The Basics of MinnesotaCare

A Guide for Legislators

December 1994

This guidebook provides an overview of the health care access and health care reform initiatives authorized by the MinnesotaCare Acts of 1992 through 1994.

Interested readers may wish to read the following information briefs related to MinnesotaCare: **Expanded Provider Network Requirements** by Randall Chun, December 1994; **Managed Care, Basic Concepts and Plan Performance** by Randall Chun, January 1995; **The MinnesotaCare Program** by Randall Chun, Revised July 1994.

A copy of this publication may be obtained by calling (612) 296-6753.

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Introduction

This guidebook provides an overview of the health care access and heath care reform initiatives authorized by the MinnesotaCare Acts of 1992 through 1994. The major goals of MinnesotaCare are to: (1) improve access to health care; (2) contain health care costs; and (3) maintain and improve health care quality. The guidebook summarizes the current status of major initiatives, defines commonly used terms, and highlights major issues that the legislature may need to address in the coming session.

Note on Terminology

In this guidebook the term "MinnesotaCare" refers to the entire set of diverse initiatives included in the MinnesotaCare Acts. The term is also commonly used to refer specifically to the subsidized health coverage program created by the acts; in this guidebook "MinnesotaCare Program" refers to this subsidized program, if the context does not already make this clear.

MinnesotaCare Legislation

The original MinnesotaCare Act (Laws 1992, Chapter 549) was the result of a bipartisan effort by leaders of the Minnesota House and Minnesota Senate, with assistance from the governor's office and executive branch agencies, to develop a health care access proposal. This followed the governor's veto of H.F. 2, a health care access proposal passed during the 1991 legislative session. The 1992 act was modified and expanded during the 1993 and 1994 legislative sessions (see Laws 1993, chapters 247 and 345; and Laws 1994, Chapter 625).

Overall Coordination

The Minnesota Department of Health is the state agency responsible for implementing many MinnesotaCare initiatives; that agency is also responsible for overall coordination. The Department of Commerce, Department of Human Services, and other state agencies play key roles in implementing specific MinnesotaCare initiatives. The Minnesota Health Care Commission serves as an advisory body to the Commissioner of Health, and also plays an important independent role in developing recommendations for various MinnesotaCare initiatives. The commission consists of 27 members representing health plan companies, health care providers, employers, consumers, labor unions, and state agencies. Membership on the commission is designed to balance competing interests in the health care system.

❑ Improving Access to Care

One goal of MinnesotaCare is to expand both financial and geographic access to health care. The Minnesota Health Care Commission has estimated that 8.9 percent of Minnesotans —about 400,000 persons—are uninsured at any point in time. (This is a preliminary estimate subject to revision.) MinnesotaCare attempts to reduce the number of uninsured by:

- providing subsidized coverage through the MinnesotaCare Program
- establishing a plan to achieve universal coverage by 1997
- funding health care access initiatives through a tax on health care providers
- requiring reforms in the private insurance market
- expanding geographic access to care, particularly in rural areas

The MinnesotaCare Program

The MinnesotaCare Program, administered by the Department of Human Services, provides subsidized health coverage to uninsured persons with incomes up to approximately 275 percent of the federal poverty level. The MinnesotaCare Program is intended to provide health care coverage for persons who do not have private-sector insurance coverage and who do not qualify for Medical Assistance (MA), General Assistance Medical Care (GAMC), and other government health care programs. MinnesotaCare eligibility and covered services have been expanded in stages. The program is funded by the MinnesotaCare provider tax and enrollee premium payments.

Covered services

Covered services are generally the same as those provided by the Medical Assistance program, with a number of exceptions. The most notable exception is a $10,000 annual inpatient hospital benefit limit for adults (this benefit limit does not apply to children).

Enrollee cost

Premiums for most enrollees are based upon a sliding scale and vary with family size and income. For example, a family of three with a monthly income of $500 would pay a total household premium of $8 a month for coverage. If this family's income increased to $1,500 a month, the monthly premium would increase to $57. A family of six with an income of $1,500 a month

would pay $35 a month in premiums. Premiums for children from families with incomes that are less than 150 percent of the federal poverty guidelines are not calculated using the sliding scale but are instead fixed at $48 a year per child. In addition to paying premiums, adults are also required to pay copayments for certain services.

Eligibility

Initial enrollment in MinnesotaCare was restricted to children, and families with children, with incomes that did not exceed approximately 275 percent of the federal poverty guidelines. Beginning October 1, 1994, eligibility was extended to single adults and families without children with household incomes that did not exceed 125 percent of the federal poverty guideline. Beginning October 1, 1995, the income limit for this group will be raised to the overall MinnesotaCare income limit of approximately 275 percent of the federal poverty guideline.

All enrollees must be ineligible for MA and must be permanent Minnesota residents. Most enrollees must also have been without insurance for the four months prior to application, and without access to employer subsidized insurance for 18 months. The four month uninsured and 18 month no access to subsidized coverage requirements were adopted as a means of keeping program spending within budget constraints, and in order to reduce the incentives for private employers to drop existing employee and dependent coverage.

Enrollment and state expenditures

As of November 1, 1994, 75,832 individuals were enrolled in the MinnesotaCare Program. The Department of Human Services estimates that the average monthly MinnesotaCare enrollment will be 84,296 individuals for FY 1995, and 114,104 individuals for FY 1996. Payments for medical services provided through MinnesotaCare are estimated to be $78.6 million in FY 1995, and $127.4 million in FY 1996.[1]

Universal Coverage

The 1994 MinnesotaCare Act includes a commitment in principle to universal coverage. It provides that, as of July 1, 1997, each Minnesota resident must "obtain and maintain" health coverage that meets state requirements. This requirement may be satisfied by coverage through an employer, individual coverage purchased in the private market, or coverage under a public program.

Universal coverage compared to universal access

The **universal coverage** concept described above differs from the concept of **universal access**. Under universal access, each Minnesotan would be provided the *opportunity* to buy coverage from some source at an affordable price. Under universal coverage, the law would require everyone to actually *have* health coverage. The legislature requested the Health Care Commission to make recommendations regarding enforcement of the universal coverage requirement.

Individual mandate compared to employer mandate

The universal coverage approach described above is known as an **individual mandate**. An alternative approach being discussed at the federal level and enacted in a few states is an **employer mandate**. An employer mandate requires employers to provide, and pay some percentage of the cost of, group coverage for their employees and often for the employees' dependents. An employer mandate does not by itself result in universal coverage because not everyone is an employee or a dependent of an employee. Even those who are will not all choose to be covered, due to the need to pay whatever share of the cost the employer does not pay. To achieve universal coverage, an employer mandate must be supplemented by an individual mandate.

ERISA and state power to enact an employer mandate

The **Employees Retirement Income Security Act (ERISA)** is a federal law that, among other things, prevents states from imposing an employer mandate. (See ERISA box.) Those states that have enacted an employer mandate have done so with a delayed effective date, in hopes of getting the federal ERISA law amended

to permit states to use employer mandates. Minnesota's individual mandate approach is not prohibited by ERISA.

What is ERISA?

The **Employees Retirement Income Security Act (ERISA)** is a federal law that prohibits states from enacting certain types of laws that affect health coverage provided to employees. ERISA preempts (invalidates) state laws that regulate or otherwise affect

- self-insured health plans operated by an employer or labor union
- an employer's decision whether to provide health coverage or whether to pay all or some of the cost
- an employer's decision to buy one type of health coverage rather than some other type

ERISA preemption does not apply only to self-insured health plans, but applies to all employer plans that provide health coverage.

ERISA does not preempt traditional state regulation of health plan companies; the state can regulate the health coverage available for purchase by employers but cannot regulate the employer's plan to provide coverage. This distinction does not always lead to a clear boundary between what states can and cannot do.

The universal standard benefit set

An individual mandate does not mean much without a specification of the minimum level of coverage that each person will be required to have. The 1994 MinnesotaCare Act directs the Commissioner of Health to recommend the **universal standard benefit set** that will be required; the benefit set recommended must cover "all appropriate and necessary care." The commission must also recommend five alternative cost-sharing packages, so that the universal standard benefit set can be purchased with different levels of enrollee cost-sharing. Enrollee **cost-sharing** can include enrollee-paid copayments, coinsurance, deductibles, lifetime maximum benefit limits, and similar consumer cost-sharing features. A choice of enrollee cost-sharing provisions will result in a choice of premium levels. Optional supplemental coverage to cover care not included in the universal standard benefit set will

be permitted. Supplemental coverage may be provided to certain MA enrollees with high medical needs.

The contingent nature of the state's commitment

The 1994 MinnesotaCare Act makes a commitment **in principle** to universal coverage as of July 1, 1997; further legislation is needed to implement this requirement. Specifically, the act makes universal coverage contingent upon the availability of affordable coverage. An individual mandate will require subsidies, probably based upon income, for persons who cannot afford to buy the required level of coverage. The act directs the Health Care Commission to determine how much universal coverage will require in subsidies and recommend how to obtain the necessary revenue. The subsidies required to extend coverage to all Minnesotans will depend upon the uniform standard benefit set required and the extent to which Minnesotans will need state subsidies to afford that level of coverage.

Financing MinnesotaCare

Premium subsidies for the MinnesotaCare Program, and other MinnesotaCare initiatives, are funded through the MinnesotaCare provider tax.

The health care access account

State spending required by the MinnesotaCare Acts, including the premium subsidies provided in the MinnesotaCare Program, is paid out of a separate account in the general fund called the **health care access account**. All money raised by the provider tax (described below) is deposited into this account.

The legislature and governor agreed before enactment of the 1992 MinnesotaCare Act that this act would need to provide its own funding and not use other general fund money. Funding for MinnesotaCare initiatives is therefore limited to the funds available for it in the health care access account. The legislation requires the Commissioner of Human Services to limit spending on the MinnesotaCare Program to the funds available in that account, and specifies how the commissioner is to restrict

enrollment and subsidies, if this is necessary to limit spending.

The provider tax

The health care access account is primarily funded by a new two percent tax on the gross revenues of health care providers. This tax was enacted in the 1992 MinnesotaCare Act and became effective January 1, 1993 for hospitals, and January 1, 1994 for all other providers.

Providers subject to the tax

The provider tax is imposed upon virtually all types of health care services and supplies. This includes, for instance, services by physicians, dentists, chiropractors, psychologists, chemical dependency counselors, and other licensed health care providers. The tax applies to all services provided by hospitals and surgical centers. The tax applies to medical equipment and supplies, such as wheelchairs and eyeglasses. The tax applies to prescription drugs, but is collected from drug wholesalers rather than from retailers. The tax does not apply to nursing homes and certain other providers exempted in the law.

Provider revenues that are exempt from the tax

Provider revenues received from certain sources are exempt from the tax. The major exempt category is payments made by governmental programs, such as Medicare, Medical Assistance, and the MinnesotaCare Program. Medical research expenditures may be used to reduce taxable revenues, subject to certain limits.

Pass-through of the provider tax

MinnesotaCare permits providers to pass the provider tax through to third party payers, such as health plan companies, who are required by law to reimburse the providers for the tax. As an alternative, MinnesotaCare permits providers to raise prices, treating the tax as a cost of doing business.

MinnesotaCare revenue sources other than the provider tax

Premiums paid by MinnesotaCare enrollees go into the health care access account. These premiums vary based upon the enrollee's income.

A new one percent tax on premiums received by nonprofit health plan companies will go into effect on January 1, 1996, and will go into the health care access account. Nonprofit health plan companies include health maintenance organizations (HMOs), Blue Cross and Blue Shield, Delta Dental, and the new integrated service networks (ISNs) and community integrated service networks (CISNs) discussed on pages 16-20. For-profit health plan companies, such as commercial insurance companies, already pay a two percent premium tax into the general fund; these payments are not used for MinnesotaCare.

Future financing revenues

The Department of Finance estimates that MinnesotaCare has sufficient funding through FY 1998, if the income eligibility level for single adults and families without children is not increased on October 1, 1995, as scheduled, to 275 percent of the federal poverty guidelines. (A deficit of $46.5 million is projected for FY 1999.) If the income eligibility level for this group is increased as scheduled, the Department of Finance estimates that MinnesotaCare has sufficient funding through FY 1996, but projects a deficit of $37.5 million for FY 1997 and higher deficit amounts for fiscal years 1990 and 1999.[2]

The Department of Human Services is required to present a plan to the legislature by February 1, 1995, to adjust benefits and eligibility guidelines for the MinnesotaCare Program, or take other steps, in order to ensure that the budget for MinnesotaCare initiatives remains in balance. The Minnesota Health Care Commission is required to present to the legislature by January 1, 1995, a plan for stable, long-term funding of the MinnesotaCare Program, universal coverage, and other reform initiatives.

Insurance Reform

One way to provide access to health care and reduce the number of uninsured Minnesotans is to increase the number of Minnesotans insured in the private insurance market by health plan companies. (See accompanying box.) A significant portion of the uninsured are employees, or dependents of employees, of small employers that do not provide health coverage. Some of these small employers may provide coverage if they can obtain affordable and dependable group coverage that does not involve the risks of rejection, refusal to renew, or large premium increases when an employee or dependent develops a health problem. Individuals seeking coverage on their own face some of these same problems of large premium variations and inability to get or keep coverage due to age, gender, health history, and other factors.

MinnesotaCare seeks to increase coverage in the private insurance market by requiring changes in the individual and small group segments of that market. These reforms of the small employer and individual markets went into effect July 1, 1993 and include the elements described below.

What is a health plan company?

MinnesotaCare uses the term **health plan company** to refer to the following different types of providers of health coverage:

Commercial (for-profit) insurance companies (example: Prudential)

Nonprofit health service plan corporations (example: Blue Cross and Blue Shield of Minnesota)

Health maintenance organizations (HMOs) (examples: Group Health and Medica)

Fraternal benefit societies (example: Lutheran Brotherhood)

Joint self-insurance employee health plans (none currently operating)

Integrated service networks (ISNs) (none permitted until 1996)

Community integrated service networks (CISNs) (permitted beginning January 1, 1995)

Guaranteed issue in the small employer market

MinnesotaCare requires guaranteed issue in the small employer market. **Guaranteed issue** means that an employer cannot be turned down for group coverage and that health plan companies cannot refuse to cover as part of the group any employee who works at least 20 hours per week, or any dependent of such an employee. MinnesotaCare does not require employers to include particular employees or dependents; the employer decides who is included under the group coverage. A **small employer** is defined as an employer that has between two and 29 employees who work at least 20 hours per week. On July 1, 1995, the definition will expand to include employers that have up to 49 employees. Guaranteed issue is not required in the individual market; the 1994 MinnesotaCare Act requires it effective July 1, 1997, as a component of universal coverage, but this requirement is contingent upon future legislation.

Guaranteed renewal

Guaranteed renewal requires a health plan company to offer renewal when coverage is about to expire. In the individual market, the renewal must be at a premium rate that does not reflect any health problems that developed during the coverage that is about to expire. In the small employer market, renewal premiums can reflect all health problems, but the renewal premium rates must be within the bands discussed below.

Rating bands

Guaranteed issue and guaranteed renewal would not mean much if health plan companies could discourage unwanted business by charging very high premium rates. MinnesotaCare specifies that only certain factors may be used in determining premium rates and also specifies that those permitted factors may be used only within limited ranges, called rating bands.

Rating bands are the permitted premium variations, expressed as plus or minus a specified percentage of the midpoint of the highest and lowest premium rates charged for that product. MinnesotaCare permits health plan companies to use health status, claims experience, industry, and duration of coverage to determine premium rates in the small employer market, but the total variations based upon those variables must not exceed plus or minus 25 percent of the midpoint of the rating

band. An additional plus or minus 50 percent premium variation is permitted to reflect age differences. No variation is permitted for gender. Health plan companies may have up to three separate rating bands to reflect geographical differences in health care costs. The rating bands in the individual market are identical to those just described for the small employer market, except that, effective January 1, 1995, occupation is substituted for industry, and duration of coverage is not a permitted factor. Rating bands can be viewed as a movement in the direction of **community rating**, described below.

Regulation of preexisting condition limitations and portability

Health plan companies have traditionally used **preexisting condition limitations**, under which coverage is excluded for health conditions that already exist when coverage of a person by that health plan company begins. MinnesotaCare provides that such a limitation must not exceed one year and must provide credit against that time period for time spent under previous public or private health coverage, if the person maintained continuous coverage. This requirement that credit be given for previous coverage is known as **portability**, because it permits a person to move from one plan to another, without facing a new preexisting condition limitation. The period of exclusion may be longer if the person is a **late entrant**, which is a person who chooses to enter group coverage after the person's initial eligibility date, without an appropriate reason.

Minimum loss ratios

A **loss ratio** is the percentage of premium payments that the health plan company pays out for health care. The portion of premium payments not spent on health care is used for administrative expenses, marketing, agent commissions, taxes, assessments, and profits.

MinnesotaCare sets minimum loss ratios at 65 percent in the individual market and 75 percent in the small employer market. This means that at least those percentages of premiums must be used to pay for health care. To meet the requirement, a health plan company may have to reduce premiums, increase payments for health care, or reduce payments for things other than health care. The loss ratios are scheduled to increase by one percentage point per year for seven years.

Future commitment to community rating

Community rating means that premium rates offered by a health plan company are the same for everyone, regardless of age, health status, or other factors. MinnesotaCare includes a conditional commitment to require community rating effective July 1, 1997. The rating bands would be gradually compressed until then. The state's commitment is conditional upon finding a financing source to pay for universal coverage as of the same date, and the effective date is left to be specified in future legislation.

Insurance reform and universal coverage

MinnesotaCare links the final stages of insurance reform to universal coverage. Guaranteed issue in the individual market, with no preexisting condition limitations permitted, is viewed as impractical without universal coverage: many people would wait to buy coverage until the moment they need health care. Full community rating without universal coverage is also viewed as impractical: under community rating, some groups such as healthy young males would be charged premium rates far higher than their own expected health care costs and would therefore tend not to buy coverage without an individual mandate under universal coverage. If healthy people drop or do not buy coverage, the average premium will increase, since the persons buying coverage will be less healthy on average. This will lead to even fewer healthy people voluntarily buying coverage, leading to yet further premium increases, and so on.

Geographic Access to Health Care

Improved financial access to health care, through lower private market premium rates or subsidized premiums through the MinnesotaCare Program, is not sufficient to ensure that the needed health care services are actually received. Patients must also have geographic access to appropriate health care providers. Some studies have shown that residents in rural areas of Minnesota, and persons receiving health care through Medical Assistance (Minnesota's Medicaid program), have problems with geographic access to health care providers.[3] MinnesotaCare includes a number of initiatives to improve access for these groups.

Rural health initiatives

MinnesotaCare includes several general rural health initiatives designed to improve access to health care providers and health care services. These include:

- expanding grant programs for rural hospitals
- creating an Office of Rural Health within the Department of Health and a rural health advisory committee
- directing the Department of Health to establish a data base on rural health personnel
- authorizing a program to establish community health centers in rural areas of Minnesota that are medically underserved

Increasing the number of rural providers

MinnesotaCare has also funded initiatives specifically designed to increase the number of health care professionals serving in rural areas of the state. These include:

- expanding the size of an existing loan forgiveness program for physicians who practice in rural areas of the state
- establishing new loan forgiveness programs for nurses who practice in nursing homes and midlevel practitioners who practice in rural areas (MinnesotaCare law defines **midlevel practitioner** as a nurse practitioner, nurse-midwife, nurse

anesthetist, advanced clinical nurse specialist, or physician assistant.)

- funding University of Minnesota Medical School initiatives to increase the number of medical school graduates who choose careers in primary care or who choose to serve in rural areas of Minnesota that are medically underserved

- funding initiatives to establish midlevel practitioner educational programs in Minnesota

- providing grants to establish continuing education programs for nurses serving in rural areas of the state.

Participation in state health care programs

MinnesotaCare attempts to ensure that an adequate number of providers participate in state-administered health care programs for low-income persons. The 1992 Act required health care providers to serve MinnesotaCare, Medical Assistance, and General Assistance Medical Care enrollees as a condition of serving enrollees in state-related health care programs that are not limited to persons with low incomes, such as workers' compensation, state employee health plans, and the Minnesota Comprehensive Health Association, the state required risk pool.

The 1992 Act also attempted to increase provider participation by increasing Medical Assistance and General Assistance Medical Care reimbursement for outpatient hospital services, and physician and dental services, by 15 to 32 percent, depending on the type of service.

Health care cooperatives

The 1994 MinnesotaCare Act permits and regulates two types of health care cooperatives. The goal is to provide an alternative structure through which health care providers can join together to provide and market their services, particularly in rural areas. A **health provider cooperative** would market the services of its members (providers) to prospective purchasers, such as health plan companies, on a capitated basis (see page 18 for an explanation of capitation). A **health care network cooperative** would directly provide health care services to enrollees, who would be the members of the

cooperative. The main difference between the two types of cooperatives is that the provider cooperatives would be provider-owned and would not contract directly with patients, while the health care network cooperative would be enrollee-owned, would contract directly with enrollees, and would be a new way of structuring a health plan company.

❑ Cost Containment

In addition to expanding access to care, MinnesotaCare has a second goal of preventing rapid increases in health care costs, which could jeopardize the success of the efforts to expand access.

Health care spending in Minnesota for major services increased by an average of 10.5 percent per year between 1980 and 1991.[4] This rate of increase is equal to that for the nation as a whole during that time period and considerably greater than the average annual rate of increase in the consumer price index for the Twin Cities of 4.7 percent.

The high rate of growth in health care spending led state policymakers to conclude that Minnesota's reliance on a competitive health care market is by itself not sufficient to contain health care costs. Policymakers were concerned that a continuation of this high rate of growth would threaten the success of any effort to provide Minnesotans with greater financial access to health care, both by making private market insurance premiums unaffordable and by increasing the cost of any state-subsidized insurance program. The 1992 MinnesotaCare Act required the Health Care Commission to propose a plan to reduce the rate of growth in health care spending in Minnesota by ten percent a year over the next five years. The 1993 Legislature enacted the major components of the commission's plan. These cost containment initiatives include:

- setting annual limits on the rate of increase in health care spending
- encouraging the use of managed care through development of integrated networks
- establishing a regulated all-payer option to control costs in the fee-for-service sector
- authorizing cost containment measures to address specific problems within the health care system

Growth Limits

One cost containment initiative is growth limits that apply to health care providers and health plan companies.

Statutory limits

During the 1993 session, the legislature adopted the following specific limits on overall health care spending:

1994: Change in Consumer Price Index (CPI) plus 6.5 percentage points (9.4 percent actual)
1995: CPI plus 5.3 percentage points
1996: CPI plus 4.3 percentage points
1997: CPI plus 3.4 percentage points
1998: CPI plus 2.6 percentage points

These limits were designed to be consistent with achieving the overall MinnesotaCare goal of reducing the rate of growth of health care spending by ten percent a year. The limits are used in several specific contexts, described immediately below and on pages 20 and 23.

Limits for providers and health plan companies

MinnesotaCare establishes expenditure growth limits for health plan companies and revenue growth limits for health care providers for calendar years 1994 through 1997. These limits must be identical to the growth limits on overall health care spending specified above.

Monitoring and enforcing compliance

The Commissioner of Health is required to monitor statewide and regional compliance with these limits, and to take action to achieve compliance with the limits. Health plan companies and health care providers are required to submit financial data necessary for the commissioner to monitor and enforce compliance with the limits.

Integrated Service Networks

The 1992 MinnesotaCare Act directed the Health Care Commission to recommend to the legislature a strategy for reducing the rate of increase in total health care spending—public and private—in Minnesota. The centerpiece of the commission's response was a recommendation that the state permit, and promote the growth of, a new type of health plan company—the integrated service network (ISN). The 1993 MinnesotaCare Act adopted this approach to cost containment. Under the 1994 MinnesotaCare Act, ISNs will be permitted to begin operating on July 1, 1996.

The concept of integrated service networks

An **integrated service network** is a nonprofit organization that agrees to provide health care to an enrollee in exchange for a fixed charge per month or other time period. An ISN therefore functions as both the provider of health care and as the insurer. The ISN acts as an insurer because the risk of needing to pay for the enrollee's health care is transferred from the enrollee to the ISN, in exchange for a fixed payment by or on behalf of the enrollee. The ISN as a provider of care has an incentive to manage the care provided, to keep average spending per enrollee below the fixed payment amount, and to keep premiums low enough to be competitive with other ISNs.

Managed Care

ISNs will likely operate as a new type of managed care plan. The term **managed care** refers to methods of health care delivery and financing that control and coordinate the services provided to patients, in order to eliminate unnecessary and inappropriate care. **Managed care plans** are systems that integrate the financing and delivery of health care services, through the use of: (1) a network of selected providers to furnish health care services to members; (2) explicit standards for choosing these network providers; (3) formal programs of quality assurance and utilization review; and (4) financial incentives for members to use network providers.

Existing managed care plans

Prior to MinnesotaCare legislation, managed care was typically associated with preferred provider organizations (PPOs) and health maintenance organizations (HMOs).

Preferred provider organizations (PPOs) contract with insurers or employers to provide health care services to members of a group, using a provider network. Generally, enrollees can use providers not in the PPO network, but are then subject to higher cost-sharing requirements (See page 4). PPO providers usually agree to discount their charges and comply with utilization review requirements in return for prompt payment and potentially higher patient volume.

Health maintenance organizations (HMOs) combine the functions of insurer and health care provider. HMOs employ or contract with a provider network to provide comprehensive health care services to enrollees, in exchange for a fixed (capitated) payment per enrollee. Enrollees are usually limited to providers in the HMO's network, and are subject to little or no cost-sharing. Open ended HMOs allow enrollees to use out-of-network providers, in exchange for higher enrollee cost-sharing.

Arrangements between ISNs and providers

An ISN may, but need not, own or employ the providers that it uses to fulfill its obligations. For instance, an ISN may own hospitals and employ physicians and other health care professionals. Alternatively, the ISN may contract with hospitals and health care professionals to provide services. These contracts between an ISN and its providers may be on a **capitated** or **fee-for-service** basis. **Capitation** means that the provider receives from the ISN a fixed fee per enrollee (**per capita**) per time period. Capitation transfers risk from the ISN to the providers, who must provide all care needed by each enrollee. A **fee-for-service** arrangement means that the ISN pays providers for each service they provide to enrollees. MinnesotaCare does not require that providers be capitated by ISNs—only that the amount that enrollees pay to the ISNs be capitated. The general approach is to require only that the ISN receive a fixed payment from the enrollee and then permit the ISN to determine the most efficient way of operating its network in order to successfully compete with other ISNs.

Except for hospitals owned by an ISN or health professionals who are ISN employees, an ISN will not be allowed to require that providers serve only that ISN's enrollees. For instance, a provider could serve the enrollees of three ISNs and also serve other patients in the regulated all-payer system option.

Expanded Provider Networks

The 1994 MinnesotaCare Act requires certain health plan companies to establish expanded networks of allied independent health care providers, and to offer enrollees the option of receiving care through these expanded networks. **Allied independent health care provider** is defined in the law to include many types of non-physician providers, including chiropractors, advanced

practice nurses, optometrists, pharmacists, various mental health professionals, and various therapy professionals.

The expanded network requirement is a form of **any willing provider** legislation (legislation that requires a managed care plan to accept into its network any provider willing to agree to contract terms). Any willing provider legislation is intended to address the concern that the use of provider networks by health plan companies can restrict enrollee choice of provider and financially penalize those providers not accepted into a network.

The expanded provider network requirement applies to health plan companies that: (1) have more than 50,000 enrollees; (2) use a provider network that includes allied independent health care providers; (3) do not operate as staff model health plan companies by employing rather than contracting with providers; and (4) are not otherwise exempted by the law.

The provision requires non-exempt health plan companies to establish an expanded provider network and accept into this network any allied independent health care provider who meets the health plan company's credentialing standards, agrees to contract terms, and agrees to comply with managed care protocols. Health plan companies must offer enrollees the option of receiving care through this expanded network. The expanded network option may be offered with separate premium rates and cost-sharing requirements, as long as these rates and requirements are actuarially justified and approved by the Commissioner of Health.

Community integrated service networks

The 1994 MinnesotaCare Act permits a smaller variant on the ISN—the community integrated service network (CISN). The CISN is limited to 50,000 or fewer enrollees and may start operating January 1, 1995, 18 months before ISNs will be allowed to start. This may permit groups of local providers to get a head start on the larger ISNs and result in more local control of the new health care delivery system created by MinnesotaCare. CISNs will operate under HMO laws, with some exceptions. CISNs are not subject to the expanded provider network requirement. At least 51

percent of a CISN's board members must be residents of the service area; the HMO requirement that at least 40 percent be consumers also applies.

Financial solvency of ISNs and CISNs

Financial solvency requirements for health plan companies generally involve some minimum level of financial strength in the form of cash, investments, or financial guarantees from some other financially strong organization. High solvency requirements reduce the likelihood of insolvency, and thereby provide greater protection to enrollees and providers. The disadvantage of high solvency requirements is that they make it harder to start a health plan company and may in effect require dependence on a financially strong entity that can provide financial guarantees.

The solvency requirements for ISNs have not yet been specified; recommendations to the legislature are due January 1, 1996.

The solvency requirements for CISNs are lower than those for HMOs and are phased in. Under some circumstances, CISNs can receive credit against the requirements reflecting risk they have shifted to financially responsible providers, known as **accredited capitated providers**.

How growth limits will apply to ISNs and CISNs

ISNs are subject to the growth limits on expenditures explained on page 16. ISNs will be required to comply with the limits, but will not be "micro-managed" regarding the method by which they contain costs. For instance, the state will not set the fees paid by ISNs to providers, as will occur in the regulated all-payer option described on pages 21–23.

Regulated All-payer Option

The 1994 MinnesotaCare Act established the framework for a **regulated all-payer option** (RAPO). The RAPO will function as an all-payer system—i.e., it will require the government, health plan companies, and other payers to pay health care providers at the same state-established rate, and will require these payers and health care providers to operate under uniform rules. The all-payer option will govern the provision of all health care services provided outside of the integrated service network system, and will offer health care providers and consumers a fee-for-service alternative to that system.

The Commissioner of Health must present recommendations to the legislature by January 1, 1995 on RAPO requirements and reimbursement methods. RAPO will be phased in beginning January 1, 1996, or when rules are adopted, whichever is later. RAPO must be fully implemented by July 1, 1997. Beginning on that date, all health plan companies must provide health coverage either as integrated service networks or as indemnity insurers operating under the all-payer option. Preferred provider organizations (see p. 17) will be allowed to operate until January 1, 1998.

Scope of the all-payer option

RAPO requirements and reimbursement rates will apply to health care services delivered outside of the integrated network system, and to out-of-network services provided by integrated networks. Health plan companies are required to pay Minnesota health care providers at the all-payer rate for these services; out of state health care providers must be paid for nonemergency health care services at the all-payer rate.

Minnesota health care providers are required to accept payment at the all-payer level as payment in full for patients who are Minnesota residents or are non-residents covered by a health plan company. Minnesota providers may charge non-residents not covered by a Minnesota health plan company a higher rate than that set by RAPO. Out of state health care providers will be allowed to balance bill Minnesota residents and patients covered by Minnesota health plan companies. **Balance billing** means the provider can collect from a patient the difference between the RAPO reimbursement rate and the provider's charges.

The Medicare, Medical Assistance, General Assistance Medical Care, MinnesotaCare, and worker's compensation programs are exempt from RAPO.

Covered services

Services covered under RAPO will be those in the universal standard benefit set, along with supplemental coverage allowed by law.

Provider reimbursement

RAPO will use a variety of reimbursement systems to pay health care providers. The reimbursement rates will be the same for all areas of the state. MinnesotaCare requires increases in reimbursement rates to be consistent with the limits on overall health care spending.

Physicians and other independent providers

Physicians and other providers with independent billing rights will be reimbursed using a Minnesota-specific fee schedule that is based upon the Medicare **resource based relative value scale (RBRVS)**. The Medicare RBRVS ties payment rates for a health care service to the level of resources used to provide that service. Each service is assigned a relative value that reflects physician time and intensity, practice expenses, malpractice expenses, and other variables. The relative value is then multiplied by a monetary conversion factor that converts the relative value into a payment amount for the service. The 1994 MinnesotaCare Act requires this conversion factor to be set at a level that is consistent with relevant health care spending, subject to the growth limits. The conversion factor must equalize total expenditures for the periods before and after implementation of the all-payer system.

The Commissioner of Health must recommend to the legislature by January 1, 1995, which health care professionals are to be paid at the full fee schedule rate and which at a lower rate. The commissioner must also report on options for determining the payment for services that are not part of the fee schedule.

Hospitals

Most hospitals will be reimbursed under a Minnesota-specific **diagnosis related groups (DRG)** system. DRG systems pay hospitals a fixed payment for each medical diagnosis. This payment rate usually does not vary with length of stay (there are usually some exceptions for long

lengths of stay). Payments rates under the DRG system must be consistent with the overall limit for health care spending.

Volume performance standard

RAPO's regulation of fees would not be effective in containing costs if providers were permitted to compensate by increasing the volume of services they provide. MinnesotaCare therefore establishes a **volume performance standard** for physician and outpatient services and another volume performance standard for inpatient hospital services. The volume performance standards will serve as expenditure targets for health care spending in those sectors; these targets will be set at levels consistent with the growth limits on health care spending. If spending for physician and outpatient services or inpatient hospital services during a particular year exceeds the expenditure target, the commissioner will reduce the reimbursement rate for a future year to offset the amount overspent.

Other health care providers

The 1994 MinnesotaCare Act also sets general reimbursement guidelines for other types of health care providers and institutions. Geographically isolated rural hospitals with 40 or fewer beds will be reimbursed on the basis of reasonable charges, subject to rate of increase controls. Hospital outpatient services and freestanding ambulatory surgical centers will be reimbursed on the basis of approved charges, subject to rate of increase controls. Nonhospital institutional providers will be subject to rate of increase limits. The commissioner must submit recommendations for paying specialty hospitals providing pediatric and psychiatric care, and distinct psychiatric and rehabilitation units in hospitals, by January 1, 1995.

Miscellaneous Cost Containment Measures

The MinnesotaCare Acts include several other cost containment initiatives.

Expenditure reporting and review

MinnesotaCare requires health care providers to report to the Commissioner of Health all capital expenditures and major spending commitments over $500,000 made after April 1, 1992. The commissioner, in consultation with the Health Care Commission, must retrospectively review these capital expenditures and major spending commitments, and evaluate statewide and regional progress toward cost containment and other state goals. The commissioner can conduct prospective review of proposed expenditures under limited conditions.

Prohibiting conflicts of interest

Some providers have been criticized for referring patients for tests and other services to facilities owned by the referring provider or with which the referring provider has a kickback arrangement. MinnesotaCare directs the Commissioner of Health to adopt rules restricting financial relationships or payment arrangements among related health care providers. These rules must be compatible with the federal Medicare anti-kickback statutes and related regulations. The rules may also be more restrictive than the federal law and apply to additional provider groups and business and professional arrangements. For the period between July 1, 1992 and the date upon which the rules become effective, MinnesotaCare applies the Medicare statutes and rules to all health care providers in Minnesota, regardless of whether the patient involved is a Medicare patient.

Restrictions on balance billing of Medicare patients

MinnesotaCare phases in limits on Medicare balance billing over the five year period beginning January 1, 1993. **Medicare balance billing** occurs when a provider charges a Medicare beneficiary an amount above the Medicare approved amount for a health care service covered by Medicare. The beneficiary is then responsible for any Medicare deductible, a copayment of 20 percent of the Medicare approved amount, and any amount charged above the approved amount. If a

physician does not balance bill, this is referred to as **accepting assignment**.

Beginning January 1, 1994, MinnesotaCare prohibits a health care provider from charging for a Medicare beneficiary who is a Minnesota resident any amount above 110 percent of the Medicare approved amount. This allowed percentage for balanced billing decreases by five percentage points each year, with no balance billing allowed (i.e. assignment required) beginning January 1, 1996. Ambulance services are exempted from limits on Medicare balance billing.

Antitrust exemptions

MinnesotaCare has established a process for health care providers and purchasers to seek antitrust exemptions from the Commissioner of Health for mergers and other cooperative arrangements. Approval of a request for an exemption provides a defense against state and federal antitrust laws. In order to obtain approval, applicants must demonstrate to the commissioner that a cooperative arrangement will result in lower health care costs, or greater access to or quality of health care, than would occur in the competitive market. Cooperative arrangements that are approved must report data on cost, access, and quality at least annually. The commissioner must review this data, as part of the commissioner's ongoing supervision and monitoring of the cooperative arrangement. This active supervision by the state is one of the criteria for a "state action exemption" from federal antitrust laws.

Limitations on mergers

The 1994 MinnesotaCare Act prohibits health plan companies with enrollments of more than five percent of the state's total number of insured persons, or more than ten percent of the seven-county metropolitan area's insured persons, from merging with or acquiring any other health plan company. This restriction expires July 1, 1996.

Administrative uniformity

MinnesotaCare establishes requirements for the use of uniform claim and billing forms and uniform electronic billing formats. MinnesotaCare creates the Minnesota Center for Health Care Electronic Data Interchange, comprised of public and private organizations

representing group purchasers, health care providers, and government programs. The center will carry out various duties related to coordinating and expanding the use of electronic data interchange in the state.

Beginning January 1, 1996, all health care providers, both institutional and non-institutional, must use the uniform billing form specified by MinnesotaCare, when an electronic billing format is not used. MinnesotaCare also sets the dates by which specified electronic transaction sets for claim payment and submission, enrollment information, and eligibility information must be used. These requirements will apply July 1, 1995 for larger group purchasers and health care providers and July 1, 1996 for smaller group purchasers and health care providers. Standard electronic billing and claims formats will apply to pharmacies beginning January 1, 1996. MinnesotaCare also sets requirements for unique identification numbers for health care providers, group purchasers, and patients.

❑ Quality of Care

MinnesotaCare attempts to maintain and improve the quality of care in the state, both as a goal in itself and also as a means of reducing health care costs by eliminating the performance of unnecessary health care procedures. MinnesotaCare attempts to accomplish this through

- collecting data on health care outcomes
- providing a process for technology evaluation
- increasing the use of practice parameters

Data Collection

MinnesotaCare cost containment and health care quality initiatives rely heavily on the collection of data from health plan companies, health care providers, and patients.

MinnesotaCare established a public/private Data Institute to assist the Commissioner of Health in developing and administering data collection procedures. The institute is governed by a 20 member board representing hospitals, health plan companies, consumers, employers, health care providers, health care researchers, and state agencies. The institute is directed to contract with a private vendor to collect data from claims forms, medical records, and patient surveys to verify the consistency and accuracy of data, and to merge data collected from different sources.

This data will be provided to the Department of Health for analysis. Reports and data will be made available to purchasers, providers, consumers, and researchers, with appropriate protections to ensure data privacy.

Data will be collected from providers for specific health conditions that account for significant total health care costs, when both the frequency of a condition and the unit cost of treatment are considered. Health care outcomes will be measured by variables such as mortality, morbidity, patient functional status and quality of life, symptoms, and patient satisfaction. The data will

be collected in a form that allows comparisons to be made between providers, health plan companies, and public programs, with adjustments for differences in the severity of patient health condition across providers.

Consumer information and report cards

MinnesotaCare attempts to increase the information on quality of care provided by health care providers and health plan companies that is available to consumers. An information clearinghouse, established within the Department of Health, will provide consumers, purchasers, and other parties with information on health care costs and quality. The information to be available will include health plan company quality report cards and data on hospital quality. An office of consumer information will serve as a resource center for health plan enrollees and provide information to enrollees on enrollee rights, complaint procedures, coverage options, and the availability of purchasing pools and enrollee subsidies.

Action plans

All health plan companies are required to file action plans annually with the appropriate commissioner and with the information clearinghouse, beginning July 1, 1994. Action plans are intended to provide consumers, purchasers, and other interested parties with information about a health plan company's policies and goals relating to provider network participation, number of providers, provider recruitment and network size, use of report card and other information to improve quality, enrolling and serving high risk populations, and providing care to areas not currently served.

Practice parameters

The Data Analysis unit within the Department of Health is authorized to develop new practice parameters, refine existing practice parameters, and encourage or coordinate private sector efforts designed to develop or refine practice parameters. A **practice parameter** is a statement intended to guide the clinical decision making of providers and patients. The legislation requires that the practice parameters used for analysis be either supported by the results of appropriately designed outcomes research studies or adopted for use by a national medical society. A practice parameter advisory committee will provide recommendations on the adoption

of practice parameters, and technical assistance, to the Commissioner of Health and the Health Care Commission.

The unit will provide health care providers with information on practice parameters for specific health conditions, but will not require the use of the practice parameters. It is hoped that the dissemination of information on practice parameters will lead to appropriate changes in practice style. The unit does, however, have the authority to require peer review by the Minnesota Medical Association, Minnesota Chiropractic Association, or the appropriate health care licensing board for specific health conditions, when practice in all or part of the state deviates from practice parameters, or when there are large variations in treatment method or frequency of treatment. Practitioners who do not change their practice style, even after educational efforts by a peer review panel, may be reported to the appropriate professional licensing board.

Malpractice defense

MinnesotaCare allows the Commissioner of Health to approve practice parameters for use as a defense in malpractice lawsuits. MinnesotaCare provides that adherence to a practice parameter approved by the Commissioner of Health is an absolute defense against allegations that a provider did not comply with accepted standards of practice in the community. This defense applies to lawsuits brought against a provider on or after August 1, 1993, or 90 days after the date the commissioner approves the applicable practice parameter. Evidence of departure from a practice parameter is admissible only on the issue of whether the provider is entitled to an absolute defense against a charge that the community standard was not complied with and may not be used as positive evidence of malpractice.

Health technology evaluation

MinnesotaCare established the Health Technology Advisory Committee (HTAC) to review existing evaluations of health care procedures and technologies, and to make recommendations on the use of these procedures and technologies to the Health Care Commission. The commission is directed to forward this report, with its comments, to the Commissioner of Health and the information clearinghouse. The

recommendations are intended to guide consumers, purchasers, and health plan companies in their decisions, not to eliminate or bar new technology. HTAC completed its first report in April 1994, and plans to complete between six to eight assessments a year.

Endnotes

1. MinnesotaCare statistics are from: DHS MinnesotaCare Program, "Enrollment Reform Sheet", November 2, 1994 and Department of Human Services, "Minnesota Family Self-Sufficiency and Medical Entitlement Programs and Related Programs, Original Projections for the FY 1996-19978 Biennium, November 1994 Forecasts" December 6, 1994 ("numbers only" version of forecast document).

2. These figures are based on Department of Finance MinnesotaCare fund balance reports for December 1994. Estimates of the MinnesotaCare fund balance are updated quarterly.

3. These access problems are noted in Minnesota Department of Health, **Providing Medical Care in Rural Minnesota: Recommendations for Meeting Personnel Needs**, March 1991 and Office of the Legislative Auditor, State of Minnesota, **Access to Medicaid Services**, February 1989.

4.This estimate is based on growth in expenditures for hospital care, physician service, and prescription drugs, as reported in Katharine R.Levit et. al. "Health Care Spending by State: New Estimates for Policy Making" **Health Affairs** Fall 1993, vol. 12, no. 3 pp. 7-26. The average annual increase for the consumer price index (Twin Cities) was calculated from figures provided in U. S. Congress, Office of Technology Assessment, **Managed Care and Competitive Health Care Markets: The Twin Cities Experience**, July 1994, p. 11.