paying the resulting health care expenses.
- *Health Maintenance Organizations* are prepaid plans providing comprehensive care to enrollees.
- *Combination plans* provide a choice of full HMO coverage or indemnity coverage from a non-HMO provider.
- *Self-insured Plans* are used by employers to assume the risk of their employees' health care costs.
- *Preferred Provider Arrangements* are used by insurance companies and self-insuring employers to contract with a limited group of physicians and hospitals who accept discounted fees in exchange for more patients.

Figure 1.1: Types of Health Plans

Blue Cross plans nationally grew from 32 million to 122 million. By 1980, 189 million Americans had hospital coverage.[1]

Traditional health plans provided fee-for-service coverage.

Corporate organization was one obvious difference between the nonprofit health service plans and the for-profit accident and health insurers. However, the two types of plans shared four important characteristics. First, they provided *fee-for-service* coverage, paying the health providers a fee for every service provided, while the enrollee's out-of-pocket cost might include significant co-payments and deductibles. Because providers were paid based on services provided, they faced obvious incentives to provide more services and to choose more expensive services.

Second, these plans paid bills and did not question providers' autonomy on matters of medical practice. Providers decided what treatments were medically necessary and whether they should be provided in a hospital or in a doctor's office. Third, the plans generally provided benefits only when the enrollee was sick and did not cover preventive check-ups. Finally, they allowed a virtually unlimited choice of licensed providers. Indeed, "Blue Shield laws" in many states banned the formation of plans which proposed to cover care only from a limited list of health providers.

The enactment of the Medicaid and Medicare programs in 1965 expanded access to health care greatly, providing insurance for the first time to millions of elderly or poor persons. As access to health care grew, so did spending on health care. Health expenditures grew from 4.4 percent of gross national product in 1950 to 10.9 percent in 1986.[2]

DEVELOPMENT OF PREPAID PLANS AND HMOs

The first pre-paid health plans in the United States were organized in the late 1930s and the 1940s by large employers such as Kaiser Industries in California, or by consumers, primarily labor organizations, e.g., the founders of the Group Health Association of Washington, D.C. These prepaid group practices provided more comprehensive care than was generally available under traditional health plans. While these plans grew steadily, they were generally concentrated on the West Coast and in certain metropolitan areas in the northeast.[3]

In 1970, the term "health maintenance organization" was first used to describe prepaid health plans. The term now describes a wide variety of organizations. Figure 1.2 describes some of the basic principles of health maintenance or-

---

1 Health Insurance Association of America, *Source Book of Health Insurance Data, 1984-1985*, 10.

2 Gerard F. Anderson and Jane E. Erickson, "National Medical Care Spending," *Health Affairs* (Fall 1987): 96.

3 Enrollment in the Kaiser plan in northern California grew from 32,000 to 146,000 between 1947 and 1952.

ganizations and indicates how they differ from fee-for-service plans. It also points out some of the ways that HMOs can differ from each other.

Prepaid health plans were promoted as a way of curtailing the growth of health care expenditures.

The term "health maintenance organization" was coined by Dr. Paul Ellwood of InterStudy, a Minnesota health policy think tank. He worked closely with the Nixon Administration to promote prepaid health plans as a way of curtailing the growth of health care expenditures, at a time when Congress was seriously considering proposals for national health insurance. The term was deliberately chosen to be politically neutral. The term also expressed the ideal that HMOs would focus on keeping people healthy, in contrast to the fee-for-service system's emphasis on curing illnesses. Prepaid plans would face economic incentives to practice preventive medicine, offering primary care before more expensive hospitalization was needed.[4]

The federal HMO Act of 1973 encouraged the growth of HMOs. It established standards for federal "qualification" of HMOs, helped HMOs gain entry to the market by requiring certain employers to offer an HMO option, and provided grants for HMO development. While the act created these advantages for federally qualified HMOs, it also placed additional responsibilities on them. They had to offer a comprehensive package of minimum benefits, calculate their premiums on a community-wide basis rather than the actual experience of specific groups, and open enrollment to members of groups each year, without health screening.

1. **The HMO assumes a contractual responsibility to provide or assure delivery of a stated range of services, including ambulatory and inpatient hospital care.**
2. **An HMO has a defined enrollment, meaning that it can know, at any point in time, the number of people for whom it is obligated to provide services and the estimated demand for those services.**
3. **The fixed annual or monthly payment (premium) to the HMO is made independently of the utilization of services. Thus, the HMO does not gain substantial revenue by providing more services. In fact, if the HMO can provide less than the expected number of services, its net revenue after expenses will increase.**
4. **Enrollment in HMOs is voluntary. Individuals who enroll in an HMO are usually offered a health benefit program with two or more options.**
5. **An HMO assumes at least part of the financial risk and/or gain from the provision of health services. Thus, the HMO also has a financial incentive to reduce the unnecessary use of expensive services and to substitute less expensive forms of treatment (e.g., ambulatory care) for more expensive services (e.g., inpatient hospital care).**

Source: Rhona L. Wetherill and Jean N. Quale, *A Census of HMOs* (Minneapolis, MN: InterStudy, August 1973).

Figure 1.2: Characteristics of Health Maintenance Organizations

4 In a review of studies on HMOs, Luft found: "While better coverage of preventive services may lead to more use of such services, evidence is lacking that this practice results in substantially better health, or accounts for the lower hospital use and lower total health care costs of HMO enrollees." Harold S. Luft, *The Operations and Performance of Health Maintenance Organizations* (San Francisco: University of California, 1981): 43. There is little evidence that doctors in HMOs differ from their fee-for-service colleagues in spending most of their time caring for the sick.

During the 1970s, federal qualification of HMOs was an important benefit, and many existing prepaid plans sought qualification. Some employers apparently viewed federal qualification as something of a "Good Housekeeping Seal of Approval" and used it to compare HMOs. The availability of federal grants for HMO development was another important reason to seek federal qualification. With the demise of federal aid and the growing familiarity of employers with HMOs, few new HMOs now seek federal qualification.

Insurers have adopted many cost-containment measures once associated with HMOs.

The growth of HMOs had an important effect on the traditional payors of health care costs: insurers and government. As late as the 1970s, they largely played a claim-processing function and did not interfere with providers' autonomy. Faced with growing costs and increasing competition from HMOs, payors decided that since they were "paying the piper," they should call the tune as well. The term "managed care" was coined to describe health plans in which the payors contracted directly with providers and began to exercise more influence over providers' practices and to intervene in the patient-provider relationship. In order to "manage" health care, they began to adopt many of the cost-containment measures associated with HMOs, such as substituting outpatient care for more expensive hospitalizations and attempting to limit hospital admissions and the length of hospital stays.

NATIONAL TRENDS IN PRODUCTS AND ENROLLMENT

HMOs

In 1974, there were 142 prepaid plans in the country, enrolling 5.3 million people. Figure 1.3 describes the four "models" now used to classify HMOs. The earliest prepaid plans were *staff models*, employing their own physicians. *Group model* HMOs were built around multispecialty group practices. *Individual practice association (IPA) model* HMOs contract with numerous independent practices who usually continue to see a majority of fee-for-service patients. Finally, the *network model HMO* is an amalgama-

***STAFF*: An HMO that delivers health services through a physician group that is controlled by the HMO. Doctors are typically salaried. Patients are limited to using doctors who are part of the HMO staff, unless they receive a referral to an outside provider.**

***GROUP*: An HMO that contracts with one independent group practice to provide health services. Typically, a member is required to choose a primary doctor or clinic that serves as a gatekeeper. The primary provider may receive a per capita payment and accept risk for the cost of services provided.**

***IPA*: An HMO that contracts directly with physicians in independent practices and typically reimburses doctors on a discounted fee-for-service basis. Enrollees may generally self-refer to specialists who are part of the HMO panel.**

***NETWORK*: An HMO that contracts with two or more independent group practices, possibly including a staff group, to provide health services.**

NOTE: Each of these models can offer a combination HMO plan, in which enrollees have full coverage for services provided within the HMO's panel and indemnity coverage for services received from outside providers.

Source: InterStudy, The InterStudy Edge (1987).

Figure 1.3: Models of HMOs

tion of staff practices which also contracts with group practices.

While the established staff model dominated the scene in the 1970s, new plans emerged which were sponsored by multi-specialty group practices, universities, hospitals, and medical societies. Few of the HMOs opened since 1980 have been staff models. Instead, the fastest growing model in recent years has been the individual practice association.

Growth of HMOs has been especially fast in the past two years. The number of HMOs nationally grew from 175 in 1976 to 243 in 1981 and to 662 in June 1987. Enrollment increased from 6 million in 1976 to 10.2 million in 1981 and to 28.6 million in 1987. In three states--Minnesota, California, and Oregon--HMO enrollment is now more than 20 percent of the population.

Minnesota is one of three states where more than 20 percent of the population is enrolled in HMOs.

According to InterStudy's census of HMOs, 62 percent of HMOs are for-profit organizations, accounting for 41.6 percent of members. Most recently opened HMOs are IPA models and for-profit operations.

Other Managed Care Plans

Two important trends have emerged in recent years: health plans began to offer similar coverages, and insurers, HMOs, and providers have become frequent partners in joint ventures.

First, insurers and Blue Cross/Blue Shield plans introduced health plans that resemble HMOs by providing comprehensive benefits with fewer deductibles or co-payments with a minimum of paperwork. As insurers began to resemble HMOs, HMOs adopted some of the features of traditional insurance plans. *Combination plans* (also called open-ended or wraparound plans) sponsored by HMOs, often as a joint venture with an insurer, have emerged in the past few years. In such plans, enrollees are not "locked in" to the HMO's providers. They can get full coverage from an HMO provider or indemnity coverage when using a provider of choice outside the HMO.

Second, new kinds of partnerships have emerged. *Preferred provider arrangements*, known as PPOs (preferred provider organizations) emerged in the early 1980s.[5] A PPO plan is a fee-for-service arrangement, in which enrollees are given incentives to use designated providers. Providers accept a reduced reimbursement in anticipation that more patients will be channeled to them. In those states which permit them, PPOs are typically used by accident and health insurers or self-insuring employers. This allows an insurer to establish a contractual relationship with a limited group of providers.

By one count, there are now 535 PPOs operating in the United States.[6] Enrollment of eligibles increased from 1.3 million in December 1984 to 16.5 million in July 1986. [7](Summer 1987): 127-135. Enrollment in PPOs is typically

5 Note that Blue Cross/Blue Shield plans were a early version of a preferred provider arrangement.

6 American Medical Care and Review Association, *Directory of Preferred Provider Organizations and the Industry Report on PPO Development*, June 1987.

7 Greg De Lissovoy, Thomas Rice, Jon Gabel, and Heidi Gelzer, "Preferred Provider Organizations: One Year Later," *Inquiry*

expressed as the number of "eligibles" who are participating in the overall plan, since few PPOs have a defined enrollment.

The importance of national HMO firms has grown significantly in the past two years. According to InterStudy, there were 42 firms operating HMOs in more than one state in 1986, and these firms now enroll three out of five HMO members. Insurance companies, which are actively involved in developing preferred provider arrangements and combination plans, are now major participants in the HMO market. Eight national firms had HMOs headquartered in at least ten states, and all but one of those firms were associated with a major insurance company.

This trend may have slowed recently. National investor-owned HMO firms have experienced serious financial problems since 1986. Once glamorous stocks have declined sharply in price. For example, stock in United Health Care, which operates two Minnesota HMOs, traded at $15 per share in 1986 but closed below $4 on December 31, 1987. Firms have closed operations in some markets, and some major insurance companies, such as Travelers and John Hancock, have sharply reduced their HMO operations. This does not mean that insurers and national companies are leaving the field, but rather that they are becoming more conservative about the value of these operations.

Some employers self-insure rather than paying an outsider to take risk.

Self-insurance

Insurance is a way of sharing risk. In accident and health insurance, health service plans, and HMOs, an employer buying coverage for employees pays a set premium, and the plan assumes the risk for the claims incurred by that group. The insurer sets the premium based on: (1) its best estimate of utilization for that group and similar groups, (2) administrative costs including applicable taxes, and (3) a margin for profit or surplus. The insurer can spread some of the risk by insuring many different groups or by purchasing additional insurance, known as "stop-loss," against catastrophic claims. Stop-loss coverage means that the primary insurer's potential liability is limited to a certain amount, e.g., $50,000, per enrollee, per year. If the claims exceed that amount, the stop-loss insurer pays the excess. HMOs can also purchase stop-loss coverage, and in addition they can share risk with their providers.

Some employers have concluded that it is to their advantage to take responsibility for paying employees' claims rather than paying a premium for an outsider to take that risk. These employers *self-insure*, paying claims out of operating funds or out of specifically designated trust funds. They may pay a third-party administrator or an insurance company to provide administrative services, and they may purchase stop-loss insurance against catastrophic claims. Smaller employers may self-insure by joining together in multiple employer trust arrangements.

HEALTH PLANS IN MINNESOTA

Chapter 2

Minnesota is regarded as a leader among the states in the development and growth of managed health care. In this chapter, we review the development of HMOs and other plans in Minnesota and report the results of a survey in which we asked employers about the health care benefits that they offer.

MINNESOTA TRENDS IN PRODUCTS AND ENROLLMENT

Prepaid health insurance faced obstacles from providers and state laws.

Nonprofit health service plans offered by Blue Cross and Blue Shield have been a major source of health coverage for Minnesotans since the 1940s. Minnesota enacted its nonprofit hospital service plan (Blue Cross) law in 1941 and its nonprofit medical service plan (Blue Shield) law in 1945.[1] In 1970, when Blue Shield of Minnesota was faced with insolvency, Blue Cross assumed management of Blue Shield. A year later, when the combined company reported a deficit of nearly $7 million, a new nonprofit health service plan law was enacted, which tightened state regulation of health service plans.[2]

As in other states, prepaid health insurance in Minnesota faced opposition from established medical providers as well as obstacles in state law. A 1937 attorney general's opinion concluded that a prepaid group medical practice would be regarded as illegal "corporate practice of medicine." But in 1955 Attorney General Miles Lord ruled that a nonprofit corporation organized to provide prepaid, comprehensive medical and dental care could be formed under Minnesota law.

HMOs

The first prepaid hospitalization plan in Minnesota was established in 1944 by railroad workers in Two Harbors. Soon after the attorney general's favorable opinion was issued in 1955, Group Health, Inc. incorporated in St. Paul. It began operation as a prepaid plan two years later. Figure 2.1 lists the HMOs operating in Minnesota today and provides general information about them.

1 *Minn. Laws* 1941, Chap. 53; *Minn. Laws* 1945, Chap. 255.

2 *Minn. Laws* 1971, Chap. 568.

FIGURE 2.1

CHARACTERISTICS OF MINNESOTA HMOs

HMO	Headquarters City	Owner or Affiliation	Year Opened	Federally Qualified	Model	History/Status
Central MN Group Health Plan	St. Cloud	Group Health, Inc.	1979	No	Staff	Pending board approval, will become operating subsidiary of Group Health, Inc., in 1988
Coordinated Health Care	St. Paul	Blue Cross/Blue Shield	1972	Yes	Network	Blue Cross/Blue Shield assumed control in 1985
First Plan	Two Harbors	Blue Cross/Blue Shield	1944	No	Network	Blue Cross/Blue Shield assumed control in 1986
Group Health, Inc.	Minneapolis	Group Health, Inc.	1957	Yes*	Network**	Includes Group Care, NFQ HMO
Health Partners	Eden Prairie	Primary Care Network	1986	No	IPA	Declared insolvent in 1987
HMO Minnesota	Eagan	Blue Cross/Blue Shield	1974	Yes*	Network	Includes Minnesota Health Plan, Inc., NFQ HMO
Mayo Health Plan	Rochester	Mayo Foundation	1986	No	Network	
Med Centers Health Plan	St. Louis Park	Partners National Health Plans	1973	Yes	Network	Formed by merger of MedCenter Health Plan and Nicollet-Eitel Health Plan in 1983
Metropolitan Health Plan	Minneapolis	Hennepin County Bureau of Health	1983	No	Group	
More HMO Plan	Virginia		1973	Yes	Group	Declared insolvent in 1987
NWNL Health Network	St. Paul	Northwestern Nat'l Life Ins. Co.	1984	No	Network	Formerly Senior Health Plan; acquired by NWNL in 1987
Physicians Health Plan	Minnetonka	United Health Care, Inc.	1975	Yes*	IPA	Includes Physicians Health Plan, LTD., NFQ HMO
Share Health Plan	Bloomington	United Health Care, Inc.	1973	Yes	Network	

* Also operates a non-federally qualified (NFQ) HMO
** InterStudy classified Group Health, Inc., as a network model, although it is primarily a staff model that contracts with a few group practices.

HMO MODELS (as used by InterStudy)

STAFF: HMO that delivers services through a physician group controlled by the HMO unit.
GROUP: HMO that contracts with one independent group practice to provide services.
NETWORK: HMO that contracts with two or more independent group practices to provide services.
IPA: HMO that contracts directly with physicians or associations of physicians in independent practices.

Until the early 1970s, Group Health, Inc. was the only major HMO in the state; HMO enrollment in 1973 was 74,167. In the early 1970s, several new prepaid plans began including one sponsored by the St. Louis Park Medical Center, a respected, multi-specialty group practice.

Minnesota law permits only nonprofit HMOs.

In 1973, the Legislature considered two HMO bills. One would permit only nonprofit HMOs, while the other would permit for-profit operations, closely regulated by the state. The compromise result was Minnesota's 1973 HMO Act which permitted only nonprofit HMOs, but imposed regulation aimed largely at perceived abuses of for-profit operations.[3] The Legislature appropriated $250,000 for grants to organizations wishing to plan and develop new HMOs in the state. Enrollment grew to 164,893 in 1976.

As shown in Figure 2.1, there has been some consolidation in the market in the past few years. For example, two small HMOs, First Plan in Two Harbors and Coordinated Health Care in St. Paul, have affiliated with Blue Cross/Blue Shield of Minnesota. Blue Cross/Blue Shield controls 51 percent of the voting power of the board and names the executive director of each HMO. Physicians Health Plan and Share Health Plan are now operated by the same parent company, United Health Care of Minnetonka.

Table 2.1 traces enrollment in Minnesota HMOs since 1977, a period of substantial growth. In 1987, total HMO enrollment in Minnesota exceeded 1.1 million. Most of the recent growth has come in two areas: combination plans and HMO Medicare plans. In June 1987, about 290,000 Minnesotans were enrolled in combination plans, including more than half of PHP's enrollees.

Since the early 1980s, the federal government has sought to use prepaid plans to control the growth of Medicare costs. As shown in Figure 2.2, Minnesota HMOs responded enthusiastically, and their HMO Medicare enrollment grew to 161,000 enrollees in 1986, or 14.2 percent of HMO enrollment in Minnesota. In November 1987, however, four HMOs announced that they would end their Medicare risk contracts in certain rural counties affecting 26,000 persons.

Table 2.2 reviews the financial performance of HMOs between 1984 and 1986. Revenues increased by 64 percent in that time. However, expenses increased even faster; HMOs reported a surplus of $18 million in 1984, but a loss of $4.5 million in 1986.

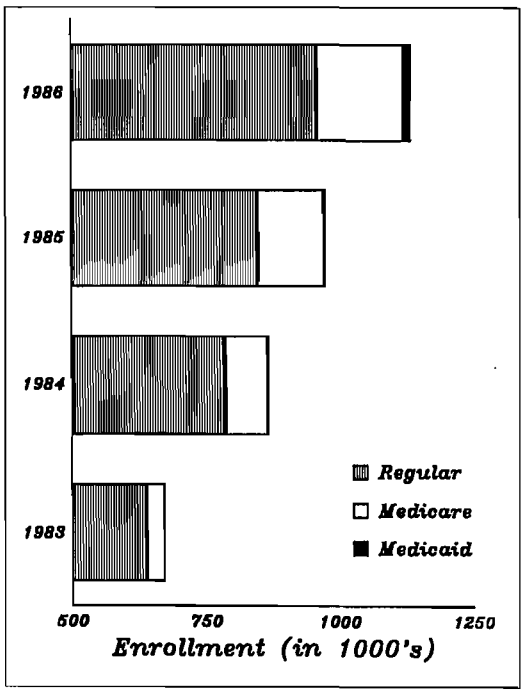


Figure 2.2: HMO Enrollment By Program 1983-86

3 *Minn. Laws* 1973, Chap. 670.

TABLE 2.1

ENROLLMENT IN MINNESOTA HMOs
1977 - 1987

	ENROLLMENT										
	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	June 1987[a]
Central Minn Group Health Plan	0	0	647	2,359	4,356	5,970	7,473	8,881	9,198	9,352	10,379
Coordinated Health Care	3,985	4,025	4,459	4,922	5,243	6,465	10,830	19,080	19,533	20,344	20,847
First Plan	1,870	1,752	1,642	1,617	1,660	1,697	1,950	2,404	2,582	3,471	3,884
Group Health, Inc.	107,517	121,184	130,810	153,869	181,328	195,011	199,919	215,553	212,145	205,848	210,000
Health Partners	0	0	0	0	0	0	0	0	0	2,020	3,600
HMO Minnesota	6,545	18,581	38,015	66,915	63,333	51,733	65,076	69,465	69,773	66,577	66,680
Mayo Health Plan	0	0	0	0	0	0	0	0	0	284	2,794
MedCenters Health Plan[b]	37,288	55,191	76,235	91,600	119,774	138,458	163,393	188,136	212,669	256,500	271,923
Metropolitan Health Plan	0	0	0	0	0	0	0	736	793	2,343	3,500
More HMO Plan	24,185	9,608	9,298	10,574	12,148	11,256	10,208	11,452	10,421	10,251	0
NWNL Health Network	0	0	0	0	0	0	0	418	5,729	11,582	8,991
Physicians Health Plan	14,227	26,422	45,240	86,073	97,961	102,876	133,149	215,484	305,569	391,220	392,079
Share Health Plan	17,121	21,862	27,449	33,898	43,311	57,091	80,013	115,508	131,107	156,564	173,500
TOTAL	212,738	258,625	333,795	451,827	529,114	570,557	672,011	847,117	979,519	1,136,356	1,168,177
Increase From Previous Year	31.6%	21.6%	29.1%	35.4%	17.1%	7.8%	17.8%	26.1%	15.6%	16.0%	2.8%

Sources: InterStudy, The InterStudy Edge, Summer 1987; Minnesota Department of Health.

[a]Includes enrollment in combination plans, reported by InterStudy as follows:

Group Health, Inc.	28,000
HMO Minnesota	11,737
Medcenters Health Plan	13,476
NWNL Health Network	1,795
Physicians Health Plan	234,507
TOTAL	289,515

[b]Includes combined enrollment for MedCenter and Nicollet-Eitel plans, 1977-1983.

HMO	SURPLUS/(LOSS) 1984	1985	1986
Central Minn Group Health Plan	$132,536	$ 222,826	($126,886)
Coordinated Health Care	(57,546)	(721,565)	97,141
First Plan	117,496	20,332	84,083
Group Health, Inc	7,773,611	2,830,949	1,566,019
Health Partners[a]	(92,400)	(192,436)	(304,154)
HMO Minnesota	(1,200,379)	(594,782)	(1,839,573)
Mayo Health Plan	0	0	13,188
Med Centers Health Plan	1,869,490	155,158	(1,622,618)
Metropolitan Health Plan	(50,624)	813,586	112,404
More HMO Plan[a]	(502,503)	(795,137)	(782,143)
NWNL Health Network[b]	0	(195,121)	(283,285)
Physicians Health Plan	6,585,000	1,246,000	154,000
Share Health Plan	3,432,000	1,675,000	(1,542,000)
TOTAL SURPLUS (Loss)	$17,966,681	$4,464,810	($4,473,824)
TOTAL REVENUES	$578,884,064	$759,285,291	$949,328,720

Source: Program Evaluation Division analysis of 1986 HMO annual reports.

[a]Declared insolvent in 1987.
[b]Based on old Senior Health Plan which was acquired by Northwestern National Life Insurance Company in 1987.

Table 2.2: Revenues and Surplus of Minnesota HMOs 1984-86

Although the final results will not be known until annual reports are filed in April 1988, it appears that the HMOs' financial experience in 1987 will be similar to that in 1986. Enrollment in the first half of the year increased by only 2.8 percent, compared to 16 percent gains in the previous two years. Two small plans, More HMO Plan in Virginia and Health Partners, were declared insolvent.

Other Managed Care Plans

Blue Cross/ Blue Shield is the largest health plan operator in Minnesota.

Blue Cross/Blue Shield of Minnesota, the largest health plan operator in the state, opened its own HMO (now called HMO Minnesota) in 1974. Its health plans have evolved since that time, so that its popular Aware plans, introduced in 1984, are similar in many ways to HMO plans. As shown in Figure 2.3, 915,000 people are enrolled in Blue Cross/Blue Shield plans, not including HMOs.

Three major preferred provider arrangements (PPOs) which contract with both insurers and self-insuring employers have emerged in the Twin Cities area. Two PPOs, Preferred One and Select Care, are sponsored by hospital organizations, while the third, Family Health Plan, is investor-owned. As shown in Figure 2.4, an estimated 200,000 individuals are eligible to participate in plans offered with those three PPOs.

Enrollment in self-insured plans has grown in recent years.

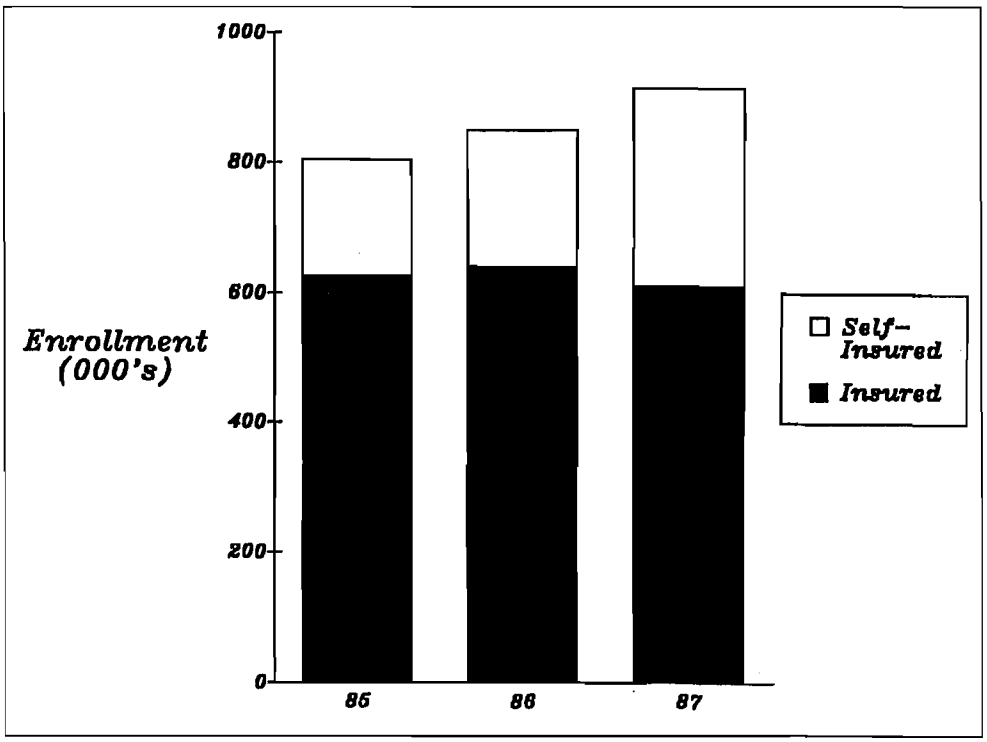


Figure 2.3: Enrollment in Blue Cross/Blue Shield Plans

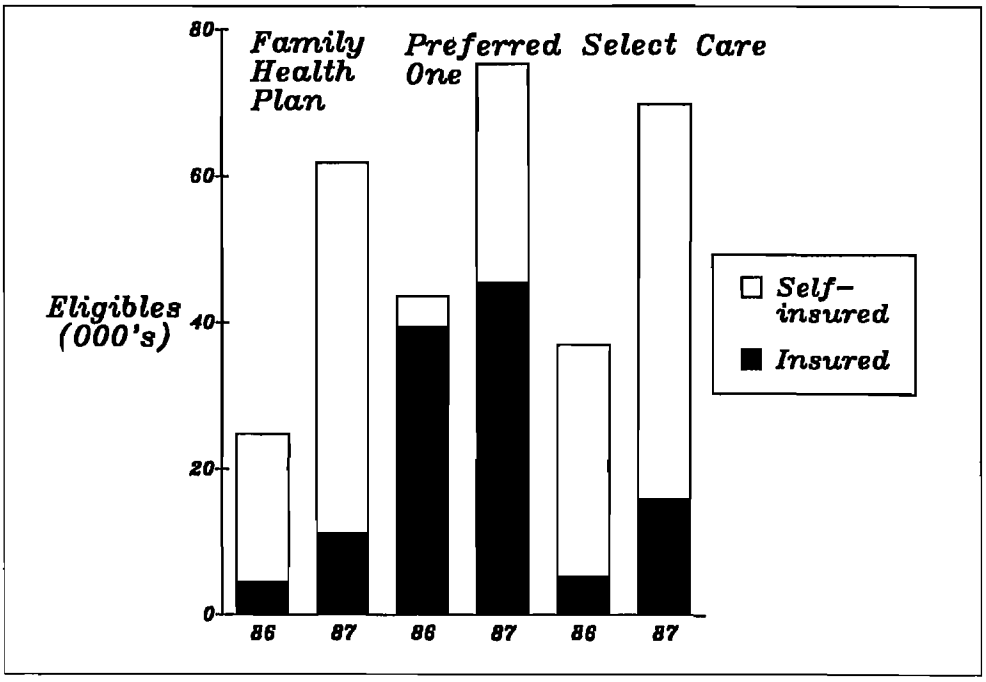


Figure 2.4: Eligibles in Twin Cities PPOs

Other PPOs which deal exclusively with self-insured employers have been developed. These include Employer Provider Network, a for-profit subsidiary of Blue Cross/Blue Shield, and Physicians Health Choice, a subsidiary of Physicians of Minnesota.

WHAT HEALTH PLANS DO MINNESOTA EMPLOYERS OFFER?

For many people, health benefits are employer-provided. One recent study estimated that more than 60 percent of Minnesotans over age 16 have health coverage through their own employment or as a dependent of an employed person. The study also estimated that about 26 percent have coverage under government programs, and 24 percent have other coverage. [4]

We asked:

- **How many Minnesotans have health benefits available through their employer?**
- **Do employees have choices among different types of plans?**
- **Does the size of the firm they work for affect the health benefits available to employees?**

We surveyed a random sample of 988 Minnesota employers to find out whether they offer health benefits to their employees and, if so, what kinds of health plans they offer. We received usable responses from 435 employers, for a response rate of 44 percent.

Most Minnesota firms offer at least one health benefit plan.

We weighted the responses to our survey to make them representative of all Minnesota firms. [5] We used the weighted responses to estimate the number of Minnesota employees who are enrolled in each type of employment-related health plan, or who are not enrolled in any plan. We grouped the responses into three categories: those from small firms (less than 50 employees), medium firms (50 to 499 employees), and large firms (500 or more employees).

Table 2.3 shows the number of health plans offered by Minnesota firms. As the table shows, most firms offer at least one plan, and many offer a choice among two or more plans. The majority of large firms offer three or more plans to their employees.

---

4 ICF Incorporated, *Analysis of Health Insurance Coverage and Health Care Utilization and Expenditures in Minnesota for 1985* (1984). These percentages total more than 100 because of double counting. For example, a person covered by Medicare who purchases a supplemental policy would be counted in both the "government" and "other" categories.

5 See Appendix A for a description of the data base, response rates, weighting techniques, and limitations in interpreting data.

	Small Firms	Medium Firms	Large Firms	All Firms
PERCENT OF FIRMS OFFERING:				
At least one plan	59.9%	98.5%	100.0%	62.5%
Two or more plans	2.9	30.7	78.4	4.9
Three or more plans	1.1	6.9	57.9	1.6

Table 2.3: Number of Health Plans Offered by Minnesota Employers

About 71 percent of Minnesota employees are enrolled in an employment-related health plan.

Figure 2.5 shows the percentage of employees of small, medium, and large firms enrolled in each type of plan, and the percentage of all Minnesota employees enrolled in each type of health plan. As the figure shows, the percentage of employees with health coverage grows as firm size increases.

- **We estimate that 29 percent of Minnesota workers are not enrolled in a health plan related to their own employment.**

However, many probably do have health coverage through the employment of a family member. The ICF Incorporated study estimated that about eight percent of adult Minnesotans had no health coverage in 1985.

We found:

- **Of all Minnesotans enrolled in an employment-related health plan, the largest group, almost 25 percent, are in self-insured plans.**

This group is discussed in greater detail in Chapter 5 of this report.

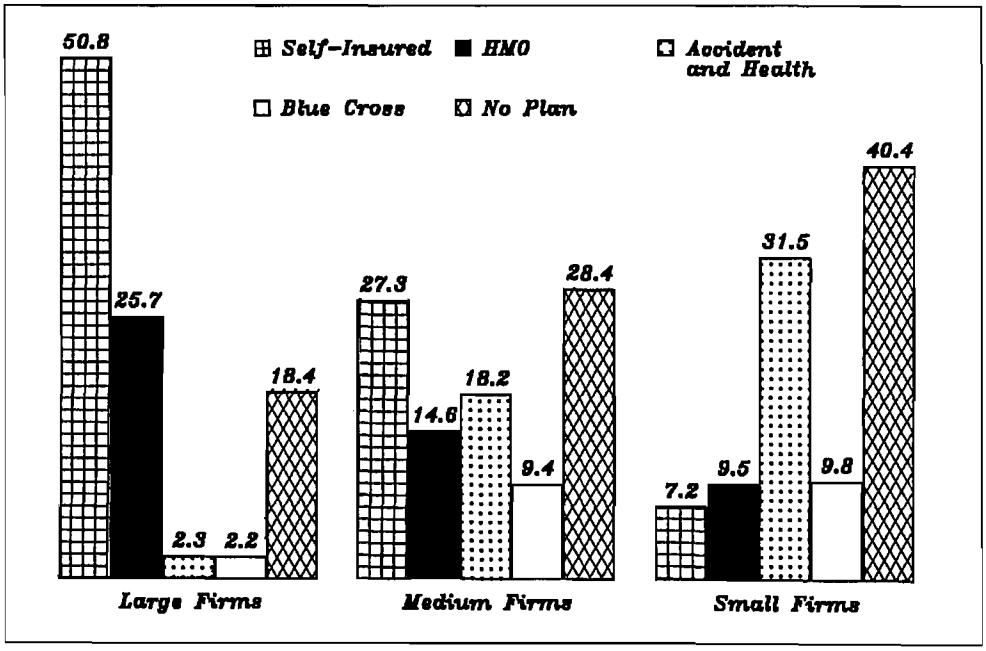


Figure 2.5: Percentage of Employees in Each Type of Health Plan

As Figure 2.5 shows, the type of health benefit plan employees enroll in varies by the size of their employer. Most employees of small firms who have any health benefits are enrolled in a traditional accident and health plan. Over half of the small firms that offer health benefits to their employees offer only this type of plan. Just under 10 percent of employees of small firms are enrolled in HMOs, and about the same number are enrolled in Blue Cross/Blue Shield plans.

Accident and health plans also enroll more employees of medium firms than any other type of plan except self-insured plans. About 18 percent of employees of medium firms are enrolled in accident and health plans, 15 percent in HMOs, and 9 percent in Blue Cross/Blue Shield plans.

Other than those in self-insured plans, the largest group of employees of large firms, 26 percent, are enrolled in HMOs. Together, Blue Cross and accident and health plans have less than 5 percent of employees of large firms enrolled. Note that while virtually all large employers offer health plans, about 18 percent of employees of large firms are not covered by those plans. They may be part-time employees who are not eligible for benefits.

REGULATION OF HEALTH PLANS IN MINNESOTA

Chapter 3

A market economy is based on the premise that vigorous competition among firms will result in the greatest benefit for the largest number of people. In such an economy, government's role is limited and generally focused on protecting consumers from abuses that might result from competition that is either excessive or inadequate.

Health care regulation is designed to protect consumers from the effects of too much or too little competition.

The health care market in Minnesota is regulated in order to protect consumers from two kinds of potential harm. First, excessive competition may lead firms to set prices for health plans too low, leading to health plan insolvency and the inability of the firms to fulfill their contracts with consumers and providers. Second, in an effort to be competitive, firms may intervene too much in the provider-patient relationship, attempting to save money by providing less service.

On the other hand, regulation carries with it dangers of its own. If regulation is too tight it stifles competition, inhibits new firms from entering the market, and results in services being offered that are not what consumers really want. Regulation may cost money if firms must spend resources to meet regulatory requirements, or to evade regulation, when they could use the resources to provide more or better service to consumers. And regulation may be harmful if it is applied unevenly to different firms in the same industry, favoring some and inhibiting others. This, too, results in decreased competition, so that consumers cannot find the products they really want in the marketplace.

RESEARCH QUESTIONS

Minnesota, like other states, has established a regulatory scheme for health plans that treats health service plans, accident and health insurance, and HMOs as distinctly different from one another. We examined this regulatory framework for health plans and asked:

- **How does Minnesota regulate different types of health plans? Does state regulation impair competition?**
- **What has been the impact of the requirement that HMOs be nonprofit organizations? Should this requirement be continued?**

OVERVIEW OF REGULATION IN MINNESOTA

As shown in Figure 3.1, health plans in Minnesota can be divided into three categories: plans regulated by the Department of Commerce, plans regulated by the Department of Health, and plans not regulated by state agencies.

The Department of Commerce regulates accident and health insurance and health service plans.

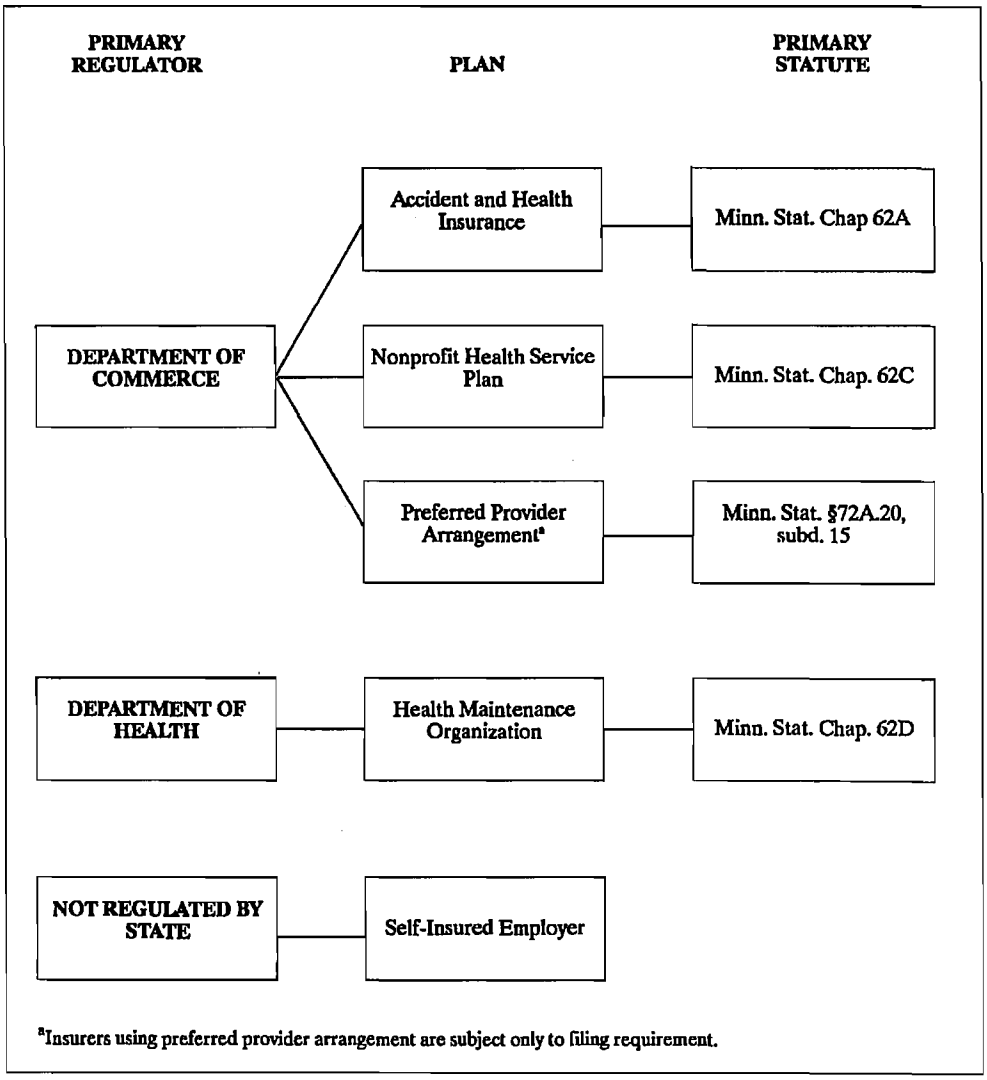


Figure 3.1: Who Regulates Health Benefit Plans?

Department of Commerce

Until the Legislature passed the HMO Act in 1973, the Department of Commerce was the sole state agency regulating health plans.[1] The department

1 The present-day Department of Commerce was created in 1983 by a reorganization of state offices which regulated insurance, banking, real estate, and securities.

regulates the two "traditional" types of plans: accident and health insurance and health service plans. It reviews certificates of coverage, regulates solvency, and investigates complaints. Blue Cross/Blue Shield of Minnesota operates a nonprofit health service plan, and has a special status because it is organized and regulated under Minn. Stat. Chap. 62C. To our knowledge, Delta Dental, Inc., is the only other plan actively operating under Chapter 62C.

Although preferred provider arrangements are not directly regulated in Minnesota, state law allows the operation of PPOs and requires that insurers using PPOs file information about those arrangements with the Department of Commerce.[2] There are no administrative rules for preferred provider arrangements. Preferred provider arrangements which deal only with self-insuring employers are not regulated by the state, although the plan administrators may be subject to licensure by the Department of Commerce.

Department of Health

Health Maintenance Organizations are regulated by the Department of Health.

In the 1973 Health Maintenance Organization Act, the Legislature designated the Department of Health as the state's regulator of HMOs. The department reviews applications by new HMOs, approves contracts with providers and enrollees, receives complaints from consumers, and monitors the solvency of HMOs.

Minnesota is one of nine states in which the state insurance department is *not* the primary regulator of HMOs.[3] Observers of the debates in 1973 suggest two reasons why the Legislature chose the Department of Health instead of the Department of Commerce. First, the Legislature saw HMOs as something new and experimental, and wanted to create a looser set of regulations to allow HMOs to grow. Other features of the 1973 law also gave HMOs a preferred status to help facilitate their development. Second, the Legislature thought that HMO regulation should include monitoring of medical care, something the Department of Commerce did not perform in regulating health service plans and accident and health insurance.

Plans not Regulated by State Agencies

In general, self-insured plans are not regulated by state agencies. The federal Employee Retirement Income Security Act of 1974 (ERISA) establishes

2 *Minn. Laws* 1983, Chap. 285; *Minn. Stat.* §72A.20, subd. 15.

3 Aspen Systems Corporation, *A Report to the Governor on State Regulation of Health Maintenance Organizations* (1987). The other states are: California (where HMOs are regulated by the Department of Corporations), Delaware, Michigan, New Jersey, New York, Oklahoma, Pennsylvania, and South Carolina. In most of those states, the state insurance department shares responsibility for HMO regulation.

federal regulation over employee benefit plans and generally preempts regulation by states.[4]

However, ERISA explicitly excludes from the preemption provision "any law of any state which regulates insurance, banking or securities."[5] This is the so-called "saving clause," which preserves the state role in regulating insurance and is widely cited by states seeking to regulate benefit plans. The saving clause is narrowed by an ERISA provision which provides that no employee benefit plan shall be "deemed" by a state to be an insurance company in order to bring that plan under state regulation. In Chapter 5, we discuss attempts by states to test the limits of the ERISA preemption of state regulation of self-insured plans.

SIMILARITIES AMONG HEALTH PLANS

Different health plans have become similar to each other in several important ways.

Despite the regulatory framework that distinguishes among various health plans, we found that, in practice, the difference among plans is blurred. In fact, different types of plans now have important similarities. They tend to (1) offer the same menu of benefits, (2) use similar cost containment measures, and (3) shift some financial risk to providers.

Benefits

As shown in Figure 3.2, the benefits of different plans can look very similar to the consumer and provider. The three plans shown all provide comprehensive, first-dollar coverage, with little paperwork required of the consumer. Each of the plans shown in the figure provides total coverage for services from the plan's own panel of doctors and also provides indemnity coverage for many services received from other providers. Each plan has its own fee schedule, and PHP and Blue Cross/Blue Shield usually withhold a percentage of the fee on a contingency basis.

Cost Containment Mechanisms

Besides similarities in the benefits they provide, health plans in Minnesota increasingly use similar methods to contain costs. As part of our survey of employers, we asked if their health plans included or required any of the following cost containment features: authorization before entering the hospital, a second opinion before surgery, and coverage of outpatient surgery. We were particularly interested in the results for the health service plans and accident and health insurers.

---

4 Section 1144(a) of ERISA provides: "The provisions of this subchapter shall supercede any and all State law insofar as they may now or hereafter relate to any employee benefit plan described in Section 1003(a)."

5 §1144 (b)(2)(B).

Characteristics	Physicians Health Plan[a]	Blue Cross & Blue Shield	Mutually Preferred[a]
Type	Health Maintenance Organization Combination Plan	Health Service Plan	Accident & Health Preferred Provider
Basic, Regulating Statute	Minn. Stat. Chap. 62D	Minn. Stat. Chap. 62C	Minn. Stat. Chap. 62A
Physician Services From Participating Provider	Paid in full	Paid in full	Paid in full
Physician Services Outside Network	80% of eligible expense, after member's annual deductible has been satisfied	80% of allowed amount, after member's annual deductible has been satisfied	80% of allowed amount, after member's annual deductible has been satisfied
Preventive Care From Participating Provider	Paid in full	Paid in full	Paid in full
Physician Payment	Fee schedule	Fee schedule	Fee schedule
Paperwork for Patient	None when using participating provider	None when using participating provider	None when using participating provider

[a]Plan design options allow employer to select a different level of coverage.

Figure 3.2: Comparison of Health Plans

As shown in Table 3.1,

A large percentage of employees are enrolled in health plans that use cost-control techniques.

- **Accident and health plans, health service plans, and self-funded plans have adopted many of the cost containment mechanisms used by HMOs.**

	Health Service Plan	Self Insured	Accident & Health
Pre-hospitalization authorization	69.0%	64.8%	57.7%
Second surgical opinion	63.1	60.3	67.5
Outpatient surgery	76.5	72.7	76.2

Table 3.1: Percent of Employees Enrolled in Health Plans Using Cost-Control Techniques

For example, employers reported that, of their employees who are enrolled in accident and health plans, 57.7 percent are enrolled in plans that require or include pre-hospitalization authorization. Sixty-eight percent are in plans that include or require second surgical opinion,and 76.2 percent are in plans that include or require outpatient surgery. An even larger proportion of employers with self-insured plans reported using those cost containment

tools. It appears that larger employers in particular are offering plans with these features.[6]

This is an important trend because accident and health insurers and health service plans traditionally respected the provider's autonomy. Now, they use cost containment measures to intervene in the provider-patient relationship. As a result, both the provider and the patient may face some reduction in reimbursement for not complying. For example, a health plan requiring advance authorization for hospitalization may impose a penalty on the patient who does not comply. The penalty may be an additional amount for the patient to pay or a reduction in benefits (e.g., the insurer might only pay 60 percent instead of 80 percent of the cost) with the same result. Similarly, plans may retrospectively review the need for hospital stays and may decline to pay the provider for days or procedures found to be medically unnecessary. Blue Cross/Blue Shield and preferred provider arrangement contracts require the providers to absorb that cost and not bill the patient.

Risk Sharing

Health plans share financial risks with providers.

A third important similarity among plans is that they share financial risk with providers and employers. Risk sharing includes a wide spectrum of business arrangements. At one end, a plan's contract with physicians may allow the plan to withhold a percentage of the payment due the physician until the end of the year. Whether all or part of it is returned depends on the profitability of the plan and, in some cases, a measure of the efficiency of that individual provider. Thus, contracts for Blue Cross/Blue Shield's Aware plans provide for withholding ten percent of physicians' fees. With certain providers, Blue Cross/Blue Shield withholds 30 percent of their fee which is returned if the provider meets certain utilization criteria. Among HMOs, Physicians Health Plan typically withholds 20 to 30 percent from physicians' fees.

A second form of this is used by Blue Cross/Blue Shield in some of its hospital contracts where the reimbursement is linked to several factors: past experience of Twin City hospitals, the category of care, and a projected length of stay. The hospital shares the risk that stays will be longer than predicted or that costs will be higher than average. Preferred provider arrangements may also contract with hospitals to pay on the basis of a per diem formula or an amount for each admission.

A more drastic form of risk sharing is for the payor to provide a capitated payment to a primary physician for all services provided by the physician. This may extend to putting the physician or clinic at risk for referrals to specialists and for hospital charges. This practice is used most often with group or network model HMOs. In Minnesota, individual practice association (IPA) models, such as Physicians Health Plan, typically do not use capitation contracts with primary care physicians. Instead, they reimburse physicians on a discounted fee-for-service basis. The Department of Health has asserted that capitation is a form of provider risk-sharing which may not be used by accident and health insurers.

---

6 A recent report from the Department of Commerce showed a similar trend, based on the results of a survey of insurers. *Commercial Health Insurance: Responses to a Rapidly Changing Market* (October 1985).

Finally, providers shoulder risk by agreeing to forego certain rights. For example, providers who contract with an HMO share risk because they agree to look only to the HMO for reimbursement. Under Minnesota law, if the HMO becomes insolvent, the provider cannot bill the patient for unreimbursed expenses. As we discuss in Chapter 4, this can be a significant risk to providers.

"LEVEL PLAYING FIELD" ISSUES: COMPARISON OF PLAN REGULATION

We compared five types of health plans: HMOs, accident and health insurance, health service plans, insured preferred provider arrangements, and self-insured plans, with or without preferred provider arrangements.[7] We reviewed state administrative rules and law, and applicable federal law. We compared the plans on these key issues:

- **Mandated benefits and providers.**
- **Ability to limit providers and enrollees.**
- **Financial requirements.**
- **Treatment for taxation purposes and the Minnesota Comprehensive Health Association, the state risk pool for uninsurable people.**
- **Quality assurance.**

In a separate section below, we discuss Minnesota's requirement that HMOs must be nonprofit organizations.

The Department of Health has focused attention on the need to review health plan regulation.

The Department of Health has carefully studied these changes in the health care market place and the appropriateness of state regulation. In 1987, the department proposed establishment of a Governor's Commission on Health Plan Regulatory Reform to study these issues. The commission held its first meeting in January 1988 and is required to complete its work by January 1, 1989.
As will be clear below,

- **Despite their similarities, different types of plans are regulated differently. Furthermore,**
- **Self-insured plans have by far the most flexibility in design and administration, since they are exempt from state regulation.**

7 We did not analyze some other types of health plans, such as those offered by fraternal benefit societies and those offered by a few self-insurance pools which are subject to some state regulation.

In Chapter 5, we discuss the extent to which Minnesota employers are self-insuring and what role the state might have in regulating those plans.

Mandated Benefits and Providers

State law mandates that health plans provide a certain level of benefits as well as guarantee certain rights. Mandates can be grouped into four categories. Some mandates require that health plans provide certain *treatments*. For example, the Legislature in 1987 mandated that coverage of treatment of temporomandibular joint disorder (TMJ) be provided in any health service plan, accident and health insurance policy, or HMO plan.[8] A second category guarantees access to certain types of *providers*, such as chiropractors. The third group mandates that eligibility for *dependent coverage* include certain categories of dependents, such as handicapped children, even if they are past the limiting age for dependent coverage. Finally, state law mandates certain rights for *continuation of coverage* or conversion of group coverage to an individual plan.

There is no clear scheme for Minnesota's system of mandated benefits. We noted that statutes and rules mandating benefits have proliferated in recent years and are very difficult to track. Advocates of state mandated benefits argue that they are necessary for the state to ensure a decent level of coverage, and that mandating benefits is the only way that certain benefits, such as mental health care, will be widely available and affordable. They also argue that mandated benefits may save costs, because treatment from non-physician providers may be less expensive.

Mandated benefits ensure a certain level of coverage, but they may also increase costs of health care.

Opponents of mandated benefits argue that state mandates result in increased utilization and cost, since providers give care based on what is covered, not necessarily based on what is medically required. Furthermore, by raising the cost of insurance, mandates may discourage employers from offering health benefits, thus limiting access to health care.

Self-insured plans can devise their own benefit schemes, without regard to state mandates.[9] Figure 3.3 compares benefits mandated under accident and health insurance, HMOs, and health service plans. As shown in the figure, state law outlines a comprehensive set of benefits that must be included in "qualifying" plans. However, health service plans and accident and health insurers may replace these benefits with others that are shown to be actuarially equivalent.

Under federal and state law,

- HMOs are required to provide "comprehensive health maintenance services," without the option of substituting benefits that are actuarially equivalent.

8 *Minn. Laws* 1987, Chap. 337, sec. 46.

9 In Chapter 5, we report on the extent to which self-insuring employers are providing certain state mandated benefits.

Benefit	Plan Type: Accident & Health	HMO	Health Service Plan
Access to Providers:			
Chiropractor	X		X
Dentist, Podiatrist	X		X
Government Institutions	X	X	X
Government Operated Facilities	X		X
Registered Nurse	X		X
Optometrist	X		X
Osteopath, Optometrist, Chiropractor, Registered Nurse	X		X
Outpatient Surgical	X		X
Treatments:			
Chemical Dependency - Inpatient	X	X	X
Chemical Dependency - Outpatient	X		X
DES	X	X	X
Mental Health - Inpatient		X	
Mental Health - Outpatient	X	X	X
TMJ	X	X	X
Phenylketonuria (PKU)	X	X	X
Reconstructive Surgery	X	X	X
Scalp Prostheses	X	X	X
Eligible for Coverage:			
Adopted Children	X	X	X
Emotionally Handicapped Children	X	X	X
Handicapped Adult Children	X	X	X
Unmarried Minor Dependents (Maternity Care)	X	X	X
Newborn Infants	X	X	X
Continuation/Conversion Rights:			
Former Spouses, Children	X	X	X
After Layoff	X	X	X
After Disability	X	X	X
For Survivors	X	X	X
After Change in Insurer	X	X	X

Minn. Stat. §62E.06 establishes minimum benefits for a qualified health plan offered by an employer. These benefits may be subject to limitations, and to copayments and deductibles. Health service plans and accident and health insurers may (and frequently do) replace these benefits with others that are shown to be "actuarially equivalent." The statute establishes three levels of qualifying plans, which are distinguished by their limit on out-of-pocket costs. An HMO plan is deemed to be a qualified plan.

Anesthetics
Convalescent Nursing Home
Up To 120 Days
Diagnostic X-Ray, Lab Test
Durable Medical Equipment
Home Health Care
Hospital Services
Occupational Therapy
Oral Surgery
Oxygen
Physical Therapy
PKU
Prescription Drugs
Professional Diagnosis Treatment
Prostheses
Radium, Other Radioactive
Scalp Prostheses
Second Surgical Opinion
Transportation
Well Baby Care

Figure 3.3: Mandated Benefits Under State Law

Comprehensive health maintenance services include emergency care, inpatient physician and hospital care, outpatient preventive, diagnostic and therapeutic services, and preventive health services. HMOs must provide "medically necessary" services and may not establish dollar limits within the contract or for the lifetime of the enrollee, a cost containment tool that is often part of other plans.

Amendments in 1984 and 1987 have largely put HMOs under the same benefit requirements as health service plans and accident and health insurance, but with some important exceptions. For example, HMOs have added flexibility to limit chemical dependency treatment and to decide when structured mental health treatment is needed. On the other hand, only HMOs have an explicit requirement to provide inpatient mental health treatment.

State law also mandates that enrollees in health and accident insurance and health service plans have access to "healing arts" providers who are not physicians. Those plans must cover services by chiropractors, optometrists, and registered nurses, within the scope of their licensure. Although HMOs must provide medically necessary services,

- **HMOs have more flexibility than other plans to limit access to providers.**

They do this in two ways. First, they are not required to guarantee access to nonphysician providers, such as chiropractors. Second, HMOs may limit referrals to specialists. Preferred provider organizations and HMO combination plans offer a limited panel of providers, but provide indemnity coverage to providers outside their panel.

Access to nonphysician providers is cited by Blue Cross/Blue Shield, in particular, as a major competitive disadvantage for it. The problem is called adverse selection, meaning that, in general, insurance will be bought by people who expect to use it. Where consumers can choose among different plans, they are likely to choose the plan that allows them access to services or providers that they expect to use. Under this theory, a person wanting chiropractic care will consider which available plan offers the best chiropractic benefit and will select on that basis. That person will then use a higher than average amount of services. When many individuals use a higher than expected amount of services, claims may exceed the plan's revenues.

Freedom to limit providers and enrollees is important to any managed care plan.

Ability to Limit Providers and Enrollees

A key element of any managed care system is the plan's ability to select providers who meet criteria for practice and to exclude those who do not. In Minnesota, HMOs and PPOs have significant flexibility in this regard and may choose to include or exclude providers from their plans. In contrast,

- **accident and health insurers must reimburse for services from any willing and licensed provider, and health service plans must take any provider willing to accept the plan's terms.**

A broad network of providers has both advantages and disadvantages. The plan may find that a wide network creates problems of adverse selection and makes it difficult to impose efficiencies on providers. However, a plan will use the size of its network as a selling point to consumers who like a broad choice, or who have already chosen a primary physician who is a member of the network.

Limitations on who can enroll are as important as what providers can participate. In this regard:

- **HMOs have less flexibility than other plans to exclude potential enrollees.**

HMOs generally have to provide an open enrollment period for groups, in which members of the group can enroll without being subject to health screening. In general, they can not impose underwriting restrictions on coverage of preexisting conditions. HMOs may request a waiver from the open enrollment and "no underwriting" requirements in limited situations. The other plans have no statutory obligation to provide an open enrollment period and may impose underwriting restrictions. They may offer an open enrollment period if a large employer requires it.

Federally qualified HMOs must set their premiums on the basis of community-wide experience, while other plans may underwrite based on actual claim experience or other characteristics of the group. Two federally qualified HMOs in Minnesota have set up sister HMOs that are not federally qualified to benefit from additional flexibility available under state law.

All plans, except self-insured firms, are subject to state and federal laws regarding who is considered an eligible dependent and enrollees' rights to continued coverage after leaving a job or becoming disabled. Self-insurers are subject to federal requirements only.

Financial Requirements

An important role of state regulators is to monitor the financial integrity of health plans. This is done by reviews of rates and reviews of solvency. State law sets different standards for how the finances of different types of plans are to be evaluated.

For example:

HMOs face less stringent financial requirements than other types of plans.

- **HMOs are not subject to a review of premiums, while other plans are.**

Accident and health insurers and health service plans must submit rates and rate changes to the Department of Commerce for review as part of an overall review of policies and forms. For accident and health insurance, the premium must be reasonable in relation to the benefits provided and the policy cannot be unfair or deceptive. Rates and forms for health service plans must meet those standards and must indicate that the plan had appropriate reserves for the coverage offered.

Premiums for health maintenance organization plans are not subject to state review. In recent years, HMOs have sometimes competed aggressively on price, particularly for Medicare contracts. Premiums of less than $10 per month have been charged, and one HMO even offered a period of free coverage to new enrollees. In states where HMO rates are subject to review, such low rates might have been questioned or disapproved by state regulators.

In our review of solvency requirements, we found:

- **Requirements for start-up capital and ongoing reserves are much less stringent for HMOs than for insurers and health service plans.**

Health service plans must maintain reserves in a range from 16 2/3 percent of service claims and administrative expenses incurred during the last two years to 33 1/3 percent of that sum. That requirement is sometimes expressed as maintaining between two and four months of reserves. An accident and health insurer must have an initial paid-up capital stock of $500,000 and surplus of $1 million. It must maintain a surplus of $500,000 (and often more, depending on the lines of insurance it sells) after it receives initial authority to operate.

Accident and health insurers, along with life insurance companies, are also responsible for maintaining a state guaranty fund to protect enrollees in the event of an insurer's insolvency. The guaranty fund provides additional protection to enrollees who lose their insurance coverage.

Under Minnesota law,

- **HMOs have no specific reserve requirements, and do not participate in a guaranty fund.**

They are required to deposit cash or securities in restricted accounts to be used in the event of insolvency. New HMOs must deposit $100,000. The deposit requirement for existing HMOs is calculated differently, and may be waived if the Commissioner of Health is satisfied that the HMO is financially healthy. An HMO may be exempted from the deposit requirement if it meets a standard for net worth or if it has sufficient guarantees of its ability to perform its obligations, including agreements with providers to continue care or guarantees from other organizations with sufficient net worth.

The requirements for HMOs are relatively limited for two reasons. First, providers bear some of the risk for claims since they do not have recourse to bill enrollees. Second, low reserve requirements have eased entry of HMOs into the market. In Chapter 4 of this report, we discuss the state's approach to regulating the solvency of HMOs.

Taxation and the State Risk Pool

State tax policy has an important impact on health plans, but it is usually decided in legislative tax committees, not committees concerned with health care. Under current tax law:

- **Accident and health insurers in Minnesota are disadvantaged by state tax law in two ways: they must pay a "premium tax" and they are subject to income taxes.**

Accident and health plans are at a disadvantage under state tax law.

First, they pay a state premium tax of two percent on their insured business.[10] The premium tax obviously affects an insurer's bottom line. HMOs and health service plans, as nonprofit organizations, and self-insured firms do not pay the premium tax.

In 1987 Governor Perpich proposed applying the premium tax to HMOs and health service plans, but the proposal did not pass. One argument offered in favor of extending the tax was that the current law gives HMOs and health service plans a competitive advantage over accident and health insurers. The Department of Revenue has estimated that the revenue loss from these exemptions was about $25 million in 1987.[11]

Furthermore, accident and health insurers are subject to state income tax to the extent their income tax liability exceeds their premium tax liability. HMOs, as nonprofit organizations, are exempt from state and federal income tax. Blue Cross/Blue Shield, despite its nonprofit status, became subject to federal income taxes in 1986 and to state income tax and alternative minimum tax in 1987.

The Minnesota Comprehensive Health Association was created to provide health coverage to persons who had been rejected by insurers. Eligibility has been broadened since then to include persons who are laid-off from their jobs and cannot exercise continuation rights for health insurance. The Department of Commerce contracts with Blue Cross/Blue Shield to administer the plan. The premium for the insurance is generally set at 125 percent of the market price for similar policies. When claims and expenses exceed premiums, an assessment is made against participating entities in proportion to their share of insured business in the state. In 1986, the association assessed participating insurers a total of $9.1 million.[12]

Self-insured plans do not contribute to the Minnesota Comprehensive Health Association.

Since 1987, all health plans (except self-insureds) are subject to assessments for the Minnesota Comprehensive Health Association. Prior to 1987, HMOs, health service plans, and other nonprofit plans were exempt from contributing to the association. With the addition of the nonprofit insurers and plans, the premium base used to calculate the assessments went from $577.2 million in 1985 to $1.9 billion in 1986. While requiring nonprofit plans to participate in the risk pool has removed one difference between insurers and the nonprofit plans, it has emphasized the special status of self-insured plans.

10 Many of the large insurers in the state sell a relatively small amount of accident and health insurance. Instead, most of their business is in administering self-insured plans, which is not subject to the premium tax.

11 Minnesota Department of Revenue, *Tax Expenditure Budget for the State of Minnesota, Fiscal Years 1986 - 1989* (January 1987): 155.

12 Minnesota Comprehensive Health Association, 1986 Final Assessment (October 8, 1987).

Quality Assurance

In the past, state government's responsibility for the quality of health care was limited to licensing and occasionally disciplining health providers. The rise in prepaid plans has been accompanied by a growing concern over the quality of health care.

Under state and federal law,

- **HMOs face unique requirements for developing systems of quality assurance and for maintaining mechanisms to receive and handle complaints from enrollees.**

Only HMOs are required to develop quality assurance systems.

No other plans face such requirements.[13] This requirement is traced to two concerns with HMOs. First, because HMOs are both providers and payors of health care, they would face incentives to "skimp" on medical care. Second, HMOs enrollees are limited in their access to providers outside the HMO because full coverage by HMOs takes place within the panel of providers with which it contracts. Therefore enrollees need some additional protection to ensure that their care is appropriate. If they had unrestricted access to providers, as is available through insurance plans, they could correct any problem with a provider by selecting a new provider.

Under state law, an HMO's complaint resolution system must include a provision for impartial arbitration of the complaint. As part of its annual report, each HMO must report the number of complaints received from enrollees, categorize them, and report how many were resolved to the enrollee's satisfaction.

HMO enrollees may also bring their complaints to the Department of Health. The department's authority is generally limited to determining whether the HMO has fulfilled its contractual obligations to the enrollee. Persons covered by accident and health insurance or health service plans may bring complaints to the Minnesota Department of Commerce. Persons covered by self-insured plans may bring complaints to the U.S. Department of Labor.

NONPROFIT AND FOR-PROFIT PLANS

In 1973, the Legislature restricted operation of HMOs to nonprofit organizations, hoping to save money and nurture a consumer orientation.[14] HMOs

13 Federal law now allows non-HMO entities, called "competitive medical plans (CMPs)," to contract for Medicare programs, and imposes a quality assurance requirement on those organizations.

14 Health service plans were always organized as nonprofits, in part because the providers who controlled those plans thought nonprofit status would maintain their autonomy and because it would be unseemly for state legislatures to grant virtual monopolies to for-profit plans. See Theodore Marmor, Mark Schlesinger, and Richard Smithey, "A New Look at Nonprofits: Health Care Policy in a Competitive Age," *Yale Journal on Regulation*, 3 (1986): 313-349.

also face a unique requirement that at least 40 percent of the members of their governing boards be consumers elected by enrollees.

The Decline of the For-profit/Nonprofit Distinction

Researchers describe a three-phase "life cycle" for nonprofit organizations.[15] In the first phase of the cycle, nonprofit organizations are often the initial "pioneers" in developing new services, because subsidies from philanthropic or public sources are required to pay high start-up costs. During that phase, state regulation may be relatively light, allowing wide latitude to the providers.

As the service becomes established and the potential profit becomes evident, for-profit providers enter the field, if allowed to do so. Government subsidies or policies help to increase demand for the service. During this second phase, for-profit firms serve to meet the increased demand for service beyond what nonprofits alone can provide.

In the third phase of the cycle, as competition becomes more intense, nonprofit organizations begin to act more like for-profit firms in order to ensure their survival. HMOs in Minnesota have entered the last phase of this "life cycle." As we will describe, many Minnesota HMOs, though officially nonprofit, have become like for-profit organizations.

The distinction between nonprofit and for-profit health care organizations has become less clear in recent years.

Certain images are associated with for-profit and nonprofit health organizations. For-profit health care has been associated with profit-maximizing, price-competition, decision-making by managers, and efficiency. Nonprofit medicine, on the other hand, has been associated with a care-giving ethic, provision of care regardless of ability to pay, professional autonomy, and high quality. We think that this distinction is no longer valid.[16]

Hospitals in the United States today provide a good example of how the distinction has blurred. Nonprofit hospitals have always been associated with care for the sick, no matter who is paying or how much. However, increased competition has reduced the ability of nonprofit hospitals to offer unprofitable services, such as charity care. Indeed, it is not clear that they are providing significant amounts of charity care today. A Minnesota Department of Health survey found that Minnesota hospitals gave $19 million in free care in 1984, which was about one percent of their gross revenues. Much of that was provided by two public hospitals, Hennepin County Medical Center and St. Paul-Ramsey Medical Center. Another $7 million in free care was provided by hospitals in fulfillment of their obligations under the Hill-Burton Act, a federal program which awarded grants for hospital construction.

In recent years, hospitals have formed national and local systems, which, in turn, have spun off for-profit operations. For example, Voluntary Hospitals of

15 Ibid.

16 "Policy-makers should shift their attention from an undue preoccupation with organizational form to take into account the massive changes in the character of American medicine. The rise of commercialism and the decline of the professional ethos are developments that cut across organizational forms." *Ibid.*

America, an umbrella corporation for more than 60 nonprofit hospitals, has formed numerous for-profit subsidiaries. One is Partners National Health Plans, a joint venture with Aetna Insurance Company. Partners operates health maintenance organizations, including MedCenters Health Plan in Minnesota.

State Requirements

Minnesota is the only state that limits HMO operations to non-profit organizations.[17] By comparison, federal policy has been to encourage for-profit entities to establish or invest in HMOs.

Minnesota is the only state that requires HMOs to be nonprofit entities.

Despite the nonprofit requirement,

- **Minnesota's HMOs are increasingly linked with for-profit entities.**

Figures 3.4 to 3.7 show the corporate "families" of the four companies that dominate the health plan market in Minnesota: United Health Care (including PHP and Share), Blue Cross/Blue Shield, Group Health, Inc., and MedCenters. The figures show that, in varying degrees, the operations of all these HMOs are closely related to for-profit operations. Even Group Health, Inc.,

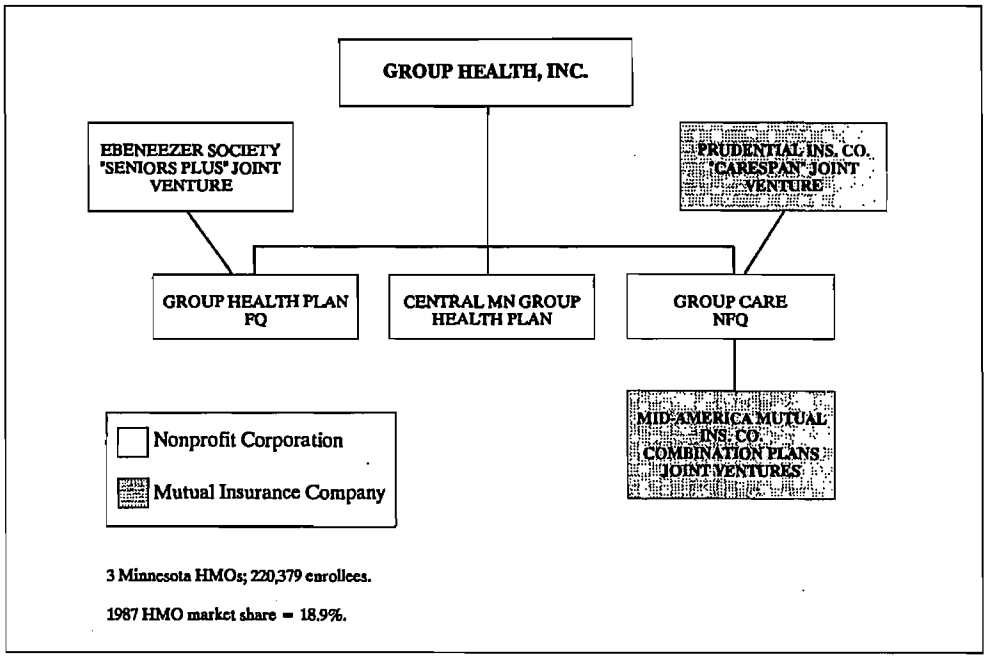


Figure 3.4: Corporate Families Group Health, Inc.

17 Minn. Stat. §62D.03, subd. 1, provides that "Any nonprofit corporation organized to do so or any local government unit may apply to the Commissioner of Health to establish and operate a health maintenance organization." Until 1984, for-profit HMOs could not organize in New York state.

which has carefully maintained its image as a consumer oriented, nonprofit organization has a joint venture with a mutual insurance company with a clear for-profit orientation.[18]

Health service plans are also required to be nonprofit in Minnesota. However, as shown in Figure 3.5, Blue Cross/Blue Shield owns three for-profit companies with operations in several states. MII, Inc., is an insurance company, and Employer Provider Network is a preferred provider arrangement for self-insuring companies. Blue Cross/Blue Shield also operates two HMOs in western Wisconsin.

Many nonprofit health care companies are linked with for-profit entities.

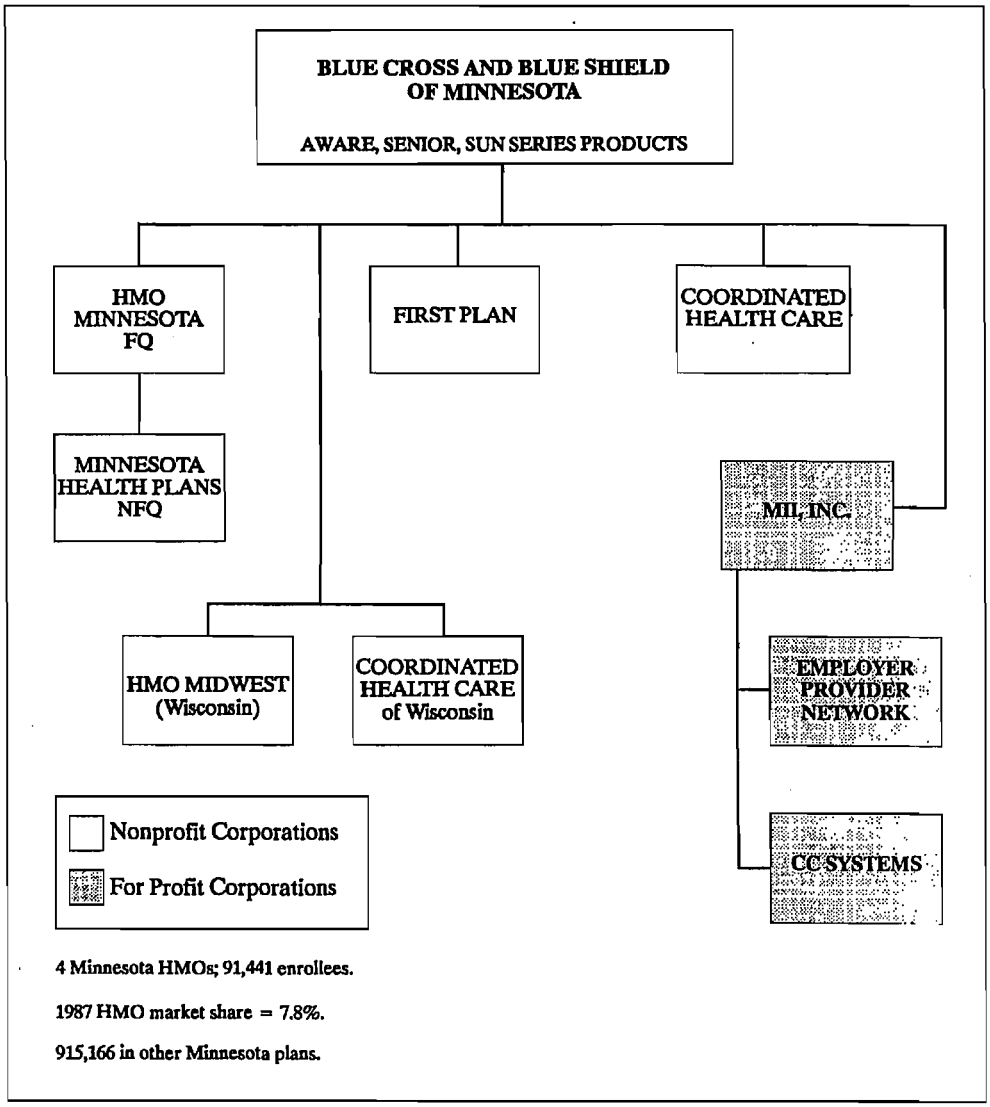


Figure 3.5: Corporate Families Blue Cross and Blue Shield of Minnesota

18 Insurance companies can organize as for-profit organizations, owned by stockholders. Some organize as *mutual companies*, in which the policyholders are the owners and where surpluses can be distributed to policyholders.

Three Minnesota HMOs are associated with large national HMO firms. United Health Care (Figure 3.6) is the parent company of two large Minnesota HMOs: Physicians Health Plan and Share Health Plan. It was created by executives at PHP in 1977. PHP is United Health Care's "flagship" operation, accounting for nearly 30 percent of its total national enrollment. Charter Med, the management company for Physicians Health Plan, is a wholly owned subsidiary of United Health Care. In 1985, United Health Care acquired Share Development Corporation, the management company for Share Health Plan and HMOs in several other states.

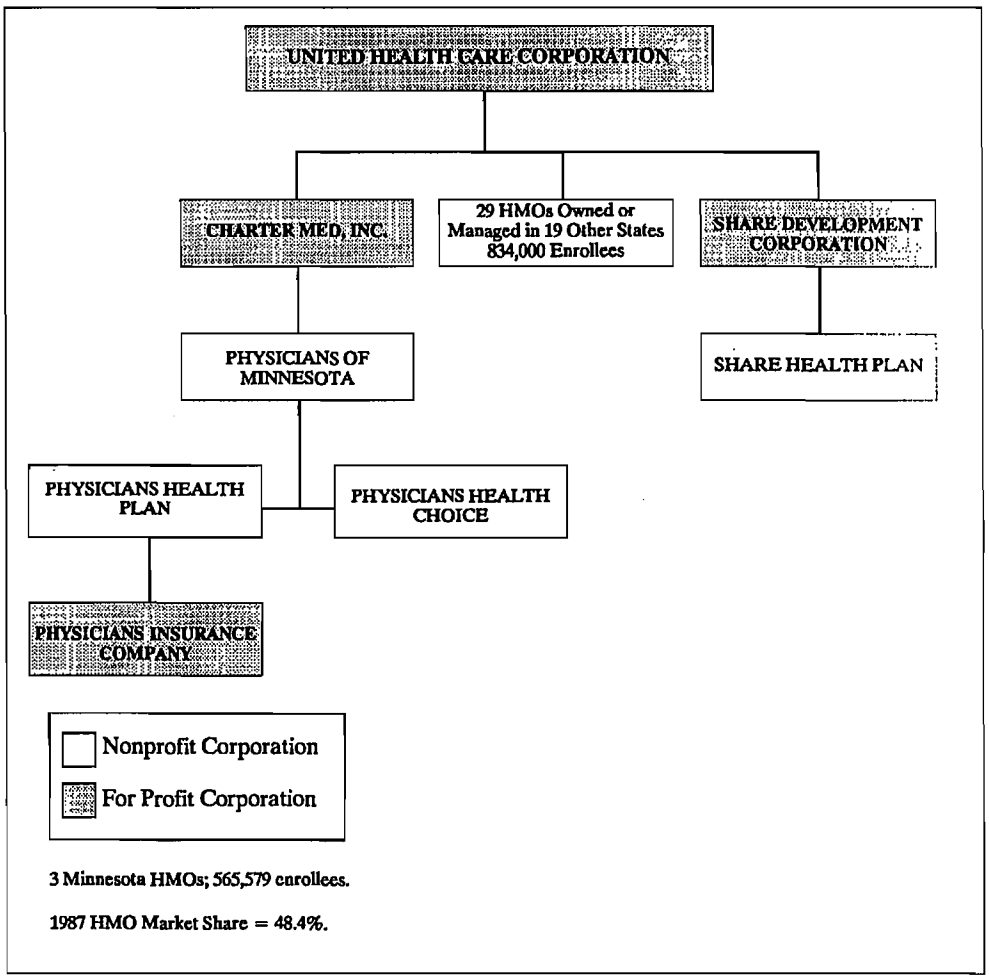


Figure 3.6: Corporate Families
United Health Care

MedCenters Health Plan is the largest HMO operated by Partners National Health Plan, a joint venture of the Aetna Insurance Company and Voluntary Hospitals of America (Figure 3.7). Partners acquired American MedCenters, which also operates an HMO in North Dakota, in 1986. Partners is heavily involved in preferred provider arrangements through Aetna. The Park-Nicollet Medical Centers are the primary provider for MedCenters Health Plan, and the medical center has the power to name a majority of the HMO's board of directors.

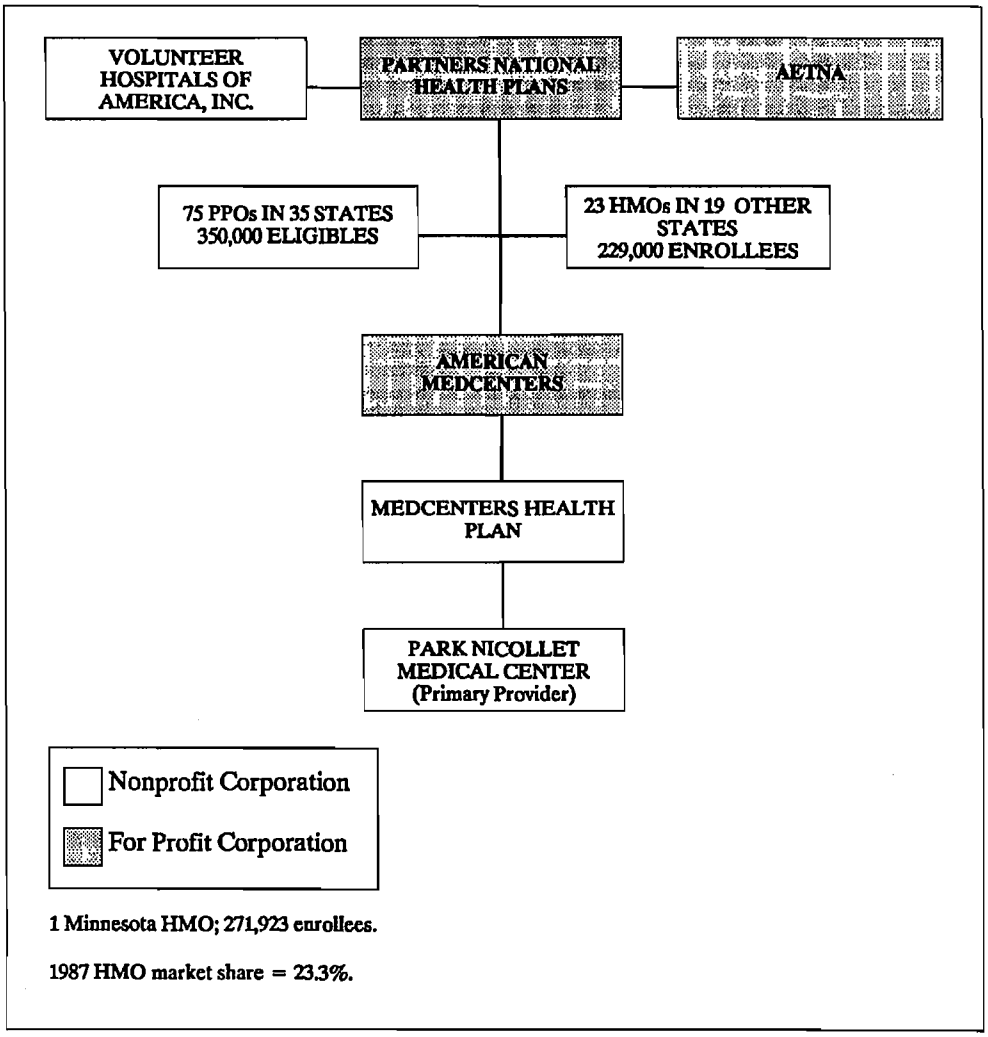


Figure 3.7: Corporate Families MedCenters Health Plan

Both of these corporations illustrate how HMO structures have evolved. In 1973, HMOs were seen as an integration of health care providers and plan management in one organization. Now, the more typical form in Minnesota is for HMOs to exist at three separate levels: (1) the medical providers, (2) the HMO company, which is often a shell, and (3) the management company.

For-profit management companies are one method HMOs have used to adapt to the non-profit requirement.

How Some HMOs Have Adapted to the Nonprofit Requirement

In 1984, the Minnesota HMO act was amended to explicitly allow the Department of Health to review contracts with outside management companies to determine if the arrangements and payments are reasonable and to require additional disclosure from the HMOs about the directors and owners of major participating entities. The state's two largest HMOs, Physicians Health Plan

and MedCenters, had already created for-profit management companies, and others have since contracted with managers.

Figure 3.8 shows the terms of management arrangements with HMOs. Management fees are typically set at a percentage of premium revenue, and have ranged up to 15 percent of premium revenue. The Department of Health reviews these fees to see if they are reasonable. We compared the administrative costs in HMOs with outside managers and in those which are self-managed, but found that differences are more closely related to size than to management arrangements.

Besides payment of management fees, other arrangements, some of which have already been widely reported, have also been used to move money from an HMO to a for-profit management company or to individuals. For example, as part of its management agreement with United Health Care, PHP paid the management company $450,000 for a right of first refusal to purchase shares in United Health Care owned by the then president of both companies. It also paid another $188,500 for computer software systems developed by the management company. The value of the consideration received by the HMO has been disputed.

HMOs may use their revenues to expand operations of related organizations outside of the HMO. For example, in its 1986 annual report, Share Health Plan indicated that it has an agreement with a medical provider (Aspen Medical Group, P.A.) "to provide long-term financing for the construction of new clinics and is also obligated through 1999 to subsidize the operating losses of Aspen's new clinics until they become profitable." In 1986, subsidy expenses of $3.9 million were recorded as *medical* expenses in Share Health Plan's financial statements. Such reporting practices make it difficult to usefully compare expenditures by HMOs.

Blue Cross/Blue Shield also moves funds from its nonprofit health service plan operations into its for-profit insurance operations. Its 1986 annual report indicates that it transferred $575,000 to MII, Inc. so that that company's reserves would meet the statutory minimum.

Conclusions

The nonprofit requirement for HMOs affects the health care market in several undesirable ways.

Given the ability of HMOs to get around the limitation that they be nonprofit operations, does the requirement still have any real impact? It does, in three undesirable ways. First, it requires companies who want to operate like for-profit firms to establish multiple layers of companies to operate the HMO. This makes effective state oversight difficult, since the Department of Health's authority to examine the operations of management companies is limited. The only way to assess the reasonableness of the management fee is to thoroughly audit the management company and evaluate the services provided, which the department does not do.

Second, the requirement may discourage national HMO companies from entering the Minnesota market. These companies could be an important source of new capital for Minnesota operations. When we asked an analyst with a national investment firm, she stated flatly that Minnesota's nonprofit restriction discourages these companies from entering Minnesota.

FIGURE 3.8

MANAGEMENT AGREEMENTS OF HMOs

HMO	MANAGER (OWNER)	MANAGEMENT FEE	1986 FEES PAID	ADMIN. COSTS %
MedCenters Health Plan	American MedCenters (Partners National Health Plans)	10% of gross revenues from groups of 26 or more; 12% of gross revenues from groups smaller than 26	$20.1 million	11.3%
Physicians Health Plan	Charter Med, Inc. (United Health Care)	$71,800 per month plus 4.25% of gross operating revenues, plus fees for pharmacy claims	$16.6 million	11.9%
Share Health Plan	Share Development Corp. (United Health Care)	Specific terms are not public data.[a]	$13.2 million	10.0%
HMO Minnesota	Blue Cross and Blue Shield of Minnesota	Administrative and management services provided and paid at cost.	$ 6.8 million	9.7%
NWNL Health Network	NWNL Health Management Company (Northwestern National Life Insurance Company)	Specific terms are not public data.[a]	EFFECTIVE 1987	
Mayo Health Plan	Mayo Management Service, Inc. (Mayo Foundation)	10% of revenues	$0.004 million	36.1%[b]

Source: Program Evaluation Division analysis of 1986 HMO annual reports.

[a]HMOs may request that certain contracts be treated as nonpublic trade secrets under Minn. Stat. §13.37.

[b]Based on limited activities in 1986.

Finally, the nonprofit label may be more confusing than helpful to consumers. They may be unaware that some HMOs do face pressure to maximize profit, and that their physicians, too, must consider costs when making treatment decisions.

Neither the for-profit nor the nonprofit form is the one, best way to deliver health care. Each has strengths and weaknesses, and each can deliver good or bad health care. However, in our view, it is important for both regulators and consumers to be aware of which form they are dealing with, so that they know what kinds of potential problems they should be alert to. That can't happen when organizations are nonprofit in name only.

CONCLUSIONS

Minnesota's regulation of health plans has evolved in a piecemeal fashion and does not reflect the current marketplace. As we have shown, the distinctions between plans have become blurred and are not very meaningful. Yet Minnesota regulates plans based on the general label used to identify the plan or who its sponsoring organization is. Thus, plans offering similar benefits and having similar contracts with providers are regulated differently because one is an HMO and one is sponsored by Blue Cross/Blue Shield.

Plans are treated differently for reasons that cannot be justified. While these differences may once have been supported by logic, they no longer are. For example, the 1973 HMO Act viewed HMOs as experimental and provided certain preferences to HMOs. Today, HMOs serve one in four Minnesotans and are clearly established as a force in the marketplace. The state no longer needs to favor HMOs over other plans.

On the other hand, the other plans have adopted many of the characteristics of HMOs that concerned legislators in 1973. Their plans offer similar benefits, they exercise influence over how providers practice medicine, and they shift financial risk to providers in ways not anticipated in the early 1970s.

We conclude:

- **Differential regulation of health plans impairs competition in several ways.**

First, accident and health insurers, health service plans, and HMOs are all competing for the same business. Regulations like the premium tax give a clear competitive advantage to nonprofit firms, including health service plans and HMOs, to the detriment of insurers. Figure 3.9 summarizes those differences that we think are most significant.

Second, differences in regulation skew business decisions. Health plans seek to evade state regulations that hurt their competitiveness. For example, as we pointed out in Chapter 2, Blue Cross/Blue Shield has shifted its marketing emphasis and a significant amount of business from its nonprofit health service plans to its HMO combination plans and its administration of self-insured plans, partly through its for-profit PPO. As a result, its health service plans,

FIGURE 3.9

COMPARISON OF HEALTH PLAN REGULATIONS

	Accident and Health	Blue Cross/ Blue Shield	HMO	Self-Insured
ACCESS TO PROVIDERS:	Must provide access to nonphysician providers	Must provide access to nonphysician providers	Not required to provide access to nonphysician providers, may limit referrals to specialists	Not regulated
ABILITY TO LIMIT PROVIDERS AND ENROLLEES:	May limit enrollees, may not limit providers	May limit enrollees, may not discriminate against pro-	Must provide open enrollment period, may limit providers	Not regulated
TAXES AND MCHA TREATMENT:	Pay 2 percent premium tax, subject to income tax, must contribute to MCHA	Not subject to premium tax, subject to income tax, must contribute to MCHA	Not subject to premium or income tax, must contribute to MCHA	Not subject to premium or income tax, exempt from MCHA
FINANCIAL REQUIREMENTS:	Subject to premium review, must maintain $500,000 surplus, must participate in state guaranty fund	Subject to premium review, must maintain 2 to 4 months reserves	Not subject to premium review, no reserve requirement, do not participate in guaranty fund	Not regulated

NOTE: Preferred provider arrangements are not directly regulated by the state. Insurers using PPOs must file information with the Department of Commerce.

providing broad access to physicians and nonphysician providers, will be available to fewer Minnesotans. One reason that Blue Cross/Blue Shield has made those changes is that regulations of health service plans make it difficult to compete.

Differential regulation of health plans impairs competition and may increase the cost of health care.

Third, we think it is inefficient when health plans establish additional companies in order to avoid state regulation. As we have described, HMOs in Minnesota have created layers of management companies so that they can operate more like for-profit firms by moving the plan's revenues upward through the management company. Health plans have created and capitalized subsidiaries which can offer certain benefit plans that the parent company is not permitted to sell.

We have not attempted to quantify the costs associated with health plans' incorporating and maintaining multiple entities, each with its own requirements for capital and regulatory reporting. But there are costs associated with these complex organizations, and the money spent on them is not available to improve health care or to provide a return to investors.

Obviously, there are cases where companies will organize subsidiaries because of good economic reasons. The federal HMO Act has also had an effect, since it generally requires a federally qualified HMO to form subsidiaries to offer nonqualified plans. Amendments now pending in Congress would eliminate that problem.

Fourth, the more complex these organizations become, the harder it is for state regulators to oversee effectively the operations of health plans. The Department of Health's review of HMO management companies is limited for this and other reasons.

Fifth, the current situation reduces accountability to the public and to providers. An HMO like Physicians Health Plan is nominally controlled by its board, composed of consumers, physicians, and executives. Yet that board has contracted with a management company to perform all administrative duties for the HMO. Who should be held accountable for the actions of Physicians Health Plan, its board or the management company? Who is at risk for the HMO's actions?

Finally, many health plans find it competitively necessary to become administrators for self-insured plans. When they direct employers toward self-insured plans, the state's opportunity for useful regulation virtually disappears.

RECOMMENDATIONS

We have concluded that the current regulatory framework for health plans in Minnesota has not kept up with changes in the marketplace and impairs competition. In our opinion, the state should wipe the slate clean and develop a new approach to health plan regulation that is based on these principles:

- **Regulation should be based on clearly articulated goals.**

- **Regulation should treat competing organizations similarly and in a way that promotes vigorous competition.**

- **Regulation should be flexible enough to keep up with new and often unforeseen changes in the marketplace.**

- **Limiting ownership of health plans to nonprofit organizations is no longer a useful way to promote professionalism and protect consumers.**

The state's role in regulating health plans should be clarified.

Clarifying the state's role is the obvious first step in changing the regulatory framework for health plans. We recommend:

- **The Legislature and state agencies should clarify the purposes of state health plan regulation and specify which roles are important for the state to play.**

The state must strike a balance between regulating to protect consumers and standing back to let competition occur. In our view, the state has an important role to play in these two areas:

- *Disclosure*: **Does the plan clearly disclose which services are not covered and what the consumer's obligations are?**

- *Financial solvency*: **Does the plan have adequate resources to ensure that enrollees will get the coverage they are paying for?**

In short, we think the state's role should be to see that consumers understand the coverage they get and get the coverage they bargained for. We also think that the state could play a useful role in collecting, analyzing and distributing information to consumers and employers about the cost of health care, and in developing measures of the quality of care. The Department of Health, through its Health Economics Unit, has provided leadership in developing the state's role in this area.

We found that health plans in Minnesota, competing for the same business, have become more and more alike, yet they are regulated differently. To correct this, we recommend:

- **In general, the state should seek to make health plans compete on the same terms. Where differential regulations create serious impediments to competition, they should be modified.**

- **In modifying state regulation, the Legislature should look beyond the general label given to identify the plan. Instead, regulation should be based on how a plan approaches certain specific issues in which the state has an interest.**

Only a few health plans now limit their role to simply receiving and paying claims. Instead, plans seek to "manage" health care using different tools. The

State regulation should be based on how health plans attempt to "manage" health care.

tools chosen and the ways in which plans use them are now the most telling ways in which plans differ. Therefore, the state should base regulation on how health plans approach these three issues:

- ***Risk*: How does the plan distribute risk among payors, providers, enrollees, and employers?**

- ***Provider autonomy*: To what extent does the plan intervene in the provider-patient relationship through techniques such as utilization review, pre-authorization reviews, and provider practice standards?**

- ***Access*: To what extent does the plan limit free choice of providers? To what extent does the plan limit enrollment?[19]**

For each issue, there is a broad range of possibilities. The extent to which plans share risk, for example, is a question of degree, and not simply a matter of yes or no. In today's marketplace, how a plan approaches those issues is much more useful in classifying the plan than the traditional labels of "HMO" or "accident and health insurance." Thus, the state should develop a new body of regulation that is forward looking and flexible enough to accommodate future changes in the marketplace. We recommend:

- **The Legislature should create a uniform body of regulation for "managed health care plans."**

These plans could be offered by different organizations, including HMOs, insurers, and health service plans. Any health plan in which the plan, *above a threshold level*, (1) shares risk of loss or gain with providers or employers, (2) intervenes in the patient-provider relationship, (3) limits access to providers, or (4) encourages the use of preferred providers through incentives or penalties, would be subject to regulation as a managed health care plan.

In some ways, the extent of regulation would derive from the degree to which the plan attempted to manage health care, based on the three issues cited above. For example, if the plan limits a patient's access to a provider of choice--a basic element of a managed health care plan--then the state may wish to impose certain quality assurance or complaint resolution requirements on the plan. If the plan offers better benefits when using certain providers, then the plan should be required to ensure that participating providers are available in all areas of the state where the plan is to be offered.

---

19 This approach is somewhat similar to the one use in Pennsylvania's recently adopted rules for preferred provider arrangements. Those rules are based on the premise that the extent to which state regulation is needed is linked to the extent to which the PPO affects an enrollee's freedom to choose a provider. Those rules also identify a need for additional regulation of PPOs which assume financial risk and "which utilize arrangements which may lead to undertreatment or poor quality care," including capitation payments and contingency fee withholding. *See* 31 PA Code, Chapter 152. In their joint attempt to draft rules for preferred provider arrangements, the Minnesota Departments of Commerce and Health also sought to use certain characteristics of the plan as the basis for defining the plan and the state's regulatory interest.

In other ways, state regulation should be uniform. For example, standards for disclosure to consumers of their rights and the limitations imposed under each plan should be applied uniformly. Rights to continue coverage after termination or to convert from individual to group coverage should be consistent in all managed health care plans, and indeed in all health plans.

Preferred provider arrangements currently have no body of formal state regulations. Since insured PPO plans presumably would meet our criteria for managed health care plans, those plans would be subject to those regulations.

Plans that offer a limited, specific benefit, such as dental or vision care, or pharmacy services, should be regulated as managed health care plans, if they meet the criteria above. However, the state should create a limited body of rules that reflect the limited nature of those plans.

The state would continue to regulate the solvency of the organization (HMO, insurer or health service plan) sponsoring the plan. The organization would need to demonstrate that it has sufficient reserves and working capital to pay claims for its managed health care plans. The state's standard for reserves would consider the impact of risk-sharing arrangements.

Similar plans now face different state requirements for quality assurance. Quality assurance was seen as necessary for HMOs because of the special economic incentives they face. Yet there is no evidence that quality of care is sacrificed in HMOs.[20] However, the federal government does see a need for quality assurance programs and is now becoming involved, particularly for Medicare plans. Similarly, employers are expressing their interest in measures of quality. We recommend:

- **The Legislature should clarify the role of the state in regulating quality of care.**

Perhaps the state's role should be as an arbitrator when consumers have questions or complaints about the care they receive. We propose that all enrollees of plans classified as "managed health care plans" should have access to such a service. After all, those plans now involve some of the same economic incentives faced by HMOs.

All enrollees of managed health care plans should have access to state assistance for problems with their plans.

Obviously, we have only sketched a broad outline for what a uniform system of regulation would be. But this outline provides a first step toward improving state regulation and for promoting vigorous competition.

The state has tried to influence health care organizations by limiting ownership to nonprofit organizations. We conclude that the state's requirement that HMOs be nonprofit has become counterproductive because it leads to in inefficiencies and may be misleading to consumers. If the Legislature in 1973 thought that requiring HMOs to be nonprofit would promote concern for care over concern for maximizing profit, then the 1988 Legislature should know that regulation of HMO ownership has not achieved that goal.

---

20 See Harold Luft, *The Operations and Performance of Health Maintenance Organizations* (1981).

We recommend:

- **The Legislature should amend state law to allow HMOs to organize as they see fit, whether as nonprofit or for-profit entities.**

The Legislature should eliminate the requirement that HMOs be nonprofit entities.

We do not expect that this will result in a swarm of new national HMO firms descending on the state. (Two national firms, United Health Care and Partners National Health Plans, already control 72 percent of HMO enrollment in Minnesota.) These companies face serious difficulties in their other markets, and Minnesota is a highly competitive market which would be difficult to enter. However, for-profit firms, whether national or Minnesota based, are a source of outside capital that the state should not exclude.

Neither do we expect that existing HMOs will immediately seek to convert to for-profit status, given the costs associated with such conversions. There are some HMOs who believe strongly that being a consumer oriented, nonprofit organization is part of their mission. If the state does open the door to for-profit operations, it should look to the experience of California and other states where some HMOs were originally organized as nonprofit organizations and were later reorganized into for-profit entities. California law requires that an HMO which converts to a for-profit organization create a public foundation and contribute a portion of the estimated value of the HMO to that foundation. Disputes have arisen about the valuation of certain HMOs whose stock was later sold in enormously successful public offerings.

SOLVENCY OF HMOs

Chapter 4

As firms compete aggressively for market share, the solvency of health maintenance organizations has become a national issue. During 1987, an estimated 50 HMO insolvencies occurred in the United States. As a result, many states are reexamining their regulation of HMOs' finances and have enacted or are considering major changes. In 1987, two small HMOs in Minnesota were declared insolvent and are now in the process of liquidation. Although the final results of those two insolvencies are not known, we wanted to assess the impact so far and determine what should be done to avoid future insolvencies.

We asked:

- **Is Minnesota's regulation of the financial health of HMOs adequate?**
- **Are additional measures needed to protect HMO enrollees?**

STATE REGULATION OF SOLVENCY

Standards for HMO solvency are inadequate.

Until 1984, Minnesota did not require HMOs to maintain a specified financial reserve. The 1973 act directed the Commissioner of Health to determine whether a newly proposed HMO can demonstrate that it is financially responsible and to consider the adequacy of the new HMO's working capital. The department evaluates an HMO's financial responsibility based on whether it has working capital for 60 days of operations or could generate cash flow sufficient to provide services for 60 days. As the two insolvencies unfolded in 1987, it became apparent that the standard established in law and administrative rule was too general to provide adequate guidance to the department.

The most important tool that the state used for ensuring that enrollees were not hurt by insolvencies of HMOs was the "hold harmless" provision requiring providers not to seek payment from enrollees:

> The providers under agreement with a health maintenance organization to provide health care services and the health maintenance organization shall not have recourse against enrollees for amounts above those specified in the evidence of coverage as the periodic prepayment, or copayment, for health care services.[1]

Note that the law does not require a "hold harmless" clause in each provider contract, although that has been the department's policy.

In 1984, the Legislature enacted those sections of the Model HMO Act dealing with solvency.[2] However, these standards also do not provide much guidance on what financial position the state should require from an HMO. By comparison with accident and health insurers, relatively little start-up funds are required. The deposit required in the law is really a fund to cover claims and other costs resulting if the HMO becomes insolvent.

The requirements, which were to be phased in for HMOs already in operation, are as follows. An HMO must maintain a *deposit* of $100,000 or up to four percent of its estimated annual uncovered expenditures, whichever is greater. "Uncovered expenditures" are defined as the cost of health care services covered by an HMO for which an enrollee would also be liable in the event of the HMO's insolvency. These include out-of-area services and referral services, presumably received from providers not under agreement with the HMO. An HMO would have to increase the deposit only after its estimated annual uncovered expenditures exceeded $2.5 million.

Most HMOs did not maintain a deposit during 1987.

However, not every HMO has to maintain even this relatively small deposit. The Commissioner of Health may *waive* the requirement if satisfied that the HMO has "sufficient net worth and an adequate history of generating net income" to assure its financial viability, or if the HMO has guarantees from another organization with adequate net worth, or the HMO's contracts with insurers and providers are sufficient to assure performance of its obligations.

Furthermore, an HMO may claim *exemption* from the deposit requirement if the HMO has net worth of at least $5 million, including land, buildings, and equipment, or at least $1 million, excluding land, buildings and equipment. Figure 4.1 shows how each Minnesota HMO complies with this requirement. We found:

- **Only four HMOs, including the two that are now being liquidated, actually maintained a deposit during 1987. Others are exempt under the law or the requirement is waived.**

We reviewed the activities of the Department of Health in monitoring the solvency of HMOs. We concluded:

---

1 Minn. Stat. §62D.12, subd. 5. Illinois did not have such a requirement prior to 1987. When the Chicagocare HMO became insolvent, about $1 million in claims were not covered and became the responsibility of the 4,000 enrollees.

2 The Model Act was developed by the National Association of Insurance Commissioners (NAIC). The most recent version was published in 1984. National Association of Insurance Commissioners, *Proceedings* 1 (1982): 530-554.

- **The Department of Health is not adequately staffed to monitor the finances of HMOs.**

The department currently has one analyst responsible for financial monitoring, and he has other duties as well. It acknowledged this problem in its request for staff increases to the 1987 Legislature. In December 1987, the department requested applications for the position of audit manager, one of the new positions approved by the Legislature during the 1987 session.

HMO	Arrangement
Central Minnesota Group Health Plan	Requirement *waived* because of agreement by Group Health, Inc. to provide continuing coverage.
Coordinated Health Care	Requirement *waived* because of agreement by Blue Cross/Blue Shield to maintain reserves of $300,000.
First Plan	Requirement *waived* because of agreement by Blue Cross/Blue Shield, in the event of insolvency, to cover any contractual obligation.
Group Health, Inc.	Requirement *waived* because of sufficient net worth. (By agreement, Group Health, Inc., guarantees continued coverage for Group Care, its non-federally qualified HMO.)
Health Partners	*Deposit* of $100,000 in restricted asset account.
HMO Minnesota	Requirement *waived* because of agreement by Blue Cross/Blue Shield to maintain reserve of $300,000.
Mayo Health Plan	*Deposit* of $100,000 in certificate.
MedCenters Health Plan	HMO *exempted* from requirement because of sufficient net worth.
Metropolitan Health Plan	HMO *exempted* from requirement based on taxing authority of Hennepin County.
More HMO Plan	*Deposit* of $100,000 in restricted account made in 1986.
NWNL Health Network	*Deposit* of $100,000 made in 1987.
Physicians Health Plan	HMO *exempted* from requirement because of sufficient net worth.
Share Health Plan	HMO *exempted* from requirement because of sufficient net worth.

Source: 1986 annual HMO reports; Department of Health.

Figure 4.1: How Minnesota HMOs Meet the Deposit Requirement

Furthermore, the reporting provisions in law may not be adequate. By law, HMOs report on their financial condition as part of their annual reports, due April 1 of the following year. Thus, the department may not hear of financial difficulties at an HMO for several months after a problem has emerged. In recent years the department has adopted a practice of requesting quarterly, unaudited financial statements from those HMOs which it is trying to monitor more closely.

The department receives financial statements and actuarial evaluations of each HMO, but generally does not see that information for major participating entities, including management companies and large medical providers. Thus, the department would not know if a major clinic under contract with an HMO was accepting more risk than its balance sheet justified.

FINANCIAL CONDITION OF MINNESOTA HMOs

Minnesota's HMOs lost $4.5 million in 1986.

We examined the financial health of Minnesota HMOs based on 1986 annual reports and audited financial statements. That was generally a poor year for HMOs, one in which the state's HMOs lost a total of $4.5 million on revenues of $759 million. Financial results for 1987 operations will be available in April 1988.

Table 4.1 shows the net worth of the HMOs in 1985 and 1986. Overall, net worth declined by $2.7 million (four percent) in 1986. With the notable excep-

HMO	Net Worth 1985	Net Worth 1986	Changes From 1985 to 1986
Central Minnesota Group Health Plan	$ 555,481	$ 486,595	-12.1%
Coordinated Health Care	4,420	396,561	8,872.0
First Plan	593,983	828,066	39.4
Group Health, Inc.	34,465,844	36,014,026	4.5
Health Partners[a]	(284,836)	(588,900)	- 106.8
HMO Minnesota	905,597	300,000	-66.9
Mayo Health Plan	0	13,188	N/A
MedCenters Health Plan	5,101,134	3,718,797	-27.1
Metropolitan Health Plan	762,962	875,366	14.7
More HMO Plan[a]	364,117	(469,092)	-222.8
NWNL Health Network[b]	(1,145,215)	(1,565,277)	-36.7
Physicians Health Plan	14,456,000	14,610,000	1.1
Share Health Plan	11,325,000	9,783,000	- 13.6
Total	$67,102,487	$64,402,240	- 4.0%

Source: Program Evaluation Division analysis of 1986 HMO annual reports.

[a]Declared insolvent in 1987.
[b]Based on old Senior Health Plan, which was acquired by Northwestern National Life Insurance Company in 1987.

Table 4.1: Net Worth of HMOs Declines in 1986

Most Minnesota HMOs have little net worth; three had negative net worth in 1986.

tion of Group Health, Inc., Minnesota HMOs have little net worth. Note that three HMOs in the table had negative net worth in 1986: More and Health Partners, which were declared insolvent in 1987, and NWNL Health Network, the new name of Senior Health Plan, which was acquired by the Northwestern National Life Insurance Company in 1987. The other tables in this section also reflect the situation prior to the two insolvencies and NWNL's purchase of Senior Health Plan.

Table 4.2 shows two measures of reserves and working capital. (Working capital is calculated as the difference between current assets and current liabilities.) With the exception of Group Health, Inc., none of the four largest HMOs in Minnesota have more than one month of reserves. By comparison, Blue Cross/Blue Shield is required to maintain reserves of at least two months expenses, but not more than four months.

HMO	Weeks of Working Capital	Weeks of Reserves
Central Minnesota Group Health Plan	-0.2	3.9
Coordinated Health Care	0.7	1.6
First Plan	4.6	11.3
Group Health, Inc.	3.4	10.5
Health Partners[a]	-11.7	-46.3
HMO Minnesota	-2.1	0.2
Mayo Health Plan	21.8	21.8
MedCenters Health Plan	0.3	1.0
Metropolitan Health Plan	29.0	29.3
More HMO Plan[a]	1.4	-2.9
NWNL Health Network[b]	-4.9	-4.1
Physicians Health Plan	0.9	2.5
Share Health Plan	-2.3	3.2

NOTE: Both ratios were calculated from 1986 annual reports based on total expenses in 1986. *Working Capital* = difference of current assets and current liabilities. *Reserves* = net worth.

Source: Program Evaluation Division analysis of 1986 HMO annual reports.

[a]Declared insolvent in 1987.

[b]Based on old Senior Health Plan, which was acquired by Northwestern National Life Insurance Company in 1987.

Table 4.2: 1986 Working Capital and Reserves Were Very Thin

Table 4.3 looks at a number of key financial indicators from HMOs' balance sheets in 1986. The first two indicators, the current ratio and the quick ratio, are measures of an organization's liquidity. The trend in 1986 was negative for seven HMOs; that is, these ratios went down that year.

The other two indicators compare an HMO's debts to its equity and to its total assets. All but three had either negative equity or a debt-to- equity ratio of more than 3.0, which we regard as heavily leveraged. As before, the

TABLE 4.3

KEY FINANCIAL INDICATORS SHOW OVERALL DECLINE IN 1986

	CURRENT RATIO			QUICK RATIO			DEBT-EQUITY RATIO			DEBT-ASSET RATIO		
	1985	1986	Trend	1985	1986	Trend	1985	1986	Trend	1985	1986	Trend
Central Minnesota Group Health Plan	1.33	0.95	-	0.73	0.38	-	3.81	4.33	-	0.79	0.81	-
Coordinated Health Care	0.78	1.06	+	0.19	0.35	+	414.37	7.30	+	1.00	0.88	+
First Plan	1.45	1.62	+	0.86	0.72	-	0.87	0.83	+	0.46	0.45	+
Group Health, Inc.	1.41	1.44	+	0.95	1.03	+	1.18	1.28	-	0.54	0.56	-
Health Partners[a]	n/a	0.37	n/a	n/a	0.34	n/a	-1.36	-1.32	-	3.78	4.17	-
HMO Minnesota	1.07	.78	-	0.86	0.47	-	13.88	41.06	-	0.93	0.98	-
Mayo Health Plan	n/a	1.56	n/a	n/a	1.50	n/a	n/a	9.36	n/a	n/a	0.90	n/a
MedCenters Health Plan	1.07	1.04	-	0.34	0.06	-	3.72	7.70	-	0.79	0.89	-
Metropolitan Health Plan	17.81	10.28	-	17.56	9.28	-	0.06	0.11	-	0.06	0.10	-
More HMO Plan[a]	0.85	1.21	+	0.10	0.08	-	7.40	-5.14	-	0.88	1.24	-
NWNL Health Network	0.94	0.72	-	0.84	0.54	-	-2.80	-4.54	-	1.56	1.28	+
Physicians Health Plan	1.13	1.07	-	0.89	0.76	-	3.76	4.93	-	0.79	0.83	-
Share Health Plan	1.18	0.73	-	0.88	0.33	-	3.29	4.01	-	0.77	0.80	-

Definitions:

Current Ratio - Ratio of current assets to current liabilities. If greater than 1.0, current assets exceed current liabilities.

Quick Ratio - Ratio of easily liquidated current assets (cash, short-term investments) to current liabilities. Also called "the acid test."

Debt-Equity Ratio - Ratio of all liabilities to net worth (difference of assets and liabilities); ratios in excess of 3.0 mean that the HMO is highly leveraged.

Debt Assets Ratio - Ratio of all liabilities to all assets. If greater than 1.0, HMO has negative equity.

Source: Program Evaluation Division analysis of 1986 HMO annual reports.

[a]Declared insolvent in 1987.

[b]Based on old Senior Health Plan, which was acquired by Northwestern National Life Insurance Company in 1987.

general trend for most of the HMOs was negative. Most have less than one month of reserves, and their reserves grew smaller between 1985 and 1986.

THE MORE AND HEALTH PARTNERS INSOLVENCIES

More HMO Plan

The More HMO Plan began operations in 1973 as the Group Health Association of Northeastern Minnesota, with operations on the Iron Range and other communities in that part of the state. It was declared insolvent in 1987 and is now being liquidated under supervision of the Department of Commerce.

More's troubles were the result of a depressed steel industry, which resulted in a decline in enrollees, and an expensive decision in 1985 to purchase the medical practice operating and leasing one of More's major participating clinics (the Lenont-Peterson, or L-P Clinic, in Virginia). The clinic purchase occurred shortly after the clinic was expanded and refinanced as part of a real estate venture. At the request of the Iron Range Resources and Rehabilitation Board (IRRRB), the Attorney General has engaged outside counsel to investigate whether the IRRRB was "misled" when it sold bonds in 1985 to finance that venture.[3]

More HMO Plan lost money in 1985 and 1986, and was ordered into rehabilitation in May 1987.

More HMO Plan lost $795,137 in 1985 and continued to lose money in 1986. Its problems were apparent in 1986, and the Departments of Health and Commerce considered stepping in at that time to order the HMO into rehabilitation under state supervision. Instead, the departments agreed to a rescue plan by which an out-of-state firm (UCI, Inc.) took over management of the HMO in July 1986 and established a $400,000 escrow for working capital. The L-P clinic closed in August. It reopened for a short time under the management of a for-profit subsidiary of the Range Mental Health Center.

In the twelve months after the management company took over More, the HMO continued to lose enrollees and money. In fact, officials at the Department of Health say that one reason they agreed to the rescue plan was to give the enrollees additional time to find alternate coverage during open enrollment periods.

In May 1987, the Department of Health asked the Commissioner of Commerce to institute rehabilitation proceedings for More. By law, rehabilitation and liquidation of HMOs are conducted according to Minn. Stat. Chap. 60B, the Insurers Rehabilitation and Liquidation Act. The Commissioner of Commerce can act at the request of the Commissioner of Health or on his own initiative. The Commissioner of Commerce appoints a special deputy commissioner to oversee the process.

3 Previous reports by our office, *Economic Development* (1985) and *Tax Increment Financing* (1986), criticized the clinic project as a poor use of public development subsidies.

The rehabilitation period was short since it was obvious that the plan could not be saved and would be liquidated. The deputy sought buyers for the HMO. While several local and out-of-state firms (including, ironically, Health Partners) expressed some interest, he received only one offer. Blue Cross/Blue Shield agreed to pay nominal consideration in exchange for the enrollees of the plan. To our knowledge, all enrollees were able to maintain continuous coverage, though not necessarily of the same type or price. In both liquidations, we think the Department of Commerce and the deputy have done a good job of working to maintain continuous coverage for the enrollees.

As of February 1988, a number of legal issues remain to be resolved before the deputy can make a final distribution of assets. First, there are numerous claims to the remaining assets, far exceeding what is available. The largest claims are not from providers or enrollees, but from investors. One of the biggest claims is for the L-P Clinic. After More stopped making lease payments, the limited partnership which leased the clinic to the doctors' group and later to More accelerated the lease payments. It is seeking more than $5 million. The management company is seeking the return of the $400,000 from its escrow, which the deputy is holding.

Enrollees of More HMO Plan could face bills of $1 million.

One unresolved issue arises from the claims made by numerous providers who had no formal contracts with the HMO, but who had treated the HMO's patients outside the service area, or for specialized or referral care. In November 1987, the deputy estimated that $1 million of claims had been received from these "nonparticipating" providers, who would seek to collect from enrollees. The deputy is asserting that all providers who did business with the HMO were "under agreement" and are bound by law to seek payment only from the HMO, not from the enrollees. Affected providers are saying that, in the absence of written contracts, they were not under agreement, and that the law contemplates that enrollees might have obligations to nonparticipating providers. If the deputy prevails, those providers will line up with the other creditors of the HMO, hoping for a partial payment of their debts. If the deputy does not succeed, enrollees of More HMO Plan will face bills of $1 million.

Participating providers have also filed numerous claims with the deputy. In January 1988, the deputy reported that $690,000 in validated claims had been received from participating providers.

The deputy and his attorneys have identified several problems with the Insurers Rehabilitation and Liquidation Act in general and some specific areas in which the act does not apply neatly to HMOs. For example, rehabilitation of an HMO may simply not be a realistic possibility under the law, because the deputy lacks authority needed to protect the HMO's assets and to maintain its provider network. The deputy does not have sufficient authority to protect assets immediately after receiving a court order, to reassure providers that they will be paid, or to use the cash receipts of the HMO to keep operations going. As the two liquidations proceed, some of these problems might be solved by state courts developing a "common law" to address issues that are not adequately addressed in the rehabilitation law.

Health Partners

The University of Minnesota Hospital was a major investor in Health Partners.

Health Partners, the product name of the HMO plan sponsored by Primary Care Network, was established in 1985. It was managed by a for-profit entity, Primary Care Network Management Company, Inc., for a fee of 15 percent of gross revenues. The majority owner of the management company was Whitehead Associates, a venture capital firm. Other stock was owned by the University of Minnesota Hospital and by University of Minnesota Clinical Associates, a corporation that represents the University's physicians. The University of Minnesota Hospital invested at least $900,000 in Health Partners through the management company, and the physicians $448,000.

The goal of Health Partners was to establish a network of physicians in rural areas which would direct patients to the University of Minnesota Hospital. Whitehead Associates saw it as a prototype for HMOs in rural areas in other states, working with major university hospitals. Health Partners' enrollees were mostly in the Brainerd area and in southwestern Minnesota. The HMO lost $304,154 in 1986 and continued to lose money during 1987.

At the request of the Commissioner of Health, the Department of Commerce received an order from the Ramsey County District Court to put Health Partners into rehabilitation at the end of July 1987. When the deputy sought buyers for Health Partners, there was even less interest than there had been in More. Again, Blue Cross/Blue Shield agreed to take the enrollees in exchange for nominal consideration. According to the deputy, nonparticipating providers have submitted about $163,000 in validated claims. Claims from participating providers are $424,000.

Prior to receiving its certificate of authority, Health Partners demonstrated to the Departments of Health and Commerce that it had adequate working capital. Apparently, much of its start-up capital was in the form of advances and lines of credit authorized by the owners, through the management company. However, the obligation of the management company in this case and in the case of More to draw on these lines of credit is not clear. Nor is it clear what obligation, if any, the sponsors had to continue lines of credit.

CONCLUSIONS AND RECOMMENDATIONS

Participating providers in More and Health Partners could lose up to $1.1 million as a result of the insolvencies. Depending on how state courts rule, enrollees in those HMOs could be subject to claims of $1.2 million from nonparticipating providers. This is a worst case scenario, and losses may well be much less. Nevertheless, it is important to learn the lessons of the two insolvencies and try to prevent future insolvencies.

Role of State Regulators

Minnesota's HMOs are generally not strong financially and should be monitored more closely. However, the Department of Health is not equipped

to perform an adequate job, and we are concerned by its slowness in hiring additional staff. We also think that the Department of Commerce has expertise as well as a useful perspective on financial regulation. We recommend:

- **The Department of Commerce should assume responsibility for monitoring the financial integrity of HMOs.**

- **The department should develop and implement an "early warning" system to identify problems with HMOs through a combination of more frequent reporting, and periodic and special examinations.**

We also recommend that:

- **The Department of Commerce should examine the solvency of major providers under contract with HMOs, i.e., those accounting for more than ten percent of claims.**

- **The Legislature should consider additional reporting requirements for major providers and management companies.**

The state should examine the financial condition of major providers.

A major premise of HMOs is that they can share risk with providers. But, if the providers are not financially secure, how can the HMO be secure? Minnesota should require financial statements from major providers in order to see what risk those providers are assuming, and whether they are capable of carrying it.

Statutory Changes

The state's current requirements for start-up capital and restricted deposits are too low and cannot be justified. The claims by nonparticipating providers of an HMO as small as More are many times its $100,000 deposit. We recommend:

- **The Legislature should increase start-up capital, ongoing reserves, and restricted deposit requirements for HMOs.**

Illinois recently increased the initial net worth requirement from $500,000 to $2 million. To accommodate existing HMOs, a phase-in period should be provided during which those organizations would have to meet the standard.

The Department of Health has closely studied the problem of HMO insolvency and has prepared a bill for legislative consideration. That bill would make changes in deposit and reserve requirements, require quarterly financial statements, and clarify the responsibilities of related organizations.

- **The Department of Commerce should adopt formal standards for evaluating the solvency of HMOs.**

More specific standards are needed for evaluating the assets of HMOs and for assessing the impact of arrangements made for spreading risk to providers and

to insurance. These standards could allow some latitude for HMOs that can demonstrate that employment of their own medical staff or use of risk-sharing arrangements reduce the need for reserves.

The status of nonparticipating providers is a major problem in the More insolvency, and the statutes should be clarified. If the district court rules that these providers are not "under agreement" with the HMO, enrollees face bills of more than $1 million.

Guaranty funds provide protection to enrollees in cases of insolvency. In the event of an insolvency, participants in the funds are assessed for the uncovered losses, in proportion to their size. In the past few years, several states have established HMO guaranty funds (Alabama and Illinois) or have brought HMOs into existing insurance guaranty funds (North Dakota, Utah, and Wisconsin). Many other states are considering guaranty funds for HMOs.

- **The Legislature should consider bringing HMOs into the Life and Health Insurance Guaranty Association.**

As a last resort, a guaranty fund would protect HMO enrollees in cases of insolvency.

In our view, the Legislature should use a guaranty fund for HMOs only as a last resort. After all, guaranty funds require successful HMOs or insurers to pay for the mistakes of bad ones. The Legislature should use other tools first to ensure the solvency of HMOs and to limit the losses faced by enrollees and providers. However, it may be necessary to enact such a requirement, if only to alert HMOs to the seriousness with which the state views their situation.

We do not think that there are enough HMOs in Minnesota or that they are currently strong enough to form their own guaranty association. Thus, we think that they should enter the life and health insurance pool. The Legislature may wish to set an effective date of 1990 on this action. That would allow some time for HMOs to strengthen their operations, and perhaps reduce the need for their participation in a guaranty fund.

REGULATION OF SELF-INSURED PLANS

Chapter 5

In our interviews with employers, regulators, representatives of health plans, and others, we found a widely-held perception that an increasing number of firms are self-insuring their health benefit plans. As we discussed in Chapter 3, self-insured plans generally are exempt from state regulation. They need not provide a package of state-mandated benefits, their solvency is not subject to outside review, and they do not pay a premium tax or contribute to the state's health insurance risk pool.

We asked:

- **What proportion of Minnesota firms self-insure some or all of their health plans? Is the proportion increasing?**
- **Does the absence of state regulation create problems, and what should be the state's role in regulating self-insured plans?**

NATIONAL ESTIMATES OF SELF-INSURED FIRMS

Self-insurance appears to be increasing nationally.

Several national studies in recent years have estimated the extent of self-insurance among employers. These studies seem to confirm the notion that self-insurance is increasing nationally.

Tables 5.1 - 5.4 present details from four national employer surveys, each of which looked at self-insurance from a different perspective. For example, the McDonnell survey concluded that eight percent of all *plans*, and over 50 percent of all *employees*, were self-insured (Table 5.1). That study found that from 6 to 80 percent of U.S. companies, depending on the size of company, self-insured health benefits.

1 to 99 Employees:	6%
100 to 249 Employees:	24%
250 to 999 Employees:	43%
1,000 to 4,999 Employees:	71%
5,000 or More Employees:	80%

Source: Patricia McDonnell, et. al., "Self-Insured Health Plans," Health Care Financing Review, 8, No. 2 (Winter 1986): 1-16.

NOTE: In addition to businesses, this survey included unions, religious organizations, government, and post-secondary schools.

Table 5.1: Percentage of U.S. Organizations Which Self-Insure Health Benefits 1984

A study by the Bureau of Labor Statistics looked at employees of firms with 100 or more employees. That study (Table 5.2) estimated that up to 38 percent of *full-time participants* in health plans were enrolled in self-insured plans.

Basic Hospital	18%
Basic Surgical	23%
Basic Medical	13%
Major Medical	38%

Source: Department of Labor, Bureau of Labor Statistics, "Employee Benefits in Medium and Large Firms, 1985:, The Medical-Economic Digest (August 1986): 8-11.

Table 5.2: Percentage of Participants in Health Plans Who Were Enrolled in Self-Insured Plans 1985

Johnson and Higgins, an employee benefits consulting firm, surveyed a very large sample of employers (Table 5.3). They found that 31 percent of small firms and 85 percent of very large *firms* self-insured health benefits.

The fourth study, by Towers, Perrin, Forster, and Crosby, benefit consultants, presents estimates for several years (Table 5.4). They show the rate of self-insurance for large firms increasing from 43 percent to 67 percent between 1982 and 1986.

Less Than 500 Employees:	31%
500 to 999 Employees	42%
1,000 to 2,499 Employees:	56%
2,500 to 4,999 Employees:	57%
5,000 to 9,999 Employees:	64%
10,000 to 19,999 Employees:	70%
20,000 to 39,999 Employees:	65%
40,000 or More Employees:	85%

Source: Johnson and Higgins Healthgroup, The Johnson and Higgins Corporate Healthcare Benefits Survey 1986: Report of Survey Findings.

Table 5.3: Percentage of Firms Self-Insuring Health Benefits 1986

1982	43%
1984	54%
1985	62%
1986 (projected)	67%

Source: Towers, Perrin, Forster and Crosby, "Self-Insurance," Business Insurance, 20, No. 4 (January 1986), cited in McDonnell, et. al.

Table 5.4: Growth in Percentage of Large U.S. Firms Self-Insuring Health Benefits 1982-86

SELF-INSURANCE AMONG MINNESOTA FIRMS: SURVEY RESULTS

Because there were no recent data on the extent to which Minnesota employers are self-insuring health benefit plans or on their reasons for doing so, we included in our employer survey a number of questions for employers who self-insure. We asked employers to list their self-funded health benefit plans and the number of employees enrolled in each plan. We also asked why they choose to self-insure, whether their self-funded plans include certain benefits which other plans are required to offer, whether they purchase stop-

loss coverage against catastrophic claims, and who administers their self-funded plans.

Based on weighted survey responses, we estimate that:

- **Almost 10 percent of all Minnesota firms that offer health benefits offer at least one self-insured plan.**

- **Nearly one-quarter of all Minnesota employees are enrolled in a self-insured plan.**

Larger firms are much more likely to self-insure health benefits than small firms. About 75 percent of large firms self-insure at least one plan, while 34 percent of medium firms, and only 4 percent of small firms do so. Many of the self-insured plans offered by small firms are employer or union trusts. These arrangement allow small firms to gain the advantages of self-insuring, while spreading risk over a larger group.

As noted earlier, self-insurers are not subject to state law regarding mandated benefits. We asked employers whether their self-insured plans include certain benefits which fully-purchased plans are required to include. Table 5.5 lists the specific benefits we asked about, and the percentage of employees enrolled in plans that include these benefits. We found:

Most enrollees in self-insured plans receive comprehensive benefits.

- **The majority of enrollees in self-insured plans receive benefits similar to those received by enrollees in other plans.**

	Employees of:			
Benefit	Small Firms	Medium Firms	Large Firms	All Firms
Chiropractic Services	29.1%	69.7%	97.9%	78.1%
80% of the first $750 each year for outpatient mental health services	22.1	59.6	80.2	64.8
At least 28 days of inpatient chemical dependency treatment	29.7	70.6	94.4	77.0
At least 130 hours of outpatient chemical dependency treatment	15.0	59.2	62.5	55.6
Continuation and conversion privileges for terminated or laid-off employees	21.9	76.2	96.9	79.6
Coverage for handicapped children after the limiting age for dependent children	10.4	54.2	79.8	61.0

Table 5.5: Percent of Employees of Self-Insured Firms With Certain Benefits Available

Larger firms generally offer state-mandated benefits.

Again, however, firm size affected the level of benefits offered. As the table shows, the larger the firm, the more likely that employees are covered by mandated benefits. Most respondents to our survey said that avoiding state-mandated benefits was not an important factor in their decision to self-insure. In fact, medium and large firms cited a desire to avoid state-mandated benefits as the *least* important reason. However, small firms rated avoiding mandated benefits as a fairly important reason for self-insuring.

Most (59 percent) of the firms that self-insure assign administrative responsibility for their self-insured plans to an insurance company or subsidiary. About 21 percent use an administrative services firm, and 20 percent administer their plans in-house. Most medium and large self-insuring firms purchase stop-loss coverage for their self-insured plans. Most small self-insurers, who participate in pool arrangements, said that they did not purchase stop-loss, although the pool arrangement itself probably includes stop-loss coverage.

The tendency of firms to self-insure varies by location and industry. About 5 percent of metro area and 8 percent of non-metro firms self-insure at least one plan. However, about 28 percent of metro area employees are enrolled in self-insured plans, while 20 percent of non-metro employees are enrolled in such plans. This difference reflects the fact that metro firms that self-insure tend to be larger than non-metro firms that do so. Table 5.6 shows the percentage of firms that self-insure at least one health plan, by location and by industry. As the table shows, firms in the transportation industry are the most likely to self-insure, while those in the services industry are least likely to do so.

	Number of Firms	Percent Offering Benefits	Percent Self-Insuring
LOCATION			
Metro	58,271	69.8%	4.9%
Non-Metro	39,306	54.3	8.1
INDUSTRY			
Mining & Construction	8,270	64.4%	9.2%
Manufacturing	14,267	65.9	16.6
Transportation	4,865	62.4	31.0
Trade	26,967	61.1	12.2
Finance, Insurance, Real Estate	11,388	67.9	8.6
Services	32,821	65.7	2.1

Table 5.6: Percent of Firms Offering Health Benefits and Self-Insuring By Location and Industry

Some concerns about self-insurers may be unjustified.

To the extent that our survey results reflect the actual practice among Minnesota firms, some of the concerns about self-insurers may be unjustified. It appears that most employees of self-insured firms are offered benefits that are very similar to those included in insured health plans. Furthermore, many self-insurers are purchasing stop-loss coverage, which offers protection from extraordinary claims.

COMPLAINTS AGAINST SELF-INSURED FIRMS

To determine whether consumers were experiencing problems with self-insured plans, we reviewed complaints received by the Department of Commerce. The department reported 85 complaints regarding accident and health coverage which it received in 1986 and 1987 and ultimately closed for lack of jurisdiction because the respondent was an administrator or self-insured employer.[1]

In an additional unknown number of cases, department investigators advise callers that the department lacks jurisdiction because the health plan is self-insured, and no complaint file is opened. In both instances, department investigators will suggest that the complainant contact the U.S. Department of Labor, which has jurisdiction over self-funded plans. The Minnesota commerce department had no information on whether these contacts were made or if they had any result.[2]

Only a small number of complaints about self-insurers have been received by the Department of Commerce.

The number of complaints reported against self-insured firms appears relatively small. The department estimates that it received 10,100 complaints regarding health insurance in 1986 and 1987, so the proportion involving self-insureds is small. This may be because the department lacks jurisdiction or because plan enrollees are not aware of the department.

Our review of a random sample of those files shows that the complaints involving self-insured firms fall into two categories in roughly equal numbers. In the first group, the plan benefits and the complaints are no different than those the Department of Commerce hears from consumers in insured plans. In one case, the plan administrator decided that chiropractic treatments after the first 20 treatments were not medically necessary and would not pay. In such cases, the coverage and the administrator's decision would probably be the same in an insured plan. However, the Department of Commerce says that if the plan had been insured, the department would have more leverage over the insurer and would encourage the insurer to negotiate with the enrollee.

In the second group of complaints that we reviewed, employers have used their flexibility in plan design to exclude benefits required for insured plans, such as covering dependents for pregnancy or covering inpatient alcohol abuse treatment. In these cases, the law would clearly require an insured plan to provide coverage.

---

1 In some cases, neither the investigator nor the complainant realizes that the complaint involves a self-insured firm until the investigation is complete. Therefore, the department's computerized complaint tracking system does not always identify these complaints against self-insureds when they are filed. In a separate calculation, the department identified 156 cases (including some of the original 85) that were filed against self-insured firms or third-party administrators of self-insured plans.

2 We contacted the Department of Labor office in Washington, D.C. That office does not compile statistics on inquiries received about self-insured health plans. ERISA and its associated administrative rules set no standards for mandated benefits or definitions of medical necessity, although the Department of Labor has set standards for claims payment procedures. The Department of Labor's role is to see that the plan administrator follows the plan's rules. If it receives a complaint about failure to follow plan rules, it may contact the plan to discuss the complaint, but it imposes no administrative penalties for noncompliance.

ATTEMPTS TO TEST THE ERISA PREEMPTION

In Other States

As we discussed in Chapter 3, the federal Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulation of *employee benefit plans*, but explicitly reserves to the states authority to regulate *insurance*. The distinction is not always clear, particularly since many self-funded plans purchase some stop-loss insurance coverage to protect against catastrophic losses, or use insurers as plan administrators.

Several states have attempted to regulate self-insurers, with mixed results.

Some states have attempted to make self-insured plans conform to state law with regard to minimum benefits and payment of premium tax. Since it is generally acknowledged that a fully self-insured plans is exempt from state regulation, those states have focused on plans that have some connection with insurance. Specifically, some states have tried to impose regulation on self-insured plans which purchase stop-loss insurance against catastrophic loss or which use insurance companies as administrators of their plans. The theory is that the stop-loss coverage makes the plan "a little bit insured" and therefore subject to state regulation.

In cases challenging these regulations, different Federal courts have reached different results: some have held that the use of stop-loss coverage is sufficient to open the door for state regulation and others have held not. Similarly, some have held that the involvement of an insurance company as administrator is enough to permit state regulation, while others have said no. Figure 5.1 summarizes those cases.

In Minnesota

During the 1987 session, the Department of Commerce tried to use the theory that self-insured firms which purchase stop-loss coverage are subject to insurance regulation to impose a new regulation on self-funded plans. The Legislature enacted a requirement that self-funding employers who purchase stop-loss coverage had to post a security or bond to ensure continued health benefits in the event of their insolvency.[3]

In limiting the requirement to self-insurers who also purchased stop loss coverage, the department was apparently hoping for support based on those

3 The law states that, "any employer who provides a health benefit plan to its Minnesota employees, which is to some extent self-insured by the employer, and who purchases stop-loss insurance coverage, or any other insurance coverage, in connection with the health benefit plan, shall annually file with the commissioner, within 60 days of the end of the employer's fiscal year, security acceptable to the commissioner in an amount specified under subdivision 2, or a surety bond in the form and amount prescribed by subdivisions 2 and 3. " *Minn. Laws* 1987, Chap. 337, Sec. 54.

1. *Michigan United Food and Commercial Workers v. Baerwaldt*, 767 F.2d 308 (6th Cir., 1985): The Court of Appeals held that purchase of stop-loss coverage was sufficient to bring the plan under the Michigan minimum benefits law.

2. *Cuttle v. Federal Employees Metal Trade Council*, 623 F.Supp. 1154 (D. Me., 1985): The district court held that state law regarding continuation privileges was preempted even though the plan purchased stop-loss coverage.

3. *General Motors Corporation vs. California State Board of Equalization*, 815 F.2d 1305 (9th Cir., 1987) takes an expansive view of insurance regulation. California imposed its insurance premium tax on self-insurance plans, based on their claims paid and the premium paid for stop-loss coverage. The tax was assessed against the insurer/administrator (Metropolitan Life), and not directly against the employer's benefit plans. The Ninth Circuit Court of Appeals reversed the U.S. District Court and held that taxation of insurance falls within the savings clause and is *not* preempted by ERISA: "Thus taxation of insurance, no less than regulation, may fall within the saving clause." At 1310. Note that the case involved a law aimed at the insurance companies administering the benefits and providing the stop-loss coverage.

4. *Insurance Board Under Social Insurance Plan v. Muir*, 635 F.Supp. 1425 (D. Pa., 1986): The District Court held that administration by Blue Cross was sufficient to impose state regulation, even though it assumed no insurance risk. *Reversed* on appeal. 819 F.2d 408 (3rd Cir., 1987).

Figure 5.1: Federal Decisions on How ERISA Preempts Regulation of Self-Insured Plans

federal court cases that we have cited above. The bill was the result of concerns that arose when Reserve Mining Company and Erie Mining Company went bankrupt in 1986, and the companies discontinued their self-insured health benefit plans for employees and retirees.

Minnesota's 1987 law was successfully challenged in federal court.

The law was challenged by the Minnesota Chamber of Commerce and Industry and other employer groups as violating the ERISA preemption. They succeeded when Federal District Judge McLaughlin enjoined enforcement of the law.[4] In its argument, the Department of Commerce relied heavily on a recent U.S. Supreme Court case which upheld a Maine state law requiring companies that are closing down to pay a one-time severance benefit.[5] Judge McLaughlin did not agree that the analogy was clear and sided with the plaintiffs, who relied on a Minnesota federal decision.[6] The Department of Commerce is preparing legislation that would address the issue in a different way.

4 *Minnesota Chamber of Commerce and Industry v. Hatch*, (D. Minn.), Civil 4-87-707, October 28, 1987.

5 *Fort Halifax Packing Co., Inc. v. Coyne*, 107 S. Ct. 2211 (1987).

6 *St. Paul Electrical Workers Welfare Fund v. Markman*, 490 F. Supp. 931 (1980).

CONCLUSIONS

Self-insured plans now cover a substantial, and probably growing, number of Minnesotans. Employers say that they choose to self-insure primarily to control costs and benefit from cash flow, and that avoidance of state mandated benefits is a less important reason. As shown in Chapter 3, self-insured plans enjoy many competitive advantages over other plans. However, self-insured firms also assume a certain amount of risk for claims beyond their expectations.

As the Reserve Mining case shows, the potential for harm to consumers from a large self-insuring firm going bankrupt is substantial. However, our review did not disclose any pervasive problems with self-insured plans. Most large firms, which account for most of the self-insured employees in the state, provide benefits that are comparable to those required of insured plans under state law, and purchase stop-loss coverage. Complaints against self-insured plans are a small proportion of those received by the Department of Commerce, although this may result from the department's lack of jurisdiction over such complaints.

Congressional amendments to ERISA will be required to give states a role in regulating self-insureds.

State attempts here and elsewhere to test the limits of the ERISA preemption have had mixed results in the courts, and in any event have not had any effect on self-insuring firms without ties to insurance. In our view, any movement to give states a role in regulating self-insureds will have to come from Congressional amendments to ERISA. If the Legislature is concerned about self-insured firms, it needs to specify those concerns, e.g., premium taxes, contributions to the state risk pool, mandated benefits, and so on. Then the state should join with other similarly concerned states to seek Congressional changes in ERISA.

ROLES OF THE DEPARTMENTS OF HEALTH AND COMMERCE

Chapter 6

The state Departments of Health and Commerce share responsibility to regulate health plans in Minnesota. As part of our evaluation, we studied their roles and analyzed how they performed their duties. We also considered where regulatory authority should be located in state government.

DEPARTMENT OF HEALTH

The HMO Act gives the Department of Health broad responsibilities for regulation of health maintenance organizations. The department is responsible for reviewing proposed HMOs, approving contracts, examining HMOs' operations for ongoing compliance, and receiving consumer complaints.

Regulation of health maintenance organizations is now located in the Health Systems Development Division of the Department of Health, along with the health economics and occupational analysis functions. Prior to 1983, the HMO unit had been located with health facilities licensing and other regulatory functions.

Until recently, the Department of Health had a very small staff for its broad responsibilities.

During most of its first ten years regulating HMOs (1973-83), the Department of Health had only one or two persons assigned to that activity, and they often had other responsibilities. During those years, the number of HMOs and their enrollment increased dramatically, as did the complexities of the plans and contracts offered by the HMOs. Clearly, the lack of resources has been an obstacle in trying to fulfill the regulatory responsibilities assigned by state law.

The department recognized these problems in 1983 and began to make internal adjustments to add staff to the unit. In 1987, it requested a major increase in staffing from the Legislature.

As shown in Table 6.1, the budget and staff complement for HMO regulation have grown in recent years, and the department received a large increase for the 1988-89 biennium. By the second year of the biennium, the department will have an authorized complement of 15 or 16 assigned to HMO regulation. However, the department has moved slowly in filling new positions. By November 1987, it had hired two support staff and two rule writers, and by December it had posted two other positions through the Department of Employee Relations.

	Budget	Complement
1985	$135,300	3
1986	158,300	4
1987	216,100 ($38,700 federal)	7 (2 federal)
1988	425,000 ($51,600 federal)	12 (2 federal)
1989	585,900 ($51,600 federal)	16 (2 federal)

Source: 1987-89 Biennial Budget.

Table 6.1: Department of Health HMO Unit Budget and Staff Complement 1985-89

The department's proposed organization reflects a shift from a small office of generalists to a larger staff of specialists.

As new staff are added, the department proposes to organize the division into three areas: regulatory compliance, audits, and quality assurance. Figure 6.1 illustrates the division's proposed structure. The new organization reflects a shift from a small office of generalists to a much larger staff of specialists.

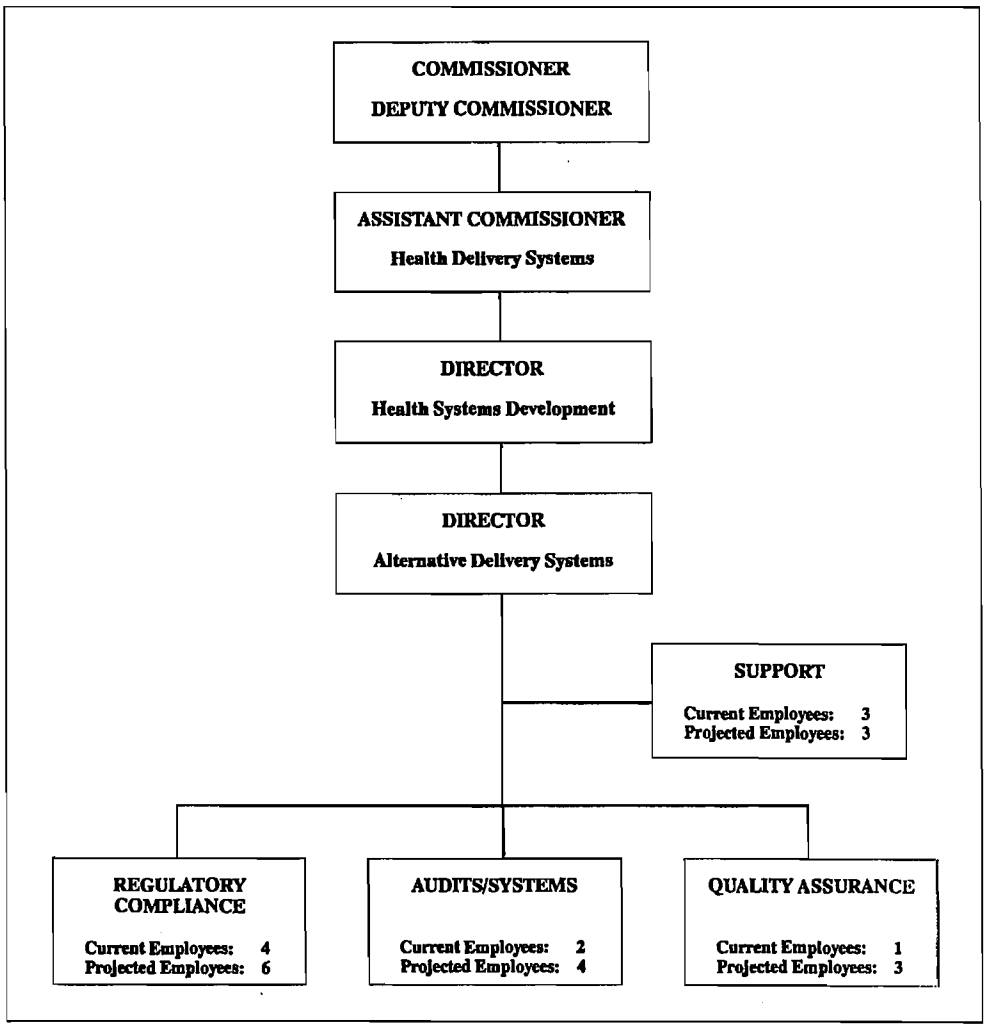


Figure 6.1: Projected Organization of Department of Health HMO Unit

Regulatory Compliance

Filings of contracts have increased substantially in recent years.

The department currently has one attorney and one analyst responsible for review of filings made by HMOs. All contracts with providers and employers, and all certificates ("evidences") of coverage are subject to review by the department and may not be used without the department's approval. According to the staff, the number of filings has increased substantially in the past few years: from 101 filings in 1984 to 369 in 1987. The number of filings has increased because changes in law required some changes in contracts or coverage and because HMOs are developing different products.

If the department finds that an HMO is violating state law, it may impose an administrative fine of up to $10,000 per violation or may impose other penalties. For example, it would be a violation for an HMO to use contracts that have been disapproved by the department. The department has imposed fines very infrequently, although it has gone through administrative hearings to assert its position in a few notable cases. In one, Physicians Health Plan used contracts that shifted a certain amount of financial risk to employers, which was then illegal.[1] PHP eventually agreed to withdraw the contracts and was assessed a fine of $25,000.

In a second case, PHP had used group contracts which excluded coverage of reconstructive surgery in certain instances. On at least three occasions, the Department of Health had approved similar contracts without objecting to the exclusion. Then, in 1985, the department refused to approve the contract, saying that it excluded a benefit which is required under state law.[2] The department prevailed in that case as well, with the administrative law judge holding that (1) PHP was not entitled to rely on the department's previous approval of similar contract language, and that (2) the department could change its interpretation of rules.

The department has hired two temporary rule writers and has identified an ambitious agenda of administrative rulemaking. Highest priority is given to rules addressing financial solvency issues as well as some technical matters, such as coordination of benefits. The department is also planning to adopt rules for its quality assurance functions. Finally, the department has authority to write rules regulating HMOs that offer combination plans without associating with an insurance company. This provision was enacted during the 1987 legislative session, but HMOs cannot offer such plans on their own until the department promulgates rules. This may not occur for two years or more, since the department has placed these rules at the bottom of its rulemaking agenda.

Audits and Other Reviews

The HMO Act provides that the Department of Health should make an "examination" of each HMO at least once every three years, including audits of

1 In 1987, the Legislature amended the HMO Act to permit HMOs to share risk with employers under certain conditions. *Minn. Laws* 1987, Chap. 130.

2 *Minn. Stat.* §62A.25.

financial records and evaluations of the quality and appropriateness of services provided.

- **The department has not come close to reviewing each HMO on a three-year cycle.**

Since 1985, when it began reviews, the department has completed two such reviews and most of a third. It has also been involved for nearly a year in a special review of a large HMO. Department staff have also conducted financial reviews of More HMO Plan and Health Partners as they experienced financial stress and eventually insolvency in 1986 and 1987.

We reviewed the audit reports for the first three reviews. These reviews were of More HMO Plan, MedCenters Health Plan, and Metropolitan Health Plan. We also reviewed the audit program developed by the department. Our review of the department's first three examinations and its audit program suggests that:

- **The examinations generally lack focus, and they have paid excessive attention to paperwork issues.**

The scope of the review is very broad. It covers everything from verifying that elections of consumer directors were conducted properly to what practices are used to underwrite groups and set premiums.

Little attention has been given to independent review of the financial conditions of HMOs or major providers.

Much of the audit program (and of one of the completed audits) deals with whether the Department of Health has received and approved all current contracts and other required filings. As a result of the completed audit, the department established a materiality standard for determining when certain amendments to contracts should be filed.

We found that relatively little attention was given to an independent review of the financial condition of the HMO as well as the major providers and other entities under contract with the HMO. The relatively small amount of time devoted to these audits precludes any in-depth review of finances. The department's records show less than 100 hours of on-site time recorded in completing the MedCenters Health Plan review.

Quality Assurance and Complaints

The Department of Health has two responsibilities for monitoring the quality of care in HMOs: reviewing quality assurance plans and receiving complaints from enrollees.

Quality Assurance

HMOs are required under state and federal law to have a quality assurance plan in place.[3] Each HMO must have in place arrangements for an ongoing evaluation of the quality of health care, and a procedure to develop and

3 *Minn. Stat.* §62D.04, subd. 1.

report statistics regarding the cost, quality, and availability of its services. Minnesota rules further require that the plans meet the standards of the Social Security Amendments of 1972, include an ongoing peer review system, and specify a set of standards and procedures for selecting providers.[4]

The requirements for quality assurance plans were motivated by the assumption that HMOs, acting as both provider and payor, face economic incentives to under-supply health care. One reason that HMO regulation was placed in the Department of Health is its expertise in health care issues. In states where HMOs are regulated by the insurance department, quality assurance is sometimes delegated or contracted to the state health department.

We found that:

- **While the department seeks an active role in quality assurance, its activity has been limited until very recently.**

A poorly defined role and lack of staff have contributed to the department's inactivity in quality assurance.

One explanation is that its role in this area is not well defined under the state HMO Act. The department is responsible for verifying that each HMO has a quality assurance system in place, and its authority to examine HMOs' operations includes inspections or evaluations of the "quality, appropriateness and timeliness of services performed." Quality assurance mechanisms, particularly for ambulatory medicine, are at a very early stage of development, and it is not clear what the department could be expected to do.

Another obvious reason for the department's limited activity is the lack of staff available. Only one person, who joined the staff in March 1987, has been working full-time on quality assurance issues. In the examinations that have been conducted, the auditor has looked to see that the quality assurance documents are in place, but has not used that system to examine the quality of services. One of the new rule writers is now devoting some time to developing quality assurance rules. The department says that it plans to add two more staff--possibly by mid-1988--who will implement the rules which are developed.

The department is committed to expanding its role in quality assurance, and has initiated several projects. In the past year, the department has been involved in three activities with the goal of developing specific standards for HMO quality assurance plans, and bringing the activities of the department up to "state-of-the-art" level. In one activity, the "Minnesota Project," the department worked with three HMOs to assess the quality of ambulatory care. In that project, HMOs reviewed cases where an enrollee was admitted to the hospital with one of 15 diagnoses that suggest some deficiency in prehospital care. For example, the patient might have been suffering from a diabetic coma. Reviewers looked to see whether the physical examination or diagnostic tests that would be expected were performed.

Under this approach, the focus is on the small percentage of cases in which something went wrong. Designers of the tool felt that it would be useful for discovering systemic problems which may exist within an HMO or with particular providers. The screening tool is currently being used by several Min-

4 *Minn. Rules*, Part 4685.1100; 42 U.S.C. §1320(c).

nesota HMOs, and has been sold to HMOs and peer review organizations in other states.

The second study completed by the department was an analysis of quality assurance programs operating in Twin Cities HMOs. For each plan, the study assessed the following components:

- accountability/responsibility for quality assurance,
- problem identification,
- standards used to measure quality,
- data sources,
- intervention to correct deficiencies,
- grievance process,
- service elements, and
- utilization review activities.

All Twin Cities HMOs have quality assurance programs in place that meet current state requirements.

The study concluded that all Twin Cities HMOs have quality assurance programs in place that meet current state requirements. The programs are reasonably well-developed, although there is variation among HMOs. Some have gone beyond the minimum requirements, while others have just begun to implement their plans.

The department has also completed a survey of quality assurance standards from other states and from national groups, such as the national association of HMO regulators. The purpose of that survey is to aid in rule writing.

Complaints

Each HMO is required to provide a complaint resolution process for enrollees. In 1984, an amendment to the HMO Act required HMOs to advise enrollees that the Department of Health was an additional resource for seeking resolution of grievances against the HMO. However, the statute does not specify what the department should do with consumer grievances.

The department closed 292 enrollee complaints between January and November 1987.

We reviewed files for 292 complaints closed by the Department of Health between January and November of 1987. When a written complaint is received, the department sends a letter to the enrollee and a letter to the HMO to inform it of the complaint and request a response. We found the files to be well organized. They included the correspondence and additional documentation, such as invoices and medical records.

The complaints involved nine of the fourteen HMOs that were certified in Minnesota at that time. Five HMOs (Central Minnesota Group Health Plan,

First Plan, Group Care, Metropolitan Health Plan, and Mayo Health Plan) had no complaints on file for that period. Table 6.2 shows the number of complaints of each type for each HMO, and the number of complaints per 10,000 enrollees for each HMO. As the table shows, HMOs differ on the numbers of complaints by their enrollees, and on the type of complaints their enrollees most frequently make. However, the table should not be used to make comparisons among HMOs, since there may be reasons for the differences which are not related to the quality of services provided.

We grouped complaints against HMOs into seven categories. The largest category of complaints, 32 percent of the total, concerned HMOs denying coverage for certain treatments or equipment. In some cases the HMO refused coverage because it deemed the treatment to be experimental or not medically necessary. In other cases, the treatment was clearly excluded under the enrollee's contract.

About 22 percent of complaints concerned late payments by HMOs. These complaints came from enrollees who were being billed for services that the HMO should have covered, and from providers who were not paid in a timely manner for services they had rendered.

Elderly enrollees had a number of complaints about their HMOs, often because they did not understand how to use them, or because they confused the relationship between the HMO and Medicare. Other complaints in this category concerned enrollees who were disenrolled, or not disenrolled when they wanted to be, or not allowed to extend coverage after employment. These complaints made up 20 percent of the total.

The quality of care received by an enrollee, or the refusal by an HMO to refer the enrollee to outside providers, was the concern in 13 percent of complaints. Premium increases were the subject of 9 percent of all complaints, although the department does not regulate rates. Three percent of complaints concerned coordination of benefits, where the enrollee was covered under more than one health plan, but neither was paying. Complaints about access to care or providers were 2 percent of all complaints. These were generally in response to certain providers leaving a plan, or failure by the HMO to renew contracts with certain providers.

Based on our review, we concluded:

- **In handling complaints, the department appears to have acted largely as a clearinghouse, noting complaints and passing them along to HMOs.**

Few complaint files showed evidence of follow up efforts by the department.

Only about 15 percent of all cases showed evidence of independent follow-up efforts by the department beyond the form letters. About half of them were complaints concerning denial of coverage. Until recently, no record was kept of telephone follow-up, even though we were told by staff that about as much time is spent on telephone contact as on written correspondence. The department is in the process of implementing an automated complaint system, which should improve record keeping and free staff time for more follow-up activities.

TABLE 6.2

1987 COMPLAINTS AGAINST HMOs, BY TYPE OF COMPLAINT

	Subject of Complaints:							
	Denial of Coverage	Late Payments	Medicare or Enrollment	Quality of Care or Referrals	Premium Increases	Access or Coordination of Benefits	Total Complaints	Complaints per 10,000 Enrollees
Group Health Plan, Inc.	6	2	5	14	0	1	28	1.57
HMO Minnesota	6	1	4	1	5	1	18	2.70
MedCenters Health Plan	9	8	13	1	3	1	35	1.36
Physicians Health Plan	59	27	22	4	12	11	135	3.45
Share Health Plan	13	20	8	15	6	1	63	4.02
TOTAL	93	58	52	35	26	15	279	

Note: Four other HMOs had complaints; Coordinated Health Care (3 complaints), Health Partners (1 complaint), More HMO Plan (6 complaints), and NWNL Health Network (3 complaints).

Source: Program Evaluation Division review of Minnesota Department of Health HMO complaint files.

Most complaints were resolved in four to six months and about half were resolved in favor of the enrollee. Complaints of late payment by the HMO, the second largest category, were almost always resolved in favor of the enrollee.

In three serious and well-publicized cases the department challenged the HMO's assertion that certain treatments were experimental or maintenance, and therefore not covered. The department conducted extensive investigations, including soliciting opinions from outside medical experts. In these cases the HMOs were eventually required to provide the services in question.

In other cases, however, the department did not challenge the response of the HMO. In those cases, enrollees alleged that the care they received was inadequate or inappropriate, and that the HMO refused to refer them to outside providers. In all of these cases, the Department accepted the response from the HMO, which was usually that the enrollee was mistaken, and the care was appropriate.

DEPARTMENT OF COMMERCE

The Department of Commerce is generally organized on a functional basis, cutting across the traditional divisions of banking, securities, real estate, and insurance. Regulation of health plans by the Department of Commerce is carried out through several different sections.

Our review of the activities of the Department of Commerce was limited to activities specifically related to managed health care plans. A recent report by our office, *Insurance Regulation* (1986), was a broader examination of the department's activities in monitoring solvency, reviewing filings, and handling consumer complaints for all forms of insurance, including health insurance. That report concluded:

- **The department has established a reasonable system for regulating the financial condition of insurance companies operating in Minnesota.**

- **On the whole, the department is adequately reviewing insurance rates and forms.**

- **On the whole, the department investigates complaints in an efficient and timely manner. The department provided results to consumers in three out of every eight complaints we analyzed.**

That report also pointed out shortcomings in the department's use of computer systems and recommended that the department improve its ability to quickly identify companies in financial trouble.

Review of Filings

The Department of Commerce has four analysts plus one supervisor responsible for review and approval of filings for all life, health, and disability insurance policies. The analysts have developed a body of standards on loss ratios, use of cost containment tools, and other policy provisions that they use to review contracts.[5] However,

- **The department has not adopted these standards through the Minnesota Administrative Procedure Act.**

Under *Minn. Stat.* §62A.02, subd. 3, the Commissioner of Commerce is required to establish a schedule of loss ratios through administrative rulemaking. The department proposed loss ratio rules several years ago, but then withdrew the proposed rules. Nonetheless, analysts use those loss ratios in their reviews of insurance policies.

Furthermore, the department has gradually imposed limitations on the use of cost containment tools. It currently does not approve any preferred provider arrangement contract in which the differential in coverage because of a patient's failure to comply with an authorization requirement exceeds 25 percent. Thus, if the plan pays for 80 percent of hospital costs, it cannot pay less than 60 percent of hospital costs if the patient does not receive authorization.[6]

After new types of plans are approved for use, the department does not look to see how those plans are implemented. For example, insurers using PPOs are required to file a statement on their use of the PPO as a supplement to their annual report. We found only one such statement on file and general confusion over who in the department is responsible for receiving and reviewing those statements.

COOPERATION AND COORDINATION

Both the Department of Health and the Department of Commerce must review HMO combination plans.

Given the overlap in their duties, we examined how well the two agencies coordinate their work and cooperate. We found:

- **The record of cooperation between the two agencies is mixed.**

For example, both departments must review HMO combination plans since they involve insurance coverage in addition to the HMO plan. While the process may be somewhat cumbersome, we saw no evidence that it created any serious problem for HMOs or insurers. Similarly, the two departments ex-

5 "Loss ratio" refers to the proportion of each premium dollar which is later paid out in claims.

6 The department's statutory responsibility to adopt rules for loss ratios is clear. However, a recent Minnesota Court of Appeals decision supported the department's use of a case-by-case method in interpreting the general standards listed in other sections of statute, and said that rulemaking was not required. *Reserve Life Insurance v. Commissioner of Commerce*, 402 N.W.2d 634 (Minn. App. 1987).

change information about preferred provider arrangement filings, particularly when the Department of Commerce is concerned that the PPO may involve risk sharing contracts with providers.

However, other joint activities have not succeeded. For example, the Department of Commerce has never adopted rules on preferred provider arrangements. A joint group from the two departments worked on PPO rules for nearly a year, but according to some individuals in the group, could not agree on how tightly to regulate PPOs or how to divide regulatory responsibility between the two agencies.

We also observed a fundamental difference in the approach taken by the two agencies. The Department of Commerce, particularly in recent years, sees its primary regulatory role as consumer advocacy. It is not reluctant to take a public, adverse stance with insurers and other industries. The Department of Commerce sees the current financial difficulties of HMOs as a problem requiring immediate state intervention. We view the Department of Health as a more passive regulator which thinks that the current situation reflects cycles in the marketplace and that its ongoing monitoring activity and changes in statute and rule are adequate responses. The Department of Health disputes this characterization, saying that it is an assertive, vigorous regulator in this area and others.

CONCLUSIONS AND RECOMMENDATIONS

Regulatory functions for all managed health care plans should be located in one agency.

We think there are sound reasons for putting these regulatory functions in one agency. As we stated in Chapter 3, we think that HMOs and other managed care plans should be viewed as variations on one theme: health care financing systems. HMOs should be viewed as financing mechanisms for health care, just like insurance companies and health service plans. One agency, with expertise in monitoring the fiscal integrity of health plans and in protecting consumers, should regulate all health plans. This is particularly necessary at a time when several HMOs are financially unsteady and when the potential public harm from any future insolvencies is enormous.

Locating the responsibility in one agency would lead to improved accountability to the Legislature and a centralized public access point. Both agencies receive numerous complaints meant for the other agency from consumers who do not understand the current division of jurisdiction.

Consolidation of regulation would also make it easier for the industry to develop new plans. Currently, an HMO offering combination plans or other similar products must receive approval from both departments, and may even need to prepare two separate evidences of coverage, one to satisfy each department.

We recommend:

- **The Legislature should turn most regulatory responsibilities for HMOs over to the Department of Commerce.**

With limited resources, the Department of Health has done much of what the Legislature asked it to do in 1973: provide a conducive regulatory atmosphere that would allow an opportunity to see if the "HMO experiment" would succeed. The department's staff has performed in a professional manner, and in many ways, the experiment has succeeded beyond anyone's expectations. Our recommendation for change is based on our view of how the state should regulate health plans in the future, not on our view of what the Department of Health has achieved or might achieve in the future, given new resources.

As we stated in Chapter 3, we think that the state's regulatory role should be to ensure that consumers know what they are bargaining for and to ensure that they get it. Of the two agencies now involved in health plan regulation, the Department of Commerce comes closest to taking this approach. We also think that this change makes sense because of the responsibilities the Department of Commerce has for regulating related areas, such as life and disability insurance.

Obviously, the Department of Commerce needs to make some improvements as well. We expect that the Department of Commerce would want to make full use of the expertise in the Department of Health and of its legal counsel in the Attorney General's office. Whether or not the Legislature implements our recommendation to adopt a uniform body of regulation for managed health care plans, the department needs to clarify the standards it is using for evaluating those plans. It should seek guidance from the Legislature, where needed, and should formally adopt the necessary rules under the Administrative Procedure Act.

We also observed that the department does not have a clear idea of how to review contracts between Blue Cross/Blue Shield and providers. Reviewing provider contracts is an important part of HMO regulation, and the department will need to make improvements in that area.

The Department of Health is best qualified to monitor quality assurance activities.

While the Department of Health has done little until now in the area of monitoring quality of care and patient satisfaction in HMOs, its recent involvement indicates that it can do a credible job, given adequate staff. We think that the department is still best qualified to perform whatever the Legislature decides should be the state's role in this area.

We recommend:

- **That the Department of Health assume responsibilities for quality assurance activities for all managed health care plans.**

To the extent health plans are required to maintain quality assurance and complaint resolution mechanisms, the Department of Health should review those activities. Furthermore, the department should maintain a staff of qualified individuals who would arbitrate disputes between enrollees and their plans about the quality of care received or the necessity for certain services. Complaint investigators at the Department of Commerce would benefit by having such expertise readily available and could refer relevant questions and cases to those people.

This split of responsibilities is followed in many other states. Clearly, the agencies would need to develop protocols for addressing certain issues that have aspects of both quality assurance and contract compliance.

The Department of Health may also be the logical agency to perform other functions. For example, we expect that managed health care plans would have to demonstrate to a state regulator that they have the appropriate number and type of providers in each geographic area that they will serve.

TECHNICAL NOTES ON EMPLOYER SURVEY

Appendix

Sample Selection

We drew our sample of Minnesota employers from the Dun and Bradstreet Electronic Yellow Pages (EYP) data base. The EYP is a computerized data base with records indexed on industrial classification, firm size, location, and other indicators. Private firms, non-profit organizations, and government are all included in the data base.

We chose a sample size of 1,000, large enough to ensure receiving a meaningful number of responses even if the response rate was not large. We used a stratified random sample design because of the different numbers of firms in each size group. The firms were divided into five groups based on number of employees, and the sample was selected to reflect the number of firms of each size in each industry. The sampling rates for each size group were:

	Rate	N	n
10 - 49 employees	2%	30,301	600
50 - 99 employees	5%	3,029	154
100 - 499 employees	6%	2,589	149
500 - 999 employees	17%	294	50
1000 or more employees	15%	321	51

Because our initial random sample of 1,000 firms included a number that were not usable because they were either duplicates or branches of larger firms, we drew a replacement sample of 35 firms. After eliminating a few more firms for various reasons, our final sample size was 988.

Data Collection

Before sending the survey to employers, we asked several experts to review and comment on our questionaire. The reviewers were John Klein and Marianne Miller, Minnesota Department of Health; Pat Drury, Minnesota Coalition on Health; Mark Anderson, Minnesota Chamber of Commerce and Industry; and Bryan Dowd, University of Minnesota Center for Health Services Research. In order to compare our results with data from earlier years, several questions were drawn from a 1985 survey conducted by the University and the Department of Health. The comments and suggestions of each reviewer were very helpful, and were incorporated into the final version of our questionaire. However, we retain all responsibility for the survey.

In the first week of September 1987 we mailed the survey along with a cover letter (included in this appendix) explaining our purpose. A follow up letter and copy of the survey went to firms that had not responded after about two weeks. As of November 1, 1987 we had received 435 usable responses, for a response rate of 44 percent.

Weighting

We found that the number of employees reported by respondents was often different from that listed in the data base. In particular, we received many responses from firms that reported fewer than 10 employees. Eventually, all responses were weighted on their self-reported number of employees. Weighting was necessary because we sampled firm-size categories disproportionately, and we wanted to be able to make population estimates. Each size category was weighted by the actual number of firms in that category, as reported by the Department of Jobs and Training (DJT). DJT reports quarterly on the number of Minnesota firms covered under the state's unemployment compensation law. The department estimates that approximately 97 percent of total state non-agriculture wage and salary employment is included in its listings.

In addition to weighting responses by firm size, we calculated weights for number of employees. Data on employment in each firm-size category is also provided by DJT. Population estimates in this report which refer to number of firms are therefore based on the first set of weights, while estimates of numbers of employees are based on the second set.

The weights themselves are simply proportions. For example, each response from a firm with less than 10 employees represents 914 other firms. Each employee of a firm with more than 1,000 employees represents 3 others. The calculation for the weights is:

$$\text{Weight} = \frac{\text{Actual Number of Firms or Employees}}{\text{Sample Number of Firms or Employees}}$$

The weights we used were:

Firms with	Weights for Firms	Weights for Employees
Less than 10 employees	68,549/75 = 913.99	241,392/ 382 = 631.92
10 - 19 employees	13,646/78 = 174.95	183,346/ 1,074 = 170.71
20 - 49 employees	996/77 = 116.83	274,406/ 2,433 = 112.79
50 - 99 employees	3,473/58 = 59.88	238,677/ 4,097 = 58.26
100 - 499 employees	2,591/94 = 27.56	493,104/19,162 = 25.73
500 - 999 employees	210/28 = 7.50	144,099/18,218 = 7.91
1,000 + employees	118/25 = 4.72	276,461/97,597 = 2.83

Based on our sample size of 435, population estimates can be made at the 95 percent confidence level, with a 5 percent error. That is, if our results show that 10 percent of all Minnesota firms self-insure health benefits, we can predict that the actual percentage is between 5 and 15. Further, if we drew 100 random samples, the percentage of self-insurers would be between 5 and 15 in 95 of the samples.

Description of Respondent Firms

The following table displays descriptive information about the firms that responded to our survey. As the table shows, the majority of respondents were located in the seven-county metro area. This was especially true for medium and large firms.

Most firms of all sizes listed their business as services or manufacturing, with more small firms in the services industry, and more large firms in manufacturing.

	Small Firms	Medium Firms	Large Firms
LOCATION			
Metro area	56.5%	62.5%	67.2%
Non-metro area	43.5	37.5	32.8
BUSINESS			
Trade	18.7%	11.8%	7.5%
Construction	7.4	6.6	0.0
Transportation	2.6	1.3	0.0
Mining	0.0	0.0	1.9
Services	39.1	37.5	24.5
Manufacturing	17.8	35.5	49.1
Government	0.9	0.7	3.8
Agriculture	1.3	0.0	0.0
Finance, Insurance, and Real Estate	12.2	6.6	13.2
PERCENT UNION EMPLOYEES			
None	89.1%	67.1%	50.9%
1 - 25 percent	3.0	7.2	17.0
26 - 75 percent	2.2	17.1	22.6
Over 75 percent	5.7	8.6	5.7
PERCENT FULL-TIME EMPLOYEES			
None	4.8%	0.7%	0.0%
1 -25 percent	17.0	13.8	5.7
26 - 75 percent	13.5	20.4	28.3
over 75 percent	64.3	65.1	64.2
GROUPS ELIGIBLE FOR HEALTH BENEFITS			
Family Members	89.7%	97.3%	96.2%
Retired Employees	20.0	33.8	65.4
All Part-time Employees	4.6	4.7	5.8
Some Part-time Employees	31.4	46.6	40.4

The largest group of respondents said that they had no union employees, although the proportion of unionized employees increased as firm size increased. Almost the same percentage of firms in each size category said that more than 75 percent of their employees were full-time.

We asked whether certain groups were eligible to participate in firms' health benefit plans. Almost all firms made benefits available to employees' family members. The greatest variation was in firms offering benefits to retired employees. Only 20 percent of small firms offered health benefits to retirees, while over 65 percent of large firms did so. The majority of firms of all sizes do not offer health benefits to part-time employees.

Employers' Rating of State Roles in Regulating Health Plans

As part of the employer survey described in our report, we asked employers to rate the importance of seven current or potential functions for state agencies in regulating health plans. The following table lists those functions and how they were ranked by employers of different sizes.

State Role:	Small Firms	Medium Firms	Large Firms
1. Ensure that plans are financially solvent	1	1	1
2. Ensure that plans do not engage in deceptive advertising	2	2	5
3. Respond to consumer complaints about health plans	3	3	6
4. Ensure that good-quality health care is provided	4	4	3
5. Ensure that contracts between plans and providers are fair	5	5	7
6. Provide public information on quality of care	6	6	2
7. Provide public information on health care costs	7	6	4

Note: 1 = Most Important; 7 = Least Important.

Based on our survey, employers of all sizes think that regulation of solvency is the most important role for state government. Small and medium employers emphasize the importance of consumer protection functions, such as watching for deceptive advertising and responding to complaints from consumers. These businesses were less interested in state agencies distributing information about the cost or quality of health care. Among large employers, distributing information about health care cost and quality was rated high. Consumer protection functions, on the other hand, were viewed as less important.

SELECTED PROGRAM EVALUATIONS

Board of Electricity, January 1980	80-01
Twin Cities Metropolitan Transit Commission, February 1980	80-02
Information Services Bureau, February 1980	80-03
Department of Economic Security, February 1980	80-04
Statewide Bicycle Registration Program, November 1980	80-05
State Arts Board: Individual Artists Grants Program, November 1980	80-06
Department of Human Rights, January 1981	81-01
Hospital Regulation, February 1981	81-02
Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill, February 1981	81-03
State Designer Selection Board, February 1981	81-04
Corporate Income Tax Processing, March 1981	81-05
Computer Support for Tax Processing, April 1981	81-06
State-sponsored Chemical Dependency Programs: Follow-up Study, April 1981	81-07
Construction Cost Overrun at the Minnesota Correctional Facility - Oak Park Heights, April 1981	81-08
Individual Income Tax Processing and Auditing, July 1981	81-09
State Office Space Management and Leasing, November 1981	81-10
Procurement Set-Asides, February 1982	82-01
State Timber Sales, February 1982	82-02
Department of Education Information System,* March 1982	82-03
State Purchasing, April 1982	82-04
Fire Safety in Residential Facilities for Disabled Persons, June 1982	82-05
State Mineral Leasing, June 1982	82-06
Direct Property Tax Relief Programs, February 1983	83-01
Post-Secondary Vocational Education at Minnesota's Area Vocational-Technical Institutes,* February 1983	83-02
Community Residential Programs for Mentally Retarded Persons,* February 1983	83-03
State Land Acquisition and Disposal, March 1983	83-04
The State Land Exchange Program, July 1983	83-05
Department of Human Rights: Follow-up Study, August 1983	83-06
Minnesota Braille and Sight-Saving School and Minnesota School for the Deaf,* January 1984	84-01
The Administration of Minnesota's Medical Assistance Program, March 1984	84-02
Special Education,* February 1984	84-03
Sheltered Employment Programs,* February 1984	84-04
State Human Service Block Grants, June 1984	84-05
Energy Assistance and Weatherization, January 1985	85-01
Highway Maintenance, January 1985	85-02
Metropolitan Council, January 1985	85-03
Economic Development, March 1985	85-04
Post Secondary Vocational Education: Follow-Up Study, March 1985	85-05
County State Aid Highway System, April 1985	85-06
Procurement Set-Asides: Follow-Up Study, April 1985	85-07

Insurance Regulation, January 1986	86-01
Tax Increment Financing, January 1986	86-02
Fish Management, February 1986	86-03
Deinstitutionalization of Mentally Ill People, February 1986	86-04
Deinstitutionalization of Mentally Retarded People, February 1986	86-05
Management of Public Employee Pension Funds, May 1986	86-06
Aid to Families with Dependent Children, January 1987	87-01
Water Quality Monitoring, February 1987	87-02
County Human Services, February 1987	87-03
Employment and Training Programs, March 1987	87-04
County State Aid Highway System: Follow-Up, July 1987	87-05
Minnesota State High School League, December 1987	87-06
Metropolitan Transit Planning, January 1988	88-01
Farm Interest Buydown Program, January 1988	88-02
Workers' Compensation, February 1988	88-03
Health Plan Regulation, February 1988	88-04
Trends in Education Expenditures, Forthcoming	
Issues in School District Management, Forthcoming	
Variation in Educational Curricula, Forthcoming	
Welfare Aid Coordination, Forthcoming	

Evaluation reports can be obtained free of charge from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-4708.

*These reports are also available through the U.S. Department of Education ERIC Clearinghouse.