Minnesota Health Care Commission

Report

January 1997

Evolution of Minnesota's Health Care Delivery System

The mission of the Minnesota Health Care Commission is to help Minnesota communities, providers, group purchasers, employers, employees, and consumers improve the affordability, quality, and accessibility of health care.

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Table of Contents

Foreword

Minnesota's health care market has been rapidly changing in response to a number of influences and trends, many of which began a number of years ago, but which are now more visible or influential. In many cases, these changes have been controversial, drawing both praise and criticism, and have been viewed variously as evidence of positive accomplishments or sources of concern.

Changes in the health care market have resulted in a strange paradox. Enrollment in managed care in the state is at an all-time high and growing. Overall satisfaction with managed care as measured by the 1995 Minnesota Health Data Institute survey is higher than with traditional fee-for-service insurance. After decades of inflationary pressure, rising health care costs have moderated in recent years. Despite these accomplishments, concerns and adverse publicity about the perceived threats or failures attributed to managed care are widespread. Other market developments or proposals are also raising apprehensions.

The Minnesota Health Care Commission established an ad hoc work group, the Service Purchasing and Delivery work group, in May 1996, to:

- help the Commission better understand recent developments and issues in health care service purchasing and delivery in Minnesota;
- provide a neutral forum for review and discussion of managed care issues; and
- lead the Commission toward consensus recommendations and an active collaboration with policy makers in addressing these issues.

This preliminary report summarizes information provided to the Service Purchasing and Delivery work group during the period May, 1996 - December, 1996. The purpose of the report is to provide a descriptive overview of a rapidly changing health care market, including key trends or developments, their impacts on Minnesota's health care purchasing and service delivery, and questions and issues for the future. The report may be subsequently used to develop recommendations at a later time.

We welcome your comments. If you have questions or comments, please contact us at:

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Introduction and Overview

Minnesota's Health Care Market Paradox

Minnesota's health care market and public policy have been responding to the challenges of containing rising health costs, while assuring access and quality. While many of the strategies to address these issues seem to be working, they are paradoxically also viewed by some as the basis for concerns and questions. A number of positive accomplishments of Minnesota's health care market are noted below, followed by current questions or concerns which have appeared in the media, in legislative debates, and other arenas.

Positive Changes in Minnesota's Health Care Market

- Minnesota's annual health care inflation rate has slowed to approximately 6%, from an estimated earlier rate of approximately 10% in 1991. This level is a better-than-expected outcome, and is now lower than the national average;[1]

- Minnesota's uninsured rate is among the lowest in the nation, and has remained stable during the period 1990-1995, while the nation's rate has risen (see also page 21) ;[2]

- A recent large survey of Minnesotans showed that between 57% and 90% were "very" or "extremely" satisfied, overall, with their health plan. [3]

- Minnesota continues to lead the nation on a number of health indicators, and continues to rank among the healthiest states in the nation[4]. Minnesota's health care industry is strong and growing.[5]

Emerging Issues

Despite evidence of Minnesota's relatively good performance overall, press reports, legislative debates, and other sources have raised issues and questions regarding the state's health care market. Concerns have been raised for example, regarding:

- consumer protections under changing market conditions;

- consolidation in the market place (both health plan and provider);

- changes in delivery of care from solo, independent providers to integrated, multispecialty systems of care;

- the range of choices (both health plan choices, and choices among providers and specialty care)

- proposals for direct contracting or competing care systems between providers and purchasers, medical savings accounts, and expansion of the Prepaid Medical Assistance Program (PMAP);

- ongoing concerns about costs of public programs, and concerns about potentially restricting eligibility for public programs to the truly financially needy, without appropriate consideration of the medical needs of the individual, including disability;

- the scope, intent, impact, and current status of MinnesotaCare health care reforms (as well as concerns regarding confusion or misinformation arising about MinnesotaCare);

- distortions or misinformation that have arisen about Minnesota's health care market, and the ability of consumers and others to distinguish legitimate differences on policy issues;

- funding of medical education and research, charity care, and core public health functions when competition is threatening cross subsidies which have funded these in the past;

- the impact and future direction of federal health care and welfare reforms, and the impact of potential changes in the funding received from the federal government;

- the impact and future direction of state health care policy in addressing these concerns.

Recent key developments and trends

Many of the questions and concerns regarding Minnesota's health care market place reflect rapid changes which have occurred in response to ongoing pressures to contain rising costs, while simultaneously maintaining or improving health care quality and access. The state's health care market also reflects national trends and developments, and has been further shaped by state and federal legislation, and by Minnesota's unique social, economic, and demographic characteristics. Many of the changes in the health care market that are viewed as controversial now are actually outgrowths of events which began a number of years ago.

Key features of the state's health care market place noted by the work group include:

- *widespread use of a variety of forms of managed care* (note: the term "managed care" is broad, and includes not only health maintenance organizations (HMOs), but also use of other quality and cost tools such as provider networks, utilization review and case management);

- the *continued shift of employers toward self-insured health care financing arrangements*;

- *a number of ongoing legislated health care reforms beginning in 1992* to address issues of health care costs, quality, and access, known collectively as MinnesotaCare;

- *greater organization of the buyers' side of the market.* This trend has been characterized by both private and public sector buyers using their group purchasing power to obtain greater value and new forms of service delivery, based on models or specifications set by the purchasers;

- *continuing realignment and consolidation on the providers' side of the market* among providers and insurers;

- *better information about health care quality and costs to guide health care decision making*, including the purchase of health care and coverage; and

- *positioning and reactions in response to debates over federal health care reform.* The impetus for massive federal health care reform was strong in 1992, but by mid-1994 had greatly dissipated. More limited recent federal reforms, such as the recently passed Kassebaum-Kennedy (now known as the Health Insurance Portability and Accountability Act of 1996 or HIPAA) and welfare reform bills, will have some effect on Minnesota.

The remainder of this report further explores the developments and trends which have shaped Minnesota's health care market, and describes salient features of the market. The report concludes with a discussion of issues and challenges facing the state's health care market and Minnesota policy makers.

Evolution of the Minnesota Health Care Market

Impetus for Changes in the Market

The evolution of Minnesota's health care market has been shaped by ongoing pressures to contain rising costs while maintaining or improving health care quality and access. During the period 1980 to 1990 for example, national health care costs rose at an average rate of approximately 10.9 percent per year. At this average annual rate of growth, health care costs would be expected to double about every six to seven years[6].

Over 64% of health care coverage in Minnesota is employer based[7]; that is, it is provided as part of the overall compensation package negotiated between the employer and employee, and represents a cost of business to the employer. As a result, employers and unions have played a key role in efforts to contain health care costs. Rising health care costs often mean that health coverage may be in jeopardy as it becomes more expensive, or that something else has to give -- possibly less take-home pay, for example, or fewer employees hired or retained by the employer.

Rising health care costs have also proved a daunting challenge to government and taxpayers. In Minnesota, costs of the state's Medical Assistance (MA) program are the fastest growing component of state spending. Projections indicate that if the state's current growth rates for MA were to continue unabated, it will consume the entire state budget by the year 2020.

This cost inflation is occurring at a time of adverse public sentiment toward increasing taxes to match rising costs, and when taxpayers are increasingly faced with making sensitive trade-offs between meeting different competing needs. At the federal level, public spending commitments which are outpacing revenues have also resulted in significant deficit spending. These pressures have led to changes in the largest publicly sponsored health care programs, Medicare and Medicaid, and are setting the stage for possibly even more significant changes in the near future.

It must be emphasized that there are many factors in these cost increases, including general inflation, continuously improving technology, and an aging population. In the public programs in particular, demographic changes have driven demand for programs. The largest part (75%) of the Medicaid budget is spent on long-term care. While cost containment efforts seem to be slowing the rate of growth in the acute care market, basic changes in the makeup of our society will play an increasingly important role in future health policy planning.

Health care costs, quality, and access are intertwined. If health care costs too much, it may become unaffordable, resulting in lack of access and poor quality outcomes. As costs have risen, so has the overall rate of persons lacking health coverage in the U.S. Helping those without health insurance, who are generally lower income, working, and younger, has been a major policy goal in Minnesota for a number of years.

Excessive health care spending causes both personal and policy problems. First, overspending on health care services can be deleterious in and of itself to individuals (aggressively treating conditions that could have been managed more conservatively may pose risks of greater complications or side effects; over-prescribing medications or treatments can be harmful). Second, but more importantly, increasing outlays for health care may limit society's resources for education, jobs, environmental protection, and other societal needs which greatly affect health and well-being.

Health care cost pressures and their consequences have rarely been felt uniformly or equitably. Cost pressures may force out of the market those who need care and coverage the most. Access to a desired supply of medical generalists, highly trained specialists, and high technology equipment may vary greatly by geographic location or other factors. Isolated rural areas differ greatly from urban areas in terms of health resources, personnel, and facilities available, and inner city areas may have markedly different health care access than their suburban or smaller city counterparts.

The solution to what has been termed the "health care crisis" is to find a way to produce more desired health outcomes with less. This has proven to be a very difficult ideal to achieve, and is made more difficult by an aging population, with more people living to advanced ages and using more health care services. Moreover, patients may expect access to the most recent, advanced technology available, regardless of whether it has been demonstrated to be necessary or helpful, and regardless of cost.

However, despite the challenges posed by simultaneously addressing cost, quality, and access, the market and public policy are responding, as described below.

Key Market and Public Policy Responses

Many responses to the challenges of containing costs, improving or maintaining access and quality have occurred in Minnesota's health care system. Many of the responses began a number of decades ago but have become more visible recently, while others have occurred only recently. Key changes include:

- *widespread use of a variety of forms of managed care* (note: the term "managed care" is broad, and includes not only health maintenance organizations (HMOs), but also use of other cost and quality tools such as preferred provider networks, utilization review and case management);
- the *continued shift of employers toward self-insured health care financing arrangements*;
- *a number of ongoing legislated health care reforms beginning in 1992* to address issues of health care costs, quality, and access, known collectively as MinnesotaCare;
- *greater organization of the buyers' side of the market.* This trend has been described as both private and public sector buyers using their group purchasing power to obtain greater value and new forms of service delivery, based on models or specifications set by the purchasers;
- *continuing realignment and consolidation on the providers' side of the market* among and between individual and institutional providers;
- *availability of better information about health care quality and costs to guide health care decision making*, including the purchase of health care and coverage; and
- *positioning and reactions in response to debates over federal health care reform.* The impetus for massive federal health care reform was strong in 1992, but by mid-1994 had largely dissipated. More limited recent federal reforms, such as the recently passed Health Insurance Portability and Accountability Act of 1996, and welfare reform bills, will have effects on Minnesota.

These responses are discussed in greater detail below.

Widespread use of a variety of forms of managed care

"Managed care" is a broad term which encompasses a variety of strategies and techniques to: prevent the need for serious, more complicated treatment; coordinate care for efficiency and effectiveness; maintain overall quality; reduce unnecessary services and reduce costs. These strategies may include for example: design of provider networks; use of practice guidelines; utilization review; case management; reviews for referrals to specialists (so-called "gate-keeping" functions); and others.

Health maintenance organizations (HMOs) are one well known form of health care delivery and health coverage which employs managed care techniques. The term "HMO" however is specific to a particular type of organization, which must meet certain criteria and be licensed by the state to do business in Minnesota. As a very broad generalization, HMOs use a primary care network of providers, with specialty care either in the network or by HMO authorization outside a network. HMOs may pay their providers on a "capitated" basis; that is, the provider is paid a set fee per enrollee, with the provider then taking on the responsibility of providing all or a specified part of that enrollee's health care needs.

Use of managed care tools is not limited to HMOs. They are currently being employed to varying degrees in most health care delivery and health insurance in the state. Few insurers in Minnesota use a pure indemnity plan, that is, a plan which simply pays or indemnifies the policyholder for the fee-for-service cost of care. Varieties of managed care are used, such as point-of-service (POS) plans, which generally have a wide network of providers with some financial responsibility if an enrollee uses providers outside the network. Use of other managed care tools, such as precertification for surgery or other utilization review, varies among POS and other forms of health plans.

The Minnesota Department of Commerce recently completed a survey of the top 42 indemnity insurance companies providing health insurance in Minnesota. Six of the ten largest insurance companies (based on Minnesota premium revenue) use preferred provider organizations (PPOs - a limited network of providers) and 13 of the top 20 contract with a provider network. A majority of companies that contract with a provider network also employ centers of excellence, large case management, negotiated fees, second surgical opinion, utilization review, and other techniques to assure quality and efficiency commonly associated with "managed care".[8]

History

Managed care and HMOs are not a recent phenomenon in Minnesota. The first HMO was organized in northern Minnesota approximately 50 years ago, in 1944. The term "health maintenance organization" was coined by a Minnesota policy analyst, Paul Ellwood, in 1970. A surge in enrollment in HMOs and use of managed care began in the 1970s, largely by employers seeking to contain costs while providing access to comprehensive, quality services for their employees and dependents. Employers and unions also had to balance increasing health care costs with increasing wages and other benefits. Federal legislation requiring that employers offer HMOs as one of their health plan offerings to employees was passed in 1973. The federal government began contracting with HMOs for Medicare recipients in the early 1980s, and the state initiated Medicaid managed care demonstrations in 1985.

In Minnesota, the State Employees Group Insurance Program (SEGIP) was one of the first to offer HMOs, as were local public employers such as the University of Minnesota, which contracted with Group Health, Inc. in the late 1960s. Building on the purchasing strategies of both the public and the private sectors, the State of Minnesota's Department of Human Services (DHS) is expanding its use of managed care for public programs (MA, GAMC, and MinnesotaCare). As a result of private and public program use of managed care, an estimated 80% or more of Minnesotans with health coverage are now receiving some form of managed care.

Growth in the number of self-insured firms

In the wake of large, well publicized private sector pension plan failures in the early 1970's , the federal government passed the Employee Retirement Income Security Act (ERISA) in 1974. ERISA placed self-funded employee benefit plans, including health plans, under federal jurisdiction. ERISA effectively allows employers who self-insure their employee health plans to be governed by federal law rather than state law, and therefore to be exempt from state insurance regulation.

As a result of this exemption, self-insured employers are not required to pay state taxes on insurance premiums or assessments levied on state regulated health insurers to support the state's high risk health insurance program (the Minnesota Comprehensive Health Association or MCHA). ERISA plans are also exempt from health benefit mandates in state law, although market forces often lead self-insured employers to offer benefits competitive with those in the insured, state-regulated market.

Self-insurance is one strategy which employers use to obtain better value for their health care dollars and to pursue innovative purchasing strategies. Employers who operate across state lines often self-insure to operate under federal rules, allowing them to offer uniform benefits for their employees in multiple states. Federal rules also give employers relatively broad discretion in how they design their health plans and contract with providers and administrators. Larger employers also have sufficient assets to bear their own insurance risk without transferring risk to another entity at added cost. Growth in the Minnesota self-insurance market has increased from 600,000 to 1,400,000 during the period 1988- 1994.[9] Self-insurance is a mechanism Minnesota employers use to continue to offer health insurance to their employees, where the trend across the nation is to reduce this benefit.

The availability and growth of self-insurance creates a number of health policy challenges at the state level. Because states cannot directly regulate ERISA plans, benefit mandates and certain types of taxes cannot be directly imposed on self-insured plans. If employers believe state regulations pertaining to licensed commercial insurers and managed care companies impede their ability to get the best value for their health care dollars, employers are more likely to choose to operate under less restrictive federal regulations by electing to self-insure.

The recent passage of the Health Insurance Portability and Accountability Act of 1996 addresses one of the most critical concerns of state policymakers with self-insured plans. Uniform federal rules now exist regarding portability and guaranteed issue of insurance in both the state-regulated insured and federally-regulated ERISA markets. However, state policymakers are still faced with the challenge of providing consumer protection for the fully-insured market without going so far as to drive employers to self-insure solely to avoid state regulations. States must also carefully consider their options for funding health care programs to avoid tax policies which create incentives for employers to self-insure to avoid state taxes.

Exemption of self-insured plans from Minnesota insurance regulation poses problems for achieving policy goals that would otherwise be applicable to all segments of the market. State policymakers are able to influence only the insured market directly. It must be remembered by policymakers that reforms affecting only the insured part of the market may not solve the problem the reform was intended to address.

Health Care Reforms

Minnesota passed comprehensive health care reforms to address the triad of costs, access, and quality, starting in 1992. The reforms were intended to augment, rather than replace, the market and have been continually modified to reflect market performance, changing attitudes or preferences, and other state priorities. The reforms are often known collectively as "MinnesotaCare".

The reforms generally can be considered in the following categories: cost control; a subsidy program to assist low- and moderate-income persons to purchase coverage; data and quality initiatives; pooled purchasing opportunities; insurance reforms; and improved access in rural and low-income areas. The reforms are summarized below:[10]

- ***Cost control:***
  Legislation established overall growth limits intended to reduce the rate of growth of health care costs 10% each year over five years. Integrated service networks (ISNs) were proposed to lead to coordinated, integrated cost-effective delivery of care. A regulated all-payer option (RAPO) was proposed to contain costs outside ISNs.

  Subsequently, RAPO was repealed. It was no longer thought necessary, because market forces were perceived to be sufficient in meeting cost containment targets, care integration and coordination were moving forward, and health care inflation had slowed.

  The other portion of the original legislative concept, ISNs, has not occurred. A smaller, more local, less-regulated delivery system known as a Community ISN (CISN) was passed in the 1993 legislature. To date, four CISNs are licensed in Minnesota.

- ***Subsidy program to assist low and moderate income persons purchase health coverage:***
  A subsidy program, also known as MinnesotaCare, was implemented to help the uninsured obtain affordable health coverage which emphasizes preventive and primary care. This program is not an entitlement program, and the enrollees contribute more than $20 million annually to the cost of their coverage.

- ***Data and quality initiatives:***
  The law established data collection initiatives to track costs, and to develop information to aid in making decisions in the market. Subsequently the Minnesota Health Data Institute (MHDI), a public-private partnership, was established to provide comparative data on health care cost and quality to consumers.

- ***Pooled purchasing opportunities:***
  The law established a state-administered purchasing pool (the Minnesota Employees Insurance Program) to facilitate greater choice of health plans, convenience, and economies of scale for private sector employers of any size to encourage employers to offer, or continue offering coverage. Further, statutory barriers were eliminated by now allowing groups or individuals to form purchasing pools as long as there are common factors for the group to form, and the pool complies with the small group reforms.

- ***Insurance reforms:***
  The MinnesotaCare insurance reforms are intended to encourage those able and willing to pay a standard premium to be able to purchase coverage, by limiting underwriting and rating differentials by insurers in the small group and individual markets. Part of the overall strategy is to shift an insurer's incentives from only selecting profitable risks, toward incentives for providing coverage and care that addresses costs while retaining quality. Improved portability of coverage and reduced "job lock" are also intended effects resulting from the changes to the pre-existing condition limitations and exclusions provisions.[11]

- ***Improved rural access and access in underserved areas:***
  The law provides loan forgiveness to recruit and retain physicians and mid-level practitioners in medically underserved and rural areas, and provides grants and technical assistance for transition planning for isolated rural hospitals. It established the Office of Rural Health and Primary Care (ORHPC) to coordinate the state's efforts regarding rural health, to serve as an information clearinghouse, to provide technical assistance to create community integrated service networks, and to develop a health professionals data base.

Greater organization of the buyer's side of the market

Health care purchasers, primarily employers and union trust funds purchasing health care on behalf of their employees and dependents, as well as public purchasers such as MA/GAMC/MinnesotaCare are increasingly playing a more proactive role in the health care market. In this new role, purchasers are organizing into larger coalitions of buyers, or, in the case of MA/GAMC/MinnesotaCare, using an existing large enrollee base, to obtain better values from the market. In many cases, this means departing from a more traditional role of purchasing products or services offered by suppliers, or simply acting as a reimburser of suppliers, to a new role of defining the product that is desired, and aggressively pursuing suppliers who will deliver the product at lowest cost and highest quality.

Several large purchasing groups including the State Employee Group Insurance Program, (SEGIP, representing 144,000 lives), the Buyers Health Care Action Group (BHCAG; a coalition of self-insured employer groups representing an additional 109,000 lives), and other purchaser coalitions such as the Employers Association have played major roles in the transitions occurring in the market. Purchasers played a strong role in the creation and growth of managed care during the 1970's after demanding alternatives to traditional indemnity coverage that was perceived as contributing to rising health care costs. Subsequently, similar purchaser coalitions have played influential roles in demanding new forms of service delivery.

Realignment of providers

Providers have consolidated and integrated in response to a variety of market pressures. In some cases, provider aggregation or mergers were directly related to specific employer demands for coordinated, integrated care delivery systems. In others, new relationships among providers were undertaken more generally to: attract buyers; ensure access to capital; have more flexibility in utilizing or eliminating excess capacity; address demands for high technology or particular mix of services; and achieve economies of scale.

During the 1980s, a number of metropolitan area hospitals were consolidated into four multihospital systems. Subsequently, many new linkages, acquisitions, and joint ventures, at a variety of levels, have been occurring on an ongoing basis. Some, such as the merger of two large HMOs (e.g., Group Health, Inc. and MedCenters formed HealthPartners) represented a specific response to an employer coalition request for proposals to provide coordinated, integrated care across the Minneapolis-St. Paul metropolitan area. Others, such as the merger of a large multihospital system (HealthSpan) and a large HMO (Medica) were in response to anticipated federal and state health reform efforts. Other realignments have been taking place in response to more local or regional competitive pressures.

Among non-hospital providers over a number of years there has been a trend away from solo, independent physicians toward multispecialty clinics, alliances between physician clinics, and alliances between clinics and hospitals. More recently, several clinical systems have acquired or allied with growing numbers of neighboring clinics, most notably in the Greater Minnesota area. Other innovative relationships include "clinics without walls". A variety of partnerships for specific activities or permanent alliances have formed.

Health care provider cooperatives, groups of providers with a common administrative structure who may market their services and assume some risk, are also a relatively new form of provider realignment. Provider cooperatives were created in MinnesotaCare 1994. To date, four cooperatives have formed.

For further detail on these issues, please see the summary time line beginning on page 14.

Quality Data

More information is becoming available on the quality of health care and of health plans. In addition to the establishment of the Minnesota Health Data Institute, many public and private organizations are increasingly concerned with quality measures.

"Quality" for health care is in many organizations defined as both best-possible outcomes, and positive patient experiences. Providers of all types are using practice parameters, continuous quality improvement programs, and peer review to improve their practices. Organizations including health plans and BHCAG are beginning to demand expanded information about their providers, benefits and patient satisfaction measures for their members.

Quality is also defined as informing consumers what their health plan should do for them, so that they have appropriate recourse if they have a problem with a plan. Minnesota has substantial consumer protections built into its HMO and CISN statute, its public programs, and its oversight of indemnity insurers. However, consumer protections are not consistent across the market. The Service Purchasing and Delivery work group will be addressing this issue in greater detail in the future.

Reactions to debates over federal health care reform

Anticipated federal reform under President Clinton also contributed to many of the market developments noted above. While the much-debated Clinton plan of 1992-93 did not come to pass, incremental reforms, Medicare reforms, and welfare reforms (including Medicaid) have affected discussions of health care reform in Minnesota.

It seems highly probable that federal funding for all of these programs will be reduced in the future. The Health Economics Program (HEP) of the Minnesota Department of Health is tracking federal changes and reporting them, for instance in their report of April 1996 entitled "Congressional Medicare Reform and Minnesota's Health Care System."[12] Minnesota policymakers must anticipate challenges. Financing health care for future beneficiaries with the same or less funding as in the past will be difficult.

Summary time line of key developments and trends in Managed Care and Health Care Reform In Minnesota 1940 through 1996

Note: The summary time line below draws upon the following reports:

U.S. Congress, Office of Technology Assessment. 1994.
Managed Care and competitive health care markets: The Twin Cities experience. OTA-BP-H-130. Washington, DC: U.S. Government Printing Office.

Minnesota Department of Health.
1994 HMO Operations in Minnesota

Baumgarten, Allan. 1995 and 1996.
Minnesota Managed Care Review. Minneapolis, MN.

1940s

- *Growth of employer sponsored coverage*
- First HMO started in Two Harbors, MN in 1944

1950s

- Group Health Inc. (HMO) opens in 1957

1960s

- Medicare and Medicaid programs initiated by federal government
- Group Health Inc. contracts with the University of Minnesota

1970s

- *Employer demand for HMOs and managed care to contain costs; HMO enrollment grows at annual rate of 27% during each year from 1971 through 1978*
- 1970 "Health Maintenance Organization" (HMO) term coined by Minnesotan Paul Ellwood
- 1972 MedCenters Health Plan (HMO) forms
- 1973 SHARE Health Plan (HMO) forms
- 1973 Federal HMO law passes, requires employers to offer HMOs
- 1973 Minnesota HMO licensure law passes establishing standards for HMO operation and regulation
- 1974 Blue Plus (HMO) health plan forms
- 1974 Senior Health Plan (HMO) health plan forms
- 1974 The federal Employment Retirement Income Security Act (ERISA) is passed, enabling development of self-funded health plans by employers
- 1975 Physicians Health Plan (HMO) forms
- 1976 Minnesota Comprehensive Health Association (MCHA) forms -- MCHA is the state's high risk pool for medically uninsurable individuals
- 1979 Central Minnesota Group Health (HMO) forms in St. Cloud, MN

1980s

- *Continued growth in HMOs and emergence of preferred provider organizations (PPOs)*
- *Most physicians affiliated with one or more health plans by the end of the 1980s*
- *Approximately half the Twin Cities metropolitan area population is enrolled in HMOs by the end of the 1980s*
- *Gradual growth of self-funded health plans*
- 1982 Federal Medicare demonstrations with capitation of Medicare payments

- 1983 Metropolitan Health Plan (HMO) forms
- 1983 MedCenters (HMO) forms from merger of MedCenter Health Plan and Nicollet-Eitel Health Plan
- 1983 Minnesota receives federal Medicaid waiver allowing managed care demonstration projects
- 1984 PreferredOne (PPO) forms
- 1984 Northwestern National Life Health Network health plan (HMO) forms
- 1984 UCare (HMO) forms
- 1985 Merger of St. Louis Park Medical Center and Nicollet Clinic into Park-Nicollet
- 1985 State of MN Group Insurance program consolidates HMO offerings, sets state share of employee premium at cost of low cost plan (not fully implemented until 1989)
- 1985 Primary Care Network licensed as HMO
- 1985 Managed care demonstration projects for Medical Assistance (Medicaid) initiated
- 1986 HealthEast hospital system forms from St. Joseph's, St. John's, Midway and Bethesda hospitals
- 1986 Mayo Health Plan (HMO) forms
- 1987 HealthOne and Health Central merge to form an extended HealthOne multihospital system
- 1987 Fairview system adds St. Mary's hospital through a partnership with the Carondolet Catholic Order
- 1987 Legislation creating the Childrens Health Plan, a forerunner of the MinnesotaCare subsidized health insurance program, is passed
- 1988 Business Health Care Action Group, a health care purchasing coalition of 23 self-insured companies, forms
- 1989 Minnesota Health Care Access Commission is created to develop recommendations to the legislature on health care reform

- 1989 HMO insolvencies (MoreHMO and Primary Care Network), and legislative action to increase solvency requirements

1990s

- *Rapid growth of self-insured segment of the market; self-insurance by employers covers up to 1/3 of consumers in market (1994)*
- *Health care reforms passed by the Minnesota Legislature*
- *Many indemnity carriers cease to do business in Minnesota, particularly the small group market*
- 1990 Antitrust action against provider groups in Mankato
- 1991 Physicians Health Plan and Share merge to form Medica (merger completed in 1993)
- 1991 Business Health Care Action Group (BHCAG) creates new health plan option for employees and dependents, requesting coordinated care to be available throughout Twin Cities metropolitan region
- 1991 House File 2, initial bill for health care reform, passes the legislature but is vetoed by the Governor because it lacks cost control provisions and an adequate funding mechanism
- 1991 Employers Association forms purchasing pool (product offered for the first time in 1993)
- 1992 HealthOne (multihospital system) and LifeSpan (multihospital system) merge to form HealthSpan
- 1992 BHCAG issues first RFP for providing health care services to employees
- 1992 MedCenters/Group Health, Inc. merge in response to BHCAG RFP. HealthPartners becomes the parent company for three HMOs.
- 1992 "HealthRight" health care reform bill passes (later renamed MinnesotaCare) with provisions for --
  - development of a plan to slow rate of health care costs by 10% each year;
  - small group and individual insurance reforms;
  - administrative simplification, uniform claims and billing forms;
  - data collection and analysis;
  - purchasing pools;

- MinnesotaCare subsidy program, first covering children and families of children previously enrolled in the Childrens Health Plan;
- funding for the MinnesotaCare subsidy program and implementation of other reforms;
- grants and other programs for rural health care access;
- other reforms.

▸ 1993 HealthPartners acquires Ramsey Health Care

▸ 1993 Healthspan (hospital system) and Medica (HMO) merge to form Allina

▸ 1993 Blue Cross and Blue Shield of Minnesota announce partnership with Affiliated Medical Center of Willmar, MN

▸ 1993 MinnesotaCare bill (II) passes, with provisions for:
- design of Integrated Service Networks (ISNs) and a Regulated All-Payer Option (RAPO) and requirements for further details on ISNs and RAPO;
- a method of setting overall limits on the rate of growth of health care spending and interim spending limits;
- creation of a public/private Minnesota Health Data Institute;
- requirements for increasing loss ratios in the small group and individual markets;
- other provisions.

▸ 1994 Metropolitan Life merges with Travelers to form MetraHealth

▸ 1994 Northern Plains Health Plan (HMO) licensed

▸ 1994 MinnesotaCare bill (III) passes with provisions for:
- further detail of ISN/RAPO system;
- Community Integrated Service Networks (CISNs);
- plans for uniform standard benefit set, implementation and transition plans;
- administrative simplification;
- ban on the use of gender based rating in the health insurance market;
- Health Care Provider Cooperatives;
- expansion of the MinnesotaCare subsidized health insurance program to adults without children
- goal of universal health coverage in Minnesota; implementation by 1997.

▸ 1995 Minnesota receives federal health care reform waiver (1115 waiver) to consolidate purchasing for and streamline public programs

▸ 1995 State of Minnesota joins BHCAG as an associate member; BHCAG changes name to Buyers' Health Care Action Plan

- 1995 MinnesotaCare bill (IV) passes, with provisions for:
  - repeal of RAPO;
  - net worth and other requirement of ISNs;
  - change in the goal of universal coverage by 1997 to fewer than 4% uninsured by 2000;
  - mental health parity;
  - establishment of a senior drug discount program;
  - clarification of research and data initiatives.

- 1995 Blue Cross and Blue Shield of Minnesota (BCBSM) forms partnerships with Park-Nicollet, Methodist Hospital, Aspen, Dakota Clinic, Mankato Clinic

- 1995 MetraHealth purchased by United HealthCare

- 1995 PreferredOne Community Health Plan (CISN) licensed

- 1995 New Pioneer Health Plan (CISN) licensed

- 1995 Dakota Community Health Plan (CISN) licensed

- 1996 General health care reforms (no MinnesotaCare bill)

- 1996 DHS expansion of PMAP into Greater Minnesota counties

- 1996 BHCAG issues second RFP; 15 care systems respond

- 1996 Federal legislation (the Health Insurance Portability and Accountability Act of 1996) is signed with provisions for portability of coverage and other insurance reforms. Most of these reforms are already in Minnesota law as a result of MinnesotaCare reforms.

Selected key features of Minnesota's current health care market

Minnesota's health care market is in transition

- The changes taking place in the health care market reflect a number of interrelated influences, some of which have been taking place over several years.

- An important impetus behind this transition has been to address escalating health care costs, while preserving or improving health care quality and access.

Health Care Spending

• Total personal health care spending in Minnesota is estimated at $14.9 billion in 1994 (including payments for long term care), and represents 12% of the state's economy.[13] Approximately 60% of the total is funded privately, largely through premium payments and personal out of pocket spending, and 40% of the total is for public programs including Medicare and MA/GAMC/MinnesotaCare.

Health care "spending" means the total spending by payers and individuals for health care services and goods. Minnesota's health care dollar, in 1993, went for: 29% for hospital care; 26% for physician services; 31% for other services including other types of providers, goods and drugs; and 14% for nursing home care.[14]

• Following years of increasing health care inflation, the annual rate of growth in overall health care spending in Minnesota has slowed to approximately 6%. This rate is far less than the rate currently allowed by the state's growth limits.[15]

Year	Growth Limit	Overall Growth
1993	---	8.0%
1994	9.4%	6.2%
1995	8.2%	6.0% (estimated)
1996	7.4%	(no estimate available)

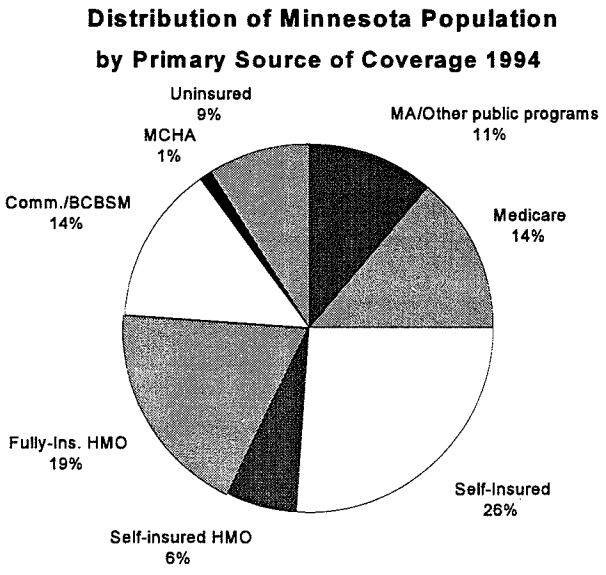
• Minnesota spends proportionately less on inpatient care and more on outpatient services than the nation as a whole. In Minnesota, the number of hospital beds, number of inpatient admissions, average lengths of stay, and average daily hospital census continues to decline.[16]

The Uninsured

• Several studies of the number of persons uninsured in Minnesota and the nation have been completed. Nationally, the percent of persons lacking health coverage at given point in time has increased from approximately 13% in 1990, to over 15% in 1995.[17] In comparison, recent estimates of the uninsured in Minnesota indicate that the state's uninsured rate has remained well below the national average, and has also remained stable over the same period. (Because of different methodologies used, estimates of the percent of uninsured persons in Minnesota at any point in time vary from approximately 6% to 9% of the state's population. The Minnesota Health Care Commission examined two existing data sources in 1995, the Current Population Survey, produced for the U.S. Census Bureau, and the Minnesota Behavioral Risk Factor Surveillance System, and concluded that the state's uninsured rate had been stable at approximately 9% over the past five years. A separate survey of the uninsured for the Robert Wood Johnson Foundation in 1993 also found that approximately 9% of Minnesotans lacked health coverage at any given time. The University of Minnesota's Institute for Health Services Research conducted a large sample survey of the uninsured in 1995, and compared the results to an earlier study conducted in 1990. On the basis of these studies, the Institute concluded that Minnesota's uninsured rate had remained stable over the period 1990-1995 at approximately 6%.[18])

Market Configuration and Distribution of Forms of Health Coverage

• According to the Minnesota Department of Health's Health Economics Program (HEP), the distribution of primary insurance coverage[19] was:



• The distribution of coverage compared to 1993 reflects continued growth in self-insured enrollment, a stable rate of persons lacking health coverage during the period 1990-1995, and slight declines recently in the total number of persons covered through public programs.[20]

• Currently, there are 9 licensed HMOs, 4 licensed CISNs and more than 750 health insurance companies currently doing business in Minnesota. Most of the 750 health insurance companies in Minnesota are currently servicing existing policies rather than marketing new policies.[21]

• Minnesota's health insurance market is consolidated. Four organizations currently enroll an estimated 78% of Minnesotans for their fully-insured health coverage[22], which comprises approximately one-fourth of the state's population. (The four include PreferredOne, a PPO which provides managed care services to policyholders of commercial insurers.) This large percentage does not include self-insured organizations, but it is estimated that the administrative organizations who serve the self-insured market approximately mirror the insured market.

• Minnesota-based HMOs and CISNs are required to be non-profit organizations. In other states, the national trend toward market consolidation often reflects the impact of larger multi-state organizations, which may be for-profit HMOs or for-profit health care management companies.

• Minnesota's provider configurations and relationships are also changing, but little information beyond press reports is available to describe this trend. Many press reports indicate that the provider market is consolidating. That is, providers are being bought by larger systems, and/or are affiliating with each other. Some affiliations are for specific initiatives, such as the recent BHCAG request for proposals, and some are to remain competitive in a changing market.

• In greater Minnesota, health care provider cooperatives have begun to appear following the 1994 MinnesotaCare legislation, which created Minnesota Statutes Chapter 62R. This allows providers to come together to negotiate as a single unit, market their services collectively and provide care through a locally-controlled corporation, to increase competition in the delivery system in their area. As of October 1996, there are four provider cooperatives in Minnesota.

Managed Care

• It is estimated that approximately 80% of Minnesotans now receive their care through some form of managed care. Managed care includes enrollment in HMOs, CISNs, and prepaid medical assistance, and also includes persons whose coverage is through an indemnity insurer or self-insured plan, but whose insurance contract includes use of managed care techniques.[23]

Initial evidence regarding levels of and quality of care under managed care

• Anecdotal accounts of dissatisfaction and/or poor outcomes of care under managed care are of concern to many through reports in the popular press. Similar anecdotes arise for consumers receiving care in fee-for-service settings. Concerns have been raised regarding presumed incentives to reduce services under managed care; concerns have also been raised regarding presumed incentives to overtreat in fee-for-service settings. Answers to questions of what constitutes "appropriate" levels of care are often unclear, and a great deal of work is being undertaken to help address these questions.

Whether studies which compare one aspect or another of health care have "bias", and how to tell a high-quality study from a poor one, is an area in which the Minnesota Health Care Commission is interested. The Commission, its subgroups, and other researchers are putting together informational material and tools to assist stakeholders in judging the quality of research.

• Claims that managed care results in rationing of care, endangering the lives of sick patients, and involuntary euthanasia, have not been borne out in reviews of rigorous scientific studies conducted to compare managed care with fee-for-service. A research review of 21 these studies has shown that managed care generally provides equal or better outcomes of care than fee-for-service for most medical conditions.[24] However, the studies also indicate that improvements are needed in managing care for mental health and chemical dependency treatment, including under managed care.

• Another study, recently published in the Journal of the American Medical Association[25], showed that chronically ill and elderly patients (in this study, those with high blood pressure, diabetes, cardiac problems, and depressive disorders) and poor patients fared worse under managed care than fee-for-service. The study used a self-report method for health status and ended with 1990 data.

• In 1995 MHDI conducted a large sample survey of health plan enrollees. The results of the survey indicated that Minnesotans were, overall, more satisfied with their managed care than were enrollees of more traditional indemnity type insurance.[26] Specifically, in the category of "overall satisfaction", 75-90% of the network-only members were "extremely" or "very" satisfied; 56-85% of the point of service members were "extremely" or "very" satisfied; and 57-79% of the indemnity insurance members were "extremely" or "very" satisfied.

• Patients and providers have brought up the issue of patient access to, and reimbursement for, treatment that is not allopathic (traditional medical). Some managed care organizations do not allow direct access to types of care other than allopathic, for example by requiring physician gatekeepers to refer patients to non-allopathic treatments. Reimbursement for non-traditional medicine may be difficult to get in managed care organizations. On the other hand, some managed care organizations are now including or studying inclusion of non-traditional care in their benefit sets, according to press reports.

• A number of market and regulatory functions exist to monitor and enhance quality of care under managed care. Consumers are entitled to numerous protections under severall parts of Minnesota and Federal law. However, some of these consumer protections are only applicable to licensed HMOs and CISNs. Indemnity carriers, PPOs and Blue Cross Blue Shield of Minnesota (BSBSM) are required to comply with only a few of these consumer protections, and employees covered under a self-insured health plan are afforded very few consumer protections under state law.

The Minnesota Health Care Commission is very interested in the policy issues surrounding appropriate consumer protection, and how consumers may be made aware of the protections available to them. Preliminary evidence suggests that although several "ombudsman" offices[27] help consumers deal more effectively with the current health care system in a advocacy role,

consumers are generally not aware of them. Effective help can only be given if the consumer knows how to ask for it, and it is within the role of all payers, public agencies, and policymakers to advance efforts to be sure that all parties in the health care system are treated fairly and equitably.

- The Department of Commerce regulates licensed health insurance carriers other than HMOs and CISNs for financial solvency and other statutory requirements.
- The Managed Care Systems section of MDH provides oversight for both financial solvency and quality and access and enrollee appeals for all Minnesota-licensed HMOs and CISNs.
- Enrollees in MA, GAMC, and MinnesotaCare programs have access to appeals processes through DHS's procedures. If the enrollee is in PMAP, they are also covered by the HMO consumer protection laws and may use the HMO's appeals process.

Department of Human Services Consolidated Purchasing for Public Programs

• The DHS is consolidating purchasing for MA, GAMC and MinnesotaCare, and is moving toward purchasing pre-paid managed care services on behalf of all its 560,000 enrollees. The prepaid medical assistance program (PMAP) is used extensively in sixteen counties in the metropolitan area, and is being implemented with local governments in counties throughout the state. PMAP has enrolled MinnesotaCare families with children into prepaid managed care plans in all 87 counties and will enroll MinnesotaCare families without children effective January 1, 1997. The combined PMAP and Prepaid MinnesotaCare enrollment in October, 1996, was 243,323.

In addition, DHS is developing prepaid managed care options for persons with disabilities and for Medicare-and-Medicaid dual eligible persons. Further developments include county-based joint purchasing projects, and coordinated purchasing with other state agencies.

Confusion regarding the scope, intent, impact, and current status of MinnesotaCare health care reforms.

• MinnesotaCare is a collection of state legislated health care reforms to improve the quality, affordability, and accessibility of health care that was initiated in 1992.

• The reforms are continually changing to reflect changing market conditions, preferences, policy agendas, and experience.

• Legislation has been passed each of the past four years to modify these reforms as needed, and they will likely continue to be modified over time.

• Further confusion arises because one particular program undertaken as part of these reforms is also named MinnesotaCare, and refers to the subsidized health insurance program for low income persons.

- Many concerns or negative perceptions regarding the state's health care market have been attributed to the MinnesotaCare health care reforms. In particular, concerns regarding market consolidation and increasing use of managed care have been attributed to MinnesotaCare reforms, when in fact these were market trends long before MinnesotaCare was initiated.

- A number of positive outcomes of the MinnesotaCare reforms, including the small group insurance reforms, greater information on cost and quality, and savings from the MinnesotaCare subsidy program have been less well publicized.

Mandated Benefits

Minnesota has one of the highest levels of mandated benefits in the nation.[28] A mandated benefit is one which all insurers licensed in the state are required to provide to and for enrollees; these mandates do not apply to plans not regulated by the state such as self-insured (ERISA) plans. Benefit mandates may help individual consumers with insurance coverage issues, but may also drive up premium costs, make controlled medical studies ineffective, and add regulatory compliance burden to insurers.

There is discussion over the value of mandated benefits, as there is over a definition of a mandate. Some mandates address insurance reforms, for example by mandating underwriting guidelines which do not discriminate against classes of persons. Other mandates address a single medical procedure, such as PSA testing for prostate cancer, and require it to be included in the insured market's benefit set. Between, there are a number of reforms or mandates, that are not readily classed, such as requiring coverage of infants immediately at birth. Neither the cost nor the benefit of most mandated benefits can be quantified, because both depend so much on the medical and financial circumstances of the insured person.

An important issue in benefit mandate legislation is that a mandate, most prominently of the single medical procedure type, may occur because of a public perception that a public need is going unmet by health plan companies. That is, persons feel that their insurer needs to be required by law to provide certain services. Insurers counter that they need not and should not provide coverage for services which have not been shown to be safe, effective and as, or more, beneficial as previously covered services. Care which is both satisfactory to the patient and that saves the insurer (and thus the employer) money, is quickly adopted.

Innovations and New Developments

Many new methods of purchasing, organizing, and delivering health care services are being tried in Minnesota. In 1992, BHCAG issued a request for proposals (RFP) for comprehensive, coordinated care for its members. The RFP requested sufficient capacity to serve the entire Twin Cities metropolitan area, as well as the ability to address issues of appropriate use of high technology procedures and to maintain high levels of quality. The RFP led to a merger of two HMOs into a single much larger entity that signaled to many a growing consolidation of the market.

In 1995, the renamed Buyers Health Care Action Group, which now included SEGIP as an associate member, developed a new request for proposals for "direct contracting" with a variety of competing care systems. Part of its motivation was to address perceptions about market consolidation.

While the BHCAG development is perhaps the largest and most visible recent market innovation, a number of others should also be noted, including:

- Interest on the part of purchasers in "24 hour care" integrating worker's compensation health care and conventional health coverage. Recently, four member companies of BHCAG, the Department of Employee Relations, (DOER, including SEGIP and the state workers' compensation program) joined together with three major health plan corporations and two provider systems for a Coordinated Benefits Plan[29] (24 hour care) demonstration grant from the Robert Wood Johnson Foundation. Some local government purchasers also have expressed interest in 24 hour care;
- New provider-with-payer system affiliations (e.g. Allina);
- Activities of the Employers Association and other purchasing pools;
- Greatly increased small-employer coverage under the 1993 MinnesotaCare reform;
- Provider joint ventures (e.g., "clinics without walls");
- Data and clinical outcomes initiatives including MHDI, the Institute for Clinical Services Integration, the Health Education and Research Foundation, and the Center for Health Care Evaluation; and
- The possibility of new products based on direct contracting concepts, medical savings accounts, and other proposals.

Monitoring the Market

Efforts to monitor the health care market are ongoing. Public and private sector organizations are constantly reviewing the market for regulatory and legislative information, for purchasing decisions, and because Minnesota continues to serve as a laboratory for change.

Among the organizations monitoring the Minnesota health care market are:

- Minnesota Department of Health, both as a regulator in the Managed Care Systems Section, and for policy purposes in the Health Policy and Systems Compliance Division. Much data used in this report is gathered on an ongoing basis by MDH's Health Economics Program, Data Analysis Program, Office of Rural Health, Regional Coordinating Boards, and the Rural Health Advisory Committee;
- Minnesota Department of Human Services, in their role as a purchaser of health services and prepaid medical care;
- Minnesota Department of Commerce, as a regulator for commercial insurers, and as a reviewer for new initiatives such as direct contracting between employers and providers;
- Minnesota Department of Employee Relations, in their role as the largest single purchaser of insurance in the state, for the State of Minnesota employees;
- Minnesota Health Data Institute (MHDI), created by the 1993 MinnesotaCare law to gather impartial data on health plan consumer satisfaction and outcomes;
- Universities, including the University of Minnesota, in their roles as educators and researchers;
- Minnesota Health Care Commission, the Legislature, and private purchasing groups;
- Public or private research and consulting firms including the Rural Health Research Institute, and consultants whose research is used in this report.

More information is becoming available to guide health care decisions, and continues to be important to a well functioning market

- MHDI has completed its first system-wide measurement of consumer service quality relating to 46 health plans offered in Minnesota, including private health insurance plans, Medicare, and state public programs. MHDI will continue to refine its surveys and plans to develop consumer-oriented quality measurements at health plan and clinical system levels in future. Several health care organizations are working together in the Institute for Clinical Systems Integration to produce clinical guidelines. In addition, several independent foundations are doing research into improved and more efficient ways of delivering care.

- Risk adjustment to allow for varying health risk among insured populations is another area of quality and access research. HEP and DHS are conducting a study of risk adjustment in the public programs to determine what measures are available and feasible, to provide a system so that health plans who enroll higher-risk members
  are not punished by the market for doing so. A report on the activities of the Risk Adjustment Work Group will be available January 15, 1997. [30]

Issues and Challenges for the Future

- **Health Care Inflation and Cost**

Health care inflation, which has moderated in recent years, may be beginning to escalate again. Some employers, for example have reported recent significant premium increases. Many researchers and analysts have also pointed to the cyclical nature of the health care market, and have predicted that, after the recent downturn in cost escalation, inflation will pick up. It will be critical to monitor cost trends so that policymakers will be able to understand them.

- **The Uninsured Population and Access**

Since its beginning, the Minnesota Health Care Commission has had a goal and a legislative commitment to reduce the percentage of Minnesotans without health care insurance. Currently, the goal is to reduce the number of uninsured to fewer than 4% of the state's population. The goal has not yet been reached; the Minnesota Health Care Commission has recently issued a report entitled "Progress Toward Universal Health Coverage in Minnesota", and will continue to produce this annual report.[31]

- **Recent Federal Legislation**

Recent federal legislation will affect Minnesota's health care market. The recent welfare reform bill may affect enrollment in public programs, with spillover effects in the market. The Health Insurance Portability and Accountability Act of 1996 signed into law on August 21, 1996[32] contains insurance reforms, medical savings accounts, and other provisions which will affect Minnesota's health care market. Two benefit mandates were also signed into law in the autumn of 1996: forty-eight hour maternity stays and mental health parity. While both of these laws were anticipated by Minnesota law and do not provide more coverage than Minnesota law already had for insured populations, some impacts may be felt as they affect ERISA plans.

While major overhaul of the health care system at the federal level is not expected, it remains to be seen how the federal government will fund public programs. In the face of expanding need due to population growth and an aging society, as well as the special concerns of the medical field, a funding crisis is likely. Such funding cuts directly affect a third of Minnesota's population, who receive health benefits through public programs, and indirectly affects all Minnesotans through cost shifts onto the private sector.

- **"Direct contracting" concepts**

"Direct contracting" refers to providers contracting directly with employers or other purchasers to provide health care services, without an intermediary such as a health plan. In some states, direct contracting which transfers insurance risk to the provider through capitated contracts has been ruled

to be the business of insurance, requiring the groups to comply with insurance regulation. In Minnesota, no direct contracting ventures which include full transfer of risk have occurred. Minnesota's regulatory agencies state that their position on direct contracting is that innovation in the health care market is encouraged, so long as it does not impinge on consumer safety.

BHCAG is moving forward to contract for health care services in a new way with a variety of "competing care systems". The initiative bears a resemblance to direct contracting, and has raised issues of what constitutes insurance arrangements, and the types and levels of consumer protection and state oversight most appropriate for these arrangements. The potential impact of this initiative is unknown, but is viewed by some as a potential bellwether for future developments in the market.

County-based purchasing will also be addressed in the near future as the issue of direct contracting evolves. At the heart of this issue is the transference of risk and the appropriate consumer protections.

- **The proportion of the market subject to state regulation has been decreasing over time thereby directly affecting the state's consumer protection efforts**

Currently, approximately 35% of the state's population is enrolled in the private, insured market, and subject to direct state oversight and regulation.[33] The remainder of the market includes the uninsured, and persons covered through self-insured arrangements in the private sector, as well as those insured through public programs such as MA or Medicare. State regulation does not necessarily apply to the larger group, although most third-party payers and administrators voluntarily conform to Minnesota guidelines.

  - Developing consistent state oversight of quality assurance and consumer protection is difficult when a large part of the market is not now subject to direct state intervention.

  - Similarly, the issue of achieving a level playing field to facilitate a sound competitive market between payers is more difficult.

  - Consumer protection for quality of care and access to care is an ongoing issue throughout the state.

- **The level playing field and consumer access to non-allopathic care**

Because the delivery systems of health plans use allopathic providers for the majority of care, there is concern that consumers do not have sufficient access to non-allopathic care, including chiropractic and other alternative health disciplines. Artificial and/or arbitrary access barriers may exist which result in provider type discrimination in networks, discrimination in benefits coverage, or difficulties in reimbursement. Systems may not be conducive to an integrated health care system which includes alternative providers or services directly. Managed care may not be responding to outcome studies which show cost effectiveness and consumer satisfaction of alternative care practices.

Minnesota has chosen market place dynamics to direct the state's health care reform efforts, and repealed much government regulation of the health care industry. However, it may be that true market dynamics are not allowed to take place due to the practices mentioned. The health care market is not a free market to the same extent as are many other large industries; much of the problem of access to alternative care lies with uninformed and misinformed consumers who do not require changes of the system. Since most of the measurement of health care quality and cost are focused on the allopathic part of the delivery system, barriers to consumer access of choice of provider will impede data gathering, and therefore miss showing the effectiveness of other types of care in achieving cost-effective, accessible, high-quality health care in Minnesota.

- **Information about the market and performance measures continue to be important to a well-functioning health care market**

Efforts are underway to provide more information on the performance of the Minnesota health care system, especially to inform consumers and purchasers about the quality and costs of the products and services they are purchasing. It will be important to continue progress in these areas.

- **An increasingly competitive market is placing pressure on traditional implicit subsidies to fund medical education, research and emerging technologies**

An effect of increasing efforts to contain costs has been price competition in the market, with resulting pressures to reduce payment for "implicit" or built-in charges which previously supported the medical education and research programs at Minnesota's teaching institutions. Challenges in this area are how to fund medical education and research, and how to discern what kinds of education and research will provide better healthcare solutions in the future. The Medical Education and Research Costs Advisory Committee[34], is focusing on these issues.

Among the groups examining effectiveness of various established and emerging technologies in medicine is the Minnesota Health Care Commission's Health Technology Advisory Committee.[35] HTAC is a non-partisan independent body working with providers, payers and the health care community to develop information about health technologies and processes, ranging from use of screening methods to high-technology interventions. HTAC is charged with reviewing existing studies on the impact, cost implications, social, legal and ethical concerns, on specific technologies. Its recommendations to the Minnesota Health Care Commission are meant to be used by participants in health care to inform their decisions.

- **DHS Implementation of PMAP, and Waiver for Future Programs**

Public programs will increasingly purchase prepaid managed care for their beneficiaries. This population includes groups with special needs which require a different, expanded benefit set in order to produce functional and productive activity. Numerous details have yet to be worked out regarding choice and access in more remote areas of the state with few providers and health plans. In addition, the market has relatively little experience to date providing managed care for persons with disabilities, and refinements may be needed to successfully implement managed care for persons with disabilities and special needs who depend on public programs.

Minnesota's public programs have long been under a "waiver" of certain rules of the federal government, which allows DHS to pursue innovations in the medical assistance programs. DHS uses a defined process including statutory authorization through the Minnesota Legislature, pilot programs, and a detailed waiver amendment application to the federal government, to propose and carry out these innovations. The Service Purchasing and Delivery Work Group is serving as a stakeholder forum for DHS in reviewing the present amendment application[36], encompassing a number of issues, and the proposed application primarily regarding programs for the disabled.

- **State legislative issues**

A number of legislative issues may emerge at the state level this year which could affect the market. They include:

- Trends in the number of uninsured persons in Minnesota*
- Differences and trends in employer-provided health insurance*
- Direct contracting*, and care system competition
- Medical Savings Accounts*
- For-profit HMOs*
- A variety of benefit mandates
- Further changes in public program health care purchasing
- Changes in health care financing, including financing of medical education and research, risk adjustment, and financing of the Minnesota Comprehensive Health Association risk pool.

Other work groups already mentioned, as well as the Minnesota Health Care Commission's Financing Work Group, are working on these issues.

* *MDH Health Economics Program issue briefs are included as Appendices.*

Summary

In summary, Minnesota's health care market has been in the process of change for many years, driven by increases in cost, availability of constantly improving medical care, and need for better and better information. Describing the market is difficult. It is even more difficult to attribute the effects of changes to causes, both those market-driven and those due to legislative reforms. Consumer protection; cost control; access to care; measuring and improving quality; and providing accurate information to stakeholders will continue to be the main focus of the Minnesota Health Care Commission.

List of Appendices:

Appendix A:

Minnesota Ombudsman Offices

FACTS ABOUT THE OFFICE OF THE OMBUDSMAN

In 1987, the Legislature created the Office of the Ombudsman for Mental Health and Mental Retardation to:

...promote the highest attainable standards of treatment, competence, efficiency, and justice... for persons receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance...

The Office is an **independent** state agency.

The Governor appoints the Ombudsman.

The Ombudsman appoints Regional Advocates.

The Governor also appoints a 15 member Ombudsman Committee for Mental Health and Mental Retardation to advise the Ombudsman. From this group a Medical Review Subcommittee is selected to work with office staff in the review of deaths and serious injuries.

The Ombudsman, after consultation with the Governor, can go public with findings and recommendations.

Death and Serious Injury Reporting

An agency, facility, or program is required to report to the Ombudsman Office the death or serious injury of a client within 24 hours. You may call:

(612) 296-8671 or 1-800-657-3506

HOW DO I CONTACT THE OMBUDSMAN OFFICE

You may call, write, or visit:

121 7th Place E, Ste 420
Metro Square Building
St. Paul, Minnesota 55101-2117

(612) 296-3848
Toll Free: 1-800-657-3506

E-Mail Address:
ombudsman.mhmr@state.mn.us

Client Advocates are located in St. Paul and at each of the Regional Treatment Centers. They provide assistance to clients living in the Community as well as at the Regional Treatment Centers.

Anoka:	**(612) 422-4269**
Fax	(612) 422-4342
Brainerd:	**(218) 828-2366**
Fax	(218) 828-2207
Cambridge:	**(612) 689-7155**
Fax	(612) 689-7203
Faribault:	**(507) 931-7821**
Fax	(507) 931-7711
Fergus Falls:	**(218) 739-7364**
Fax	(218) 739-7243
Metro:	**(612) 296-3848**
Fax	(612) 296-1021
Moose Lake:	**(218) 485-5150**
Fax	(218) 485-5151
St. Peter:	**(507) 931-7669**
Fax	(507) 931-7711
Willmar:	**(320) 231-5962**
Fax	(320) 231-5329

TTY/TDD - Minnesota Relay Service
(612) 297-5353 or 1-800-627-3529

State of Minnesota

Office of the Ombudsman for Mental Health and Mental Retardation

Assisting Persons Receiving Services for:

MENTAL ILLNESS

DEVELOPMENTAL DISABILITIES
(Mental Retardation)

CHEMICAL DEPENDENCY

EMOTIONAL DISTURBANCE
(Children and Adolescents)

Revised 06-30-96

AN OMBUDSMAN IS

An official who is designated to assist you to overcome the delay, injustice or impersonal delivery of services.

WHY YOU MIGHT CALL THE OMBUDSMAN OFFICE

You may choose to call because:

- of a concern or complaint about services.
- of a question about rights.
- of a grievance.
- of access to appropriate services.
- of an idea for making services better.
- of a general question or need for information concerning services for persons with mental disabilities.

When you make a complaint in good faith, Minnesota State Law protects you from retaliation.

Equal Opportunity Statement

The Ombudsman Office does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability in employment or the provision of services.

Please give the Ombudsman Office advance notice if you need reasonable accommodations for a disability such as, wheelchair accessibility, an interpreter, Braille, or large print materials.

HOW WE DECIDE WHO WE CAN ASSIST

Concerns or complaints can come from any source. They should involve the actions of an agency, facility, or program and can be client-specific or a system-wide concern.

Matters given priority are:

- Matters affecting the health, safety, or welfare of clients.
- Laws or rules, their interpretation and their affect on services to clients.
- Policies and practices that diminish client dignity or independence.
- A disregard of client rights.
- Situations of abuse or neglect.
- The deaths and serious injuries of clients.
- The quality of services provided.

ACTIONS WE MAY TAKE

The Office tries to resolve concerns or complaints in a way that improves the quality of care clients receive.

Possible actions by the Office include:

- Mediate or advocate on behalf of a client.
- Consult with providers about policies, practices, and procedures.
- Gather and analyze information.
- Conduct investigations.
- Review Deaths and Serious Injuries.
- Examine records.
- Make site visits.
- Make recommendations, issue reports and monitor results.

THINGS YOU TRY BEFORE CALLING THE OMBUDSMAN

A difference of opinion or misunderstanding is often resolved by simply taking the time to talk and listen. Here are some basic steps in trying to resolve the issue yourself.

- BE PREPARED - have relevant information available before you call the agency or program.
- TRY CALLING FIRST - a short telephone call may save hours of time and headaches.
- BE PLEASANT - treat others as you would like to be treated. Getting angry or rude will not resolve the problem and may confuse the real issues.
- KEEP RECORDS - take notes, ask for names and titles of those you speak to and keep all correspondence.
- ASK QUESTIONS - ask why the agency or program did what they did. Ask for the relevant rules, policies or laws.
- READ EVERY THING SENT TO YOU- Many agency decisions may be appealed but there are deadlines and procedures to follow.

If you have followed all of these suggestions and still cannot resolve your problem, then give us a call. We may be able to assist you.

4. Call your County Advocate and ask for help.

Anoka County	612/323-5169
Benton County	320/968-7223
Carlton County	218/879-4583
Carver County	612/361-1746
Cook County	218/387-2282
Dakota County	612/450-2785
Hennepin County	612/879-3718
	612/879-3735
	612/879-3719
Itasca County	218/327-2981
Koochiching County	218/283-8405
Lake County	218/834-8424
Ramsey County	612/266-4375
	612/266-4374
St. Louis County	218/726-2570
	218/749-9724
	218/262-6000
Scott County	612/496-8447
Sherburne County	612/241-2600
	1-800-433-5239
Stearns County	320/656-6445
	1-800-450-3663
Washington County	612/430-6634

5. Call the State Ombudsman at 296-1256 or toll free at 1-800-657-3729 extension 6-1256.

6. File a State Appeal with the Department of Human Services. An appeal means you will have the chance to explain your case at a hearing. A referee will decide your case. This referee is not part of your health plan.

■ **You may file an appeal when:**

- ▶ You need to change your health plan outside of your first year change and open enrollment. For example, if you move too far from your primary clinic.
- ▶ You need a service and you cannot get it from your health plan.
- ▶ You are getting bills that you think your health plan should pay.
- ▶ You have services that are being denied, reduced, or stopped.

You must file an appeal within **30 days** after the health plan sends you a notice saying they are going to deny, reduce or stop services.

■ **How to file a State appeal:**

If you have questions about how to file an appeal, call 296-1256 or toll free 1-800-657-3729 extension 6-1256.

Write to:

Managed Health Care Ombudsman
MN Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3854

or

Appeals Office
MN Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3813

If you ask, we will give you this information in another form, such as Braille, large print or audiotape.
For TTY service call 1-800-627-3529.

This has important information. If you do not understand it, get help now.

Información importante. Hágala traducir inmediatamente.

Lus tseem ceeb. Yog koj tsis to taub, nriav neeg twm thiab txhais rau koj sai sai.

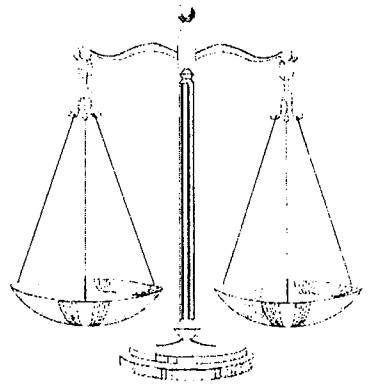
Tin tức quan trọng vé. Xin nhờ thông dịch tức khắc.

ЗДЕСЬ СОДЕРЖИТСЯ ВАЖНАЯ ИНФОРМАЦИЯ. ВЭЛФЕРЕ ПОЖАЛУЙСТА. ПОСТАРАЙТЕСЬ НАЙТИ КОГО-ЛИБО, КТО СМОЖЕТ ВАМ ЭТО ПРОЧИТАТЬ, КАК МОЖНО СКОРЕЕ!

DHS 3214 (6/96)

Notice

About Your Rights and Responsibilities



For The Prepaid Minnesota Health Care Programs

Your Responsibilities

■ **ID Cards** - have your health plan card AND your Minnesota Health Care Programs card with you every time you go for medical care.

■ **Medical care** - Know how to get medical care in an emergency, or when you are out of your home area. Refer to your health plan's certificate of coverage for this information.

■ **Anytime you have questions...** or don't know what to do, call your health plan member services number listed on the back of your health plan ID card.

Your Rights

■ **To be treated with respect.**

■ **To have your medical questions answered.**

■ **To get good medical care.**

If you are not getting good medical care through your health plan, you may file a complaint with your health plan or the State.

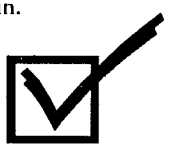
■ **To change your health plan.**

First Year Change - You have a one time change option during the first 12 months after enrolling.

Open Enrollment - There will be an open enrollment time every year. The State will notify you about your option to change health plans at that time.

If a health plan stops being part of the Minnesota Managed Health Care Program, you will have to choose a new health plan. You will have 60 days after you choose a new health plan to change your health plan again.

■ **To know the following:**



If you are in the hospital on the day that your health plan will change, the start date of the new health plan will be delayed. This change will begin on the 1st day of the month after you leave the hospital. Until that time, you will be covered by the old health plan.

If the health plan denies, reduces, or stops services, or denies payment for services, the health plan must tell you:

- ▶ What action the health plan is taking.
- ▶ The reason for not giving you the service or paying the bill.
- ▶ The state or federal laws and health plan policies that apply to the action.
- ▶ How to file an appeal with the health plan or the State Department of Human Services.

The health plan must send you written notice if services are denied, reduced, or stopped.

If the health plan wants to reduce or stop ***ongoing*** medical services a health plan doctor ordered, ***and*** you have filed an appeal with the health plan or the State, the health plan ***must pay for*** services you receive while waiting for an answer.

- ▶ An appeal must be filed within ten days after the health plan sends you the letter, or by the date the action is to happen (whichever is later).
- ▶ If you lose the appeal, you may be responsible for the bill.

If You Have A Problem With Your Health Plan Here Are Some Things You Can Do:

1. Contact member services at your health plan.

The health plan is required to respond to your problem within 10 days. The phone numbers are listed below:

Blue Plus 612/456-5545
1-800-711-9862
Central MN Group Health .. 320/259-7356
1-800-713-9080
First Plan 218/724-3083
1-800-635-4159
HealthPartners 612/883-5000
1-800-883-2177
Itasca Medical Care 218/326-7707
1-800-843-9536
Medica Choice Care 612/922-2322
1-800-373-8335
Medica Choice -TDD 612/922-2357
1-800-841-6753
Metropolitan Health Plan .. 612/347-6308
1-800-647-0050
UCare Minnesota 612/647-2632
1-800-203-7225

2. Ask for a second medical opinion from your health plan.

- ▶ The health plan will give you the name of a doctor who is part of the health plan.
- ▶ You may get a second medical opinion for mental health or chemical dependency from a provider who is not a part of the health plan.

3. File a complaint with your health plan.

- ▶ Write a letter to your health plan. Include your name, address, telephone number, and an explanation of your problem.
- ▶ Your health plan is required to answer your letter within 30 days.
- ▶ The health plan will notify the State Ombudsman within three working days after a written complaint has been filed with the health plan.

Appendix B:

Minnesota Department of Health, Health Economics Program:

Health Care Expenditures and Trends;

Direct Contracting;

Medical Savings Accounts;

For-profit HMOs;

Measuring Trends in the Number of Uninsured;

Employer Health Insurance.

HEALTH REFORM IN MINNESOTA

Health Economics Program

Issue Brief 95-03

Minnesota Health Care Expenditures and Trends

June 1995

Data Collection

Pursuant to MinnesotaCare, the Minnesota Department of Health developed a plan for collecting uniform and consistent state-level data on health care spending. Revenue and expense reports are collected from both payers and providers on an annual basis using consistent guidelines and data definitions. The goal of the data collection is to compile aggregate data on health care revenues and expenditures by payer type and service category for both public and private spending.

Aggregate data from HMOs and hospitals are based on modified versions of pre-existing annual financial reporting forms. New surveys were developed for commercial insurers, Blue Cross/ Blue Shield, and physician clinics. In addition, self-insured plans were surveyed on a voluntary basis. Data has also been obtained for federal, state, and local health care programs from the government entity responsible for each public program.

Data was submitted for the first time in the spring of 1994 and reflects 1993 baseline data. MDH anticipates that information will be limited in the initial years but will evolve as additional sources of data are developed and submitted on either a voluntary basis or through legislative requirements. Data definitions and collection techniques will be refined over time to assure the collection of uniform and accurate information.

Health Care Spending

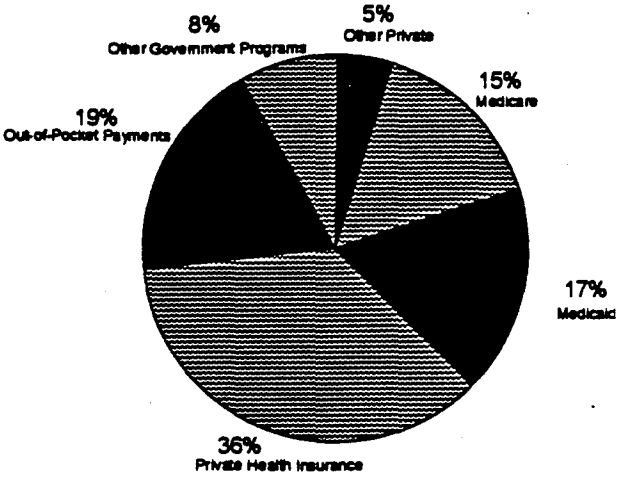
Figures 1 and 2 show the distribution of health care spending by source of payment. Figure 1 shows the percent of spending by payer source. Figure 2 shows the distribution of expenditures by type of service.

Total spending in personal health care services in the State of Minnesota in 1993 is estimated at $14.1 billion.

- Spending for personal health care in Minnesota was $14.1 billion in 1993. Excluding long term care, spending per person was $2,685.

- Total government health care programs accounted for 40% ($5.6 billion) of Minnesota's health care expenditures, while

Figure 1
Minnesota's Health Care Dollar: 1993
Where It Came From



Note: The figures do not include expenditures for research, education, and construction costs.

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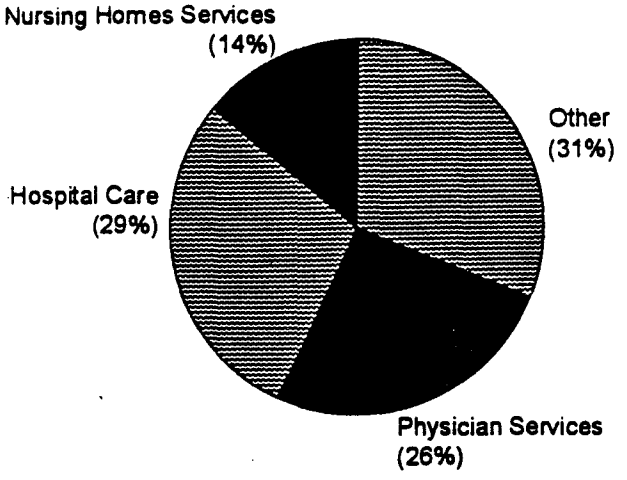
(612) 282-5641

private dollars (private health insurance, other private, out-of-pocket) accounted for 60%.

- Out-of-pocket share of the total health care spending was approximately $2.7 billion, representing 19% of health care spending.

Figure 2
Minnesota's Health Dollar: 1993
Where It Went



- Over half (55%) of all spending in Minnesota was for physician and hospital services representing $7.8 billion.

Trend in Health Care Spending

The estimated increase in total spending for personal health care services in Minnesota between 1992 and 1993 was 8.0%.

Trend in health care spending refers to actual dollars spent for all health care services and is distinct from trends in health care premiums or medical price, which tend to be lower in Minnesota than the national average.

Spending data for 1994 will be submitted in the spring of 1995 and the estimated increase in personal health care spending between 1993 and 1994 will be available in the summer of 1995. Preliminary estimate of trend for 1994 over 1993 is 7.9%. Figure 4 represents Minnesota's cost containment goals as expressed by limits on the rate of growth of health care spending.

Figure 3
Minnesota's Cost Containment Goals-Limits on the Rate of Growth of Health Care Spending

	Growth Limit	Preliminary Estimated Increase
1994	9.4%*	7.9%
1995	8.2%*	–
1996	7.4%*	–
1997	6.7%*	–
1998	6.0%*	–

**Projected growth limit. Based on change in Consumer Price Index from previous year.*

Growth in health care expenditures in Minnesota has slowed. In 1991, expenditures in Minnesota were estimated to be growing at 10% per year. By 1993, growth had slowed to 8.0% and is projected at 7.9% in 1994. Growth in expenditures are expected to continue to meet Minnesota's state cost containment goals.

While health care spending appears to be moderating in both Minnesota and the rest of the country, there is debate over whether the downward trend will continue. Others have questioned whether the slowdown in expenditures is really a trend, or merely a deviation from overall upward growth. The Department of Health will continue to monitor health care spending and trend both at the state and national level and report information based on the best available data.

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MDH.HCDP3.014r

Vol. 1 No. 01 January 1996

Direct Contracting

Health Economics Program Issue Paper

Introduction

The health care market, especially in Minnesota, has been in a period of rapid and dramatic change in recent years. To cope with the changing marketplace, public and private buyers of health care services have begun to pursue new purchasing strategies, including the formation of purchasing pools and direct contracting arrangements. In turn, health care providers have in some cases begun to create cooperatives to market their services to these entities.

Purchasing pools are authorized under *Minn. Stat.* §62Q.17. Pools may comprise employers, groups, and individuals who share common factors such as geographic location or similar occupations, and exist for the purpose of purchasing health insurance coverage. Pools are not licensed, although they must comply with small group insurance laws. Purchasing pools face no financial, solvency, or quality requirements. Insured pools must register with the Commissioner of Commerce and are required to report to the Information Clearinghouse in the Department of Health and to the Commissioner of Commerce before formation, and annually thereafter. Only one of the purchasing pools currently in operation is fully-insured, and therefore required to register and report. Self-insured purchasing pools are exempt from these requirements under ERISA.

Health Care Provider Cooperatives are authorized under *Minn. Stat.* §62R. Co-ops may comprise individual providers, clinics and/or hospitals organized for the purpose of marketing and delivering health care services to purchasers. Payments to cooperatives by purchasers are required to be substantially capitated or to involve similar risk-sharing arrangements. Providers co-ops are not licensed.

Direct contracting refers to a contract for health care services made between an employer or group of employers and health care providers. This is in contrast to the typical situation where employers purchase health care coverage from an insurer or from a health plan such as an HMO or Blue Cross Blue Shield. The remainder of this paper discusses possible advantages and disadvantages of direct contracting arrangements, as well as issues that remain to be addressed by state regulators.

Risk Assumption

Direct contracting arrangements may be of concern to the state because of the assumption of *insurance risk* by groups that have not carried such risk in the past, and which are largely unregulated. Insurance risk means that the health of the insured group may be worse than the insurer expected, and the insurer must cover the higher costs associated with a sicker enrolled population. Generally, this risk is assumed by a licensed health plan company, such as an HMO, commercial insurer, or BCBSM, which must meet minimum quality and solvency standards. These tend to be larger organizations, with enough experience to reasonably predict risk, and with enough assets to ensure that their enrollees do not lose health care coverage even if losses are greater than anticipated.

Insurance risk can be transferred to other entities in several ways. An HMO or a self-insured employer may purchase *stop-loss coverage* or *reinsurance*. This product ensures that the first insurers will only be responsible for insurance losses up to some aggregate or per-enrollee limit. When that limit is reached, the stop-loss insurer or reinsurer assumes the additional loss.

Risk may also be *transferred by contract*, the situation envisioned in direct contracting. In this case, the provider assumes some of the risk from the insurer or employer by agreeing to provide health care to enrollees for a capitated rate, regardless of the

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amount of service the enrollee uses. The provider agrees that the capitated amount will constitute full payment, and will not try to collect additional amounts from the enrollee except for any deductibles, co-insurance, or co-payments required by the contract.

Possible Advantages of Direct Contracting

- *May encourage increased competition.*

To the extent that purchasers are willing to negotiate contracts with smaller provider groups, more small groups will be able to compete. Provider groups will not need to have all health care services available within their organization, though they may contract themselves with HMOs or other groups for ancillary services.

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

With increased competition among providers, purchasers may have more leverage to require providers to provide information about quality. The information will allow consumers or group purchasers to shop for health coverage based on quality as well as cost, enhancing consumers' influence in the health care market.

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

When health care is purchased from some types of health care plans, individual providers may not be held accountable for the quality of care they provide. With direct contracting, providers would be competing in the health care market, and would need to be accountable for both cost and quality of care.

Possible Disadvantages of Direct Contracting

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

Smaller provider groups may not have all necessary specialties represented within the group, or may not have broad geographic availability of all provider types. Provider groups can arrange for this coverage by contract with specialty groups, but the multiple layers may make it difficult for regulators to assure that enrollees have adequate access to health care.

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

To the extent that the state lacks regulation of direct contracting arrangements, or the arrangements are beyond state regulation because of ERISA considerations, enrollees may be inadequately protected against poor-quality health care, denials of services, or deceptive or incomplete marketing information. Without the guarantee of an appeal process, enrollees could be left with no recourse in these cases.

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

Direct contracting arrangements are meant to reduce administrative costs by eliminating the "middle man," i.e., the health care plan. But some functions usually performed by the plan, such as marketing and claims processing, will instead have to be done for each individual arrangement, possibly resulting in increased administrative costs.

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

Risk may increase because the size of the provider group, and therefore its assets, are likely to be relatively small. The number of high cost cases needed to cause insolvency is therefore smaller. In addition, administrators of the provider groups may be less experienced in assessing risk, and may underestimate the amount of risk and the assets required to protect against insolvency.

State Issues

Direct contracting has begun to be discussed at the national level, by such groups as the National Association of Insurance Commissioners (NAIC) and the Group Health Association of America (GHAA).

The NAIC has taken the position that capitated provider networks can be exempted from state insurance regulation only if the provider agrees to assume all or part of the risk for health care expenses or service delivery under a contract with a licensed health insurer.

While direct contracting arrangements are not specifically licensed or regulated in Minnesota, some of the new types of arrangements created by MinnesotaCare legislation, such as the health care provider co-ops discussed above, appear to contemplate direct contracting between health care providers and employers. In September 1994, the Departments of Commerce and Health released a joint bulletin that addressed a number of related issues, including:

- *Under what circumstances may a health care provider cooperative contract to provide services directly to a self-insured employer?*

The bulletin noted that payments to cooperatives by purchasers are required to be on a "substantially capitated or similar risk-sharing arrangement," and that the transfer of risk inherent in such contracts makes them insurance as defined in *Minn. Stat.* §60A.02, subdivision 3. The bulletin added that a self-insured purchaser of such a product has purchased insurance, and would therefore be subject to state law provisions from which self-insured purchasers are ordinarily exempt under ERISA.

In addition, a provider cooperative that entered into a contract directly with purchasers would be deemed an insurance company as defined in *Minn. Stat.* §60A.07, subdivision 4, and therefore could not transact business in the state without holding an insurance license. A 1995 MinnesotaCare® amendment specifically authorizes a demonstration project of direct contracting between a certain cooperative (Quality Health Alliance) and qualified employers or self-insured employer plans.

Community Integrated Service Networks (CISNs) may also be provider organizations. Ernst & Young reported on regulation of physician hospital organizations (PHOs), formed to share administrative services and to improve physician and hospital bargaining position with payers. The report noted that most PHOs would meet the definition of CISNs, and suggested that Minnesota's CISN regulation may be a model for other states as they look to regulate direct contracting agreements.

- *How should direct contracting arrangements be regulated?*

How these arrangements should be regulated depends, in part, on how much risk is involved and how it is shared between employer and provider. For example, whether the employer's plan provides that the employer is ultimately responsible to see that services remain available in the event of provider insolvency affects risk. The state will need to determine the appropriate level of quality of care standards and develop a mechanism to investigate consumer complaints. In addition, the state will need to determine what level of protection against insolvency, through reinsurance or reserve fund requirements, is necessary.

In the case of relatively small employers contracting with a small number of provider groups, there would be increased risk that enrollees would be left without coverage if a provider becomes insolvent. The increased risk results from relatively low levels of experience and expertise in managing insurance risk, and the availability of fewer assets to draw upon in case of inadequate revenues. The problem for the state will be to regulate adequately to protect enrollees' interests, yet not so tightly as to stifle the development of new ways for providing health care coverage that may encourage competition based on both quality and price.

The Buyers Health Care Action Group (BHCAG) currently contracts with a single large HMO, HealthPartners, for some of its employees' coverage. However, representatives of the group say that it intends to directly contract with small groups of providers by 1997. Under their plan, BHCAG members would remain self-insured, paying providers on a fee-for-service basis. Because BHCAG comprises very large employers and will contract with many providers, some of which will also be very large, the risk to enrollees is presumably small.

- *Who should regulate the arrangements? The Department of Commerce, Department of Health, or both?*

Currently, Health Care Provider Cooperative *members* are licensed by their professional boards as providers. Contracts between provider cooperatives and purchasers must be filed with the Commissioner of Health. HMOs and CISNs are licensed and regulated by the Commissioner of Health. CISN regulation is similar to that of HMOs, though it is less stringent in the requirements for net worth and insolvency protection. Purchasing pools register with the Commissioner of Commerce, and must comply with small group insurance laws.

Because payments to cooperatives by purchasers are required to be substantially risk-sharing, they can only be between an appropriately licensed risk-bearing entity, such as a CISN, HMO, indemnity insurer, or Blue Cross/Blue Shield of Minnesota, and the cooperative. The risk-bearing entities are licensed by either the Department of Health (CISN, HMO) or the Department of Commerce (indemnity, BCBSM).

For further information about Direct Contracting, contact Kathleen Vanderwall at 612-282-6362, or Lynn A. Blewett, Director of the Health Economics Program at 612-282-6367.

Vol. 1 No. 02 January 1996

Medical Savings Accounts

Health Economics Program Issue Paper

Introduction

In light of recent legislative action at both the federal and state level, new emphasis is being placed on medical savings accounts (MSAs) as a possible tool in health care reform. Federally, HR 1818, introduced in June 1995, would allow individuals to establish accounts from which to pay for out-of-pocket medical expenses with pre-tax dollars. In addition, Congressional proposals to reform Medicare include the establishment of MSAs for the elderly and the disabled. At the state level, 15 states have enacted MSA legislation, with eight states establishing them during the 1995 legislative session.[1]

In Minnesota, the recent Weber-Brandl report on Minnesota's budget included recommendations to allow for the establishment of pilot Medical Savings Account programs in Minnesota. Bills that would have allowed employers to begin offering MSAs were introduced in both the House and the Senate in 1994. Under these proposals, MSAs would have been offered in conjunction with catastrophic insurance policies with relatively high deductibles ($1,000 to $5,000). Although the proposals in Minnesota ultimately were not passed into law, they remain a topic of interest among legislators. In February 1994, the Minnesota Department of Health issued a feasibility study of medical savings accounts outlining advantages and disadvantages of medical savings accounts and suggesting issues requiring further analysis.[2] This issue paper updates that study by giving a brief description of MSAs, providing a revised set of advantages and disadvantages, and discussing unresolved issues of interest to the state.

What are Medical Savings Accounts?

Medical savings accounts are tax-exempt accounts established to (1) allow for payment of all aspects of an individual's yearly out-of-pocket medical and health care expenses incurred to a pre-determined limit, and (2) allow for the accumulation of individual savings to pay for future medical and health care expenses. An employer could establish MSAs for individual employees, and funds could be deposited by the employer, the employee, or both. Under most proposals, funds contributed to the MSA would be pre-tax. In addition, as usually proposed, MSA legislation would allow individuals not currently covered by employer insurance to establish MSAs. Individuals would then draw from the MSA to pay for out-of-pocket medical expenses as they are incurred.

MSAs are designed to operate in conjunction with a high-deductible health insurance policy. As often conceived, the amount deposited into the MSA by an employer would be the difference between the premium on the high-deductible plan and a standard-deductible health plan. Individuals could supplement this initial deposit with additional funds up to the level of the deductible and could then use MSA funds to pay for deductibles or for medical procedures or supplies not covered under their insurance policy. Deposits to an MSA, up to a certain maximum, would be tax-deferred and any interest earned would not be taxed if funds were used to pay for medical care. If the MSA funds were withdrawn for purposes other than medical care, they would be fully taxable as income. Any unused balance in an individual's account at the end of the year could be carried forward to the following year, allowing an accumulation of balances over years.

Possible Advantages of MSAs

- *More consumer choice of providers and control over health care spending*

Since money will go to individuals in the form of deposits to their MSAs rather than going to insurance companies in the form of premiums, individuals will have increased ability to decide how best to spend the money in their accounts. Consumers can choose among competing providers for the service that best meets their needs.

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- *An incentive for consumers to be more cost-conscious when utilizing health care*

Under the current insurance system, many individuals face very low out-of-pocket cost for using health care. As a result, they may tend to over-utilize health care. With an MSA, people will have to spend their own money, up to the deductible level, to pay for health care services and, as a result, may reduce their utilization of services. Estimates vary widely as to how strong this "induction effect" would be. The best known study of the effect of consumer cost-sharing on health care utilization, the RAND Health Insurance Experiment, found that consumers used less medical care as out-of-pocket costs increased.[3]

- *May help during periods of uninsurance*

MSA accounts will provide a source of funds with which to purchase health care services during times of unemployment. In addition, individuals would be able to use MSA funds to purchase "bridge" insurance coverage for short periods of unemployment.

- *A source of funding for future long-term care needs*

An MSA that accrues interest over a person's lifetime may accumulate funds to pay for long-term care. At present, very few individuals have insurance that will provide coverage for long-term care services. In addition, as Medicaid is reformed, the level of long-term care services covered by public programs may decrease. MSAs may help to bridge this gap by providing another source of funds for long-term care.

- *Lower administrative costs*

Claims processing for services that are purchased below the deductible will be eliminated as people pay for services directly from their accounts. Thus, administrative costs will be lower as claims will only be submitted once the deductible is reached.

- *Restoration of doctor-patient relationship*

Some observers argue that the move to managed care has resulted in a deterioration of the relationship between patients and their doctors. MSAs could help to restore that relationship by encouraging individuals to choose their own physicians without regard to managed care affiliation.

- *May entice the currently uninsured to join the insurance market*

The combination of lower premiums and tax incentives may provide enough of an incentive for individuals who currently choose not to purchase insurance to purchase a catastrophic care plan and open an MSA.

Possible Disadvantages of Medical Savings Accounts

- *Incentives may cause people to forego preventive care*

Under some MSA proposals, individuals are allowed to spend MSA funds for non-health care related purposes. Individuals may therefore forego out-of-pocket preventive care spending in order to use MSA funds for something other than health services. In addition, some individuals may be inclined to pass up preventive care in order to keep a large balance of savings to pay for large future medical expenses.

- *Savings may not be substantial compared to overall health care spending*

Most people spend little on health care each year. In 1991, 72 percent of those 65 and under spent less than $3,000 per year (in 1994 dollars) on health care and they account for only 17 percent of total spending.[4] Therefore, if the deductible for high-deductible plans is set at $3,000, little total cost savings is likely to be achieved from reduced utilization. In addition, the possible decline in preventive care mentioned above could lead to a need for more expensive care in the future. Finally, analysis of Medicare MSA proposals have found that overall spending on Medicare is likely to increase, rather than decrease, with the introduction of MSAs.[5]

Vol. 1 No. 03 January 1996

Nonprofit and For-Profit HMOs

Health Economics Program Issue Paper

In recent years there have been discussions about whether to allow for-profit payers to enter the HMO market in Minnesota. Currently, state law requires that all HMOs operate as nonprofit entities. This issue paper provides background information on the for-profit issue and includes a discussion of possible advantages and disadvantages of allowing for-profit HMOs. A discussion of key state policy issues is also presented.

Background

An HMO is an organization that delivers a stated range of services to a defined enrolled population for a fixed monthly or annual premium. In addition, the HMO must assume at least part of the financial risk and/or gain from providing the services. *Minn. Stat.* §62d.02 defines a HMO as:

> *...a nonprofit corporation ...which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services, or arranged for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent or services furnished to any particular enrollees.*

Health maintenance organizations (HMOs) are not a new phenomenon in Minnesota. The first prepaid health plan was established in 1944 by railroad workers in Two Harbors. Despite their long history, however, it is only recently that HMOs have become a major force within the health care delivery system and viewed as a potential vehicle to curb rising health expenditures.

For-Profit and Nonprofit HMOs

In many states, HMOs may be either for-profit or non-profit entities. A nonprofit HMO is one which the residuals or reserves (the difference between revenues and costs) are not legally claimed by anyone. Since there is no residual claimant, there is a possibility that the nonprofit's objectives will differ from profit-making. For example, a nonprofit can spend this generated residual by providing some charitable good or community service.

Nonprofit HMOs need not satisfy the demands of equity holders, and have greater access to tax-exempt bond issues and donations. However, nonprofit HMOs are excluded from raising capital from the equity and venture capital markets.

In Minnesota, all HMOs must be organized on a nonprofit basis. Chapter 317A of Minnesota statute defines a nonprofit corporation as one that may not:

> *...be formed for a purpose involving pecuniary gain to its members ... [or] pay dividends or other pecuniary remuneration, directly or indirectly, to its members...*

For-profit HMOs fall into two general categories: partnerships and corporations. Many for-profits are operated by holding companies. This allows the HMO to incorporate, an advantage because many states do not levy general income tax on corporations. The federal government has actively supported the for-profit HMO sector in several ways. First, the Tax and Fiscal Responsibility Act of 1982 (TEFRA) enabled Medicare and Medicaid beneficiaries to enroll in an HMO. The HMO may be either for-profit or nonprofit, but must be federally qualified. Second, a 1982 change in federal HMO regulations allows the secretary of the Department of Health and Human Services (DHHS) to "waive all or part of the amount of funds repayable to the Secretary when an HMO converts to for-profit."

States have also begun to eliminate their long-standing bans on for-profit health care organizations. New York, for instance, allows for-profit HMOs to operate in the state. As a result of federal and state support, the for-profit HMO sector is growing rapidly and may well become a dominant factor in the health care delivery system. As growth has occurred, debate over the role of profit in health care has been heated.

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Proponents of for-profit providers have argued that their expansion will lead to a more efficient delivery system. Opponents counter that the profit motive does not belong in health care and that it will lead to a lower quality health care, especially for the poor and disadvantaged.

Possible Advantages to Permitting For-Profit HMOs

- *For Profit entities may be more efficient. For-profits may instill greater cost consciousness and operate in a more cost-effective manner.*

It has been argued that for-profit institutions will make the delivery of health care more efficient because they are purportedly able to "generate otherwise unavailable capital though equity financing, to offer more attractive employee incentives and operate with a simpler corporate and administrative structure".[1] When providers share in an organization's profits, they are thought to provide care in a more cost conscious manner. Although the literature dealing with HMOs is voluminous, there is little empirical analysis, and no studies have assessed the efficiency of for-profits versus nonprofits. There is no conceptual reason, however, to believe that for-profits should achieve greater economies of scale than nonprofits.

- *Profit making facilities are thought to attract more capable managers, leading to lower administrative costs and other managerial efficiencies.*

For-profit HMO may be able to attract better managers because they can offer more attractive employee incentives than nonprofits. For-profit HMOs are in a good position to reward management for outstanding achievement though financial incentives. They are not faced with the prohibitions faced by the non-profits and may establish profit-sharing plans and incentive stock option plans.

- *Because they can issue stock, investor-owned institutions are thought to have access to capital at lower costs. The ease in generating capital can lead to expanding to new locations and markets.*

The most compelling force driving nonprofit HMOs to convert to for-profit status is their need to acquire capital to maintain operations and expand into new locations. The need to acquire capital occurs in new HMOs that face extensive start-up costs, as well as in mature plans that are growing and acquiring more sophisticated plant (e.g. laboratories) and expanded facilities (e.g. owned hospitals). As Leonard Schaeffer, past president of Group Health in Minnesota said, "Capital markets are only interested in for-profit entities. It is not our desire to become for-profit that drives us in this direction. It is our determination to compete."[2] Although nonprofit HMOs have obtained capital from the sale of tax-exempt state bonds, this source has been limited because many state bonding authority enabling statutes do not include nonprofit HMOs as eligible participants. Therefore, HMOs in need of capital have found the private capital markets attractive and are assuming a for-profit status in order to compete for available funds.

- *For-profits can stimulate growth and competition.*

For-profit HMOs will likely play an increasing role in the HMO industry as a result of the development of new for-profit entities as well as the conversion of nonprofits to for-profit. Such conversions are seen by health care officials as a trend toward more fierce competition among health care insurers as a means of survival, a way of raising capital and a response to pressures from the government, business, and labor to hold down health care costs.

Possible Disadvantages to Permitting For-Profit HMOs

- *The profit-maximizing philosophy may lead to decreases in the quality of care.*

There is an ongoing controversy concerning the quality of care provided in prepaid plans. In addition, there is concern that the economic incentive faced by for-profit HMOs tend to drive them to provide fewer rather than more services, in order to contain costs and make a profit. Luft, in his review of the HMO literature, states, "One commonly held assumption is that HMOs achieve lower costs by under serving and skimping on quality. There is very little evidence to support this notion. The quality of care in HMOs seems comparable to or somewhat better than the community average." There is no research examining differences in the quality of care delivered in for-profit HMOs from that delivered by nonprofit HMOs. However, a database compiled by Schlessinger at Harvard comparing for- and nonprofits does provide us with one structural measure of quality. For-profits had a much higher ratio of physicians to members than did nonprofits.

- *For-profit HMOs may be less willing to serve the disadvantaged.*

Some observers question the willingness of for-profit HMOs to serve the disadvantaged. Recent changes in federal and state laws allow Medicare- and Medicaid-eligible elderly and low income individuals to receive health care services in HMOs. The Schlessinger data show nonprofits serving a greater percentage of both Medicare-eligible and Medicaid-eligible populations. However, neither for-profit nor nonprofit HMOs enrolls very many, and only a few plans account for the majority of Medicaid patients. More research will be needed to answer this question.

- *It is not entirely clear that a for-profit HMO will necessarily behave efficiently.*

Future growth of the for-profit sector will depend on its ability to compete on both cost and quality. The Schlessinger data provides some insights in the cost comparisons between for-profits and nonprofits. These data show for-profits to be more costly. For profits had a higher cost per inpatient day ($538 vs. $495), higher average total ambulatory cost ($364 vs. $330), and higher average inpatient cost per enrollee ($214 vs. $196). In addition, for-profits averaged higher revenues per enrollee ($695) vs. $654). It is impossible to discern from these data the causes for the higher costs (e.g., higher utilization; higher capital costs; newer, more expensive facilities; different patient mix; greater use of ancillary services; or inefficient operations). However, this does force a careful evaluation of the consequences of the profit motive in HMOs and the significance for the payers of health care.

State Issues

In Minnesota, by state law, all HMOs must be organized on a nonprofit basis. If Minnesota were to allow nonprofit HMOs to convert to for-profit status, there are four key issues that will need to be addressed:

- *The tax code may need to be re-examined.*

A for-profit HMO would no longer receive financial advantages (such as exclusion from property, state and federal taxes) and would be required to pay taxes. Currently nonprofits pay the Minnesota Comprehensive Health Association (MCHA) surcharge and the Minnesota care tax.

- *There needs to be discussion on how for-profit HMOs should be regulated.*

Should a for-profit HMO be required to be headquartered in Minnesota? Should a review or oversight board be created to monitor for-profit HMO activities? Will financial requirements currently in place for non-profit HMOs need to be reconsidered? Will current complaint procedures and controls on utilization review be adequate in the case of for-profit HMOs?

- *How for-profits would fit in with Minnesota's overall health care reform goals of cost containment and access to quality health care will need to be considered.*

Would for-profit HMOs stimulate growth and competition? Would this lead to lower costs? How would the quality of health care services be affected? How would the impact be evaluated over time.

- *What happens to the assets of an HMO when a nonprofit HMO converts to a for-profit HMO?*

Although laws vary from state to state, many states require HMOs to contribute their net worth (the difference between their assets and liabilities) to a charitable trust upon conversion. The laws of California resulted in over $3 billion being distributed to the state when an HMO converted to a for-profit corporation. New Jersey passed a law which gives Blue Cross of New Jersey the option to convert to a mutual insurance company. If conversions are allowed several questions need to be addressed: What happens to the assets of a nonprofit when it converts to a for-profit entity? Should those assets be applied to the for-profit business? Or should the assets be turned over to another nonprofit organization dedicated to similar purposes? Should an HMO's charitable settlement be based on its actual value as a nonprofit entity or its anticipated value as a for-profit entity?

Notes

1. Ermann, Dan (1986). Health Maintenance Organizations: The Future of the For-Profit Plan. *Journal of Ambulatory Care Management.*

2. Ermann, 1986.

For further information on Not-For-Profit and For-Profit HMOs, contact Stella Koutroumanes of the Health Economics Program at (612) 282-6341 or Lynn A. Blewett, Director of the Health Economics Program at (612) 282-6367.

MDH.HCDP3.022

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Measuring Trends in the Number of Uninsured in Minnesota

Health Economics Program Issue Paper

Minnesota's health care reform initiatives over the past several years were in part prompted by a concern that individuals in the state did not have adequate access to health insurance. As a result, studies that estimate how many Minnesotans lack insurance coverage are of importance to policy makers as they debate issues related to health care reform. This issue paper describes differences between various surveys of health insurance conducted in Minnesota, provides information about Minnesota's rate of uninsurance over time, and outlines changes in the demographic composition of the uninsured population during the 1990s.

Estimates of Minnesota's Uninsured Differ and Are Not Directly Comparable

Each year, a number of surveys measuring health insurance coverage are conducted in Minnesota. For example, the national Current Population Survey (CPS), and Minnesota's Behavior Risk Factor Surveillance System (BRFSS) annually survey Minnesotans about their health care coverage. In addition, periodic studies are conducted that examine health care coverage in the state, often funded by non-profit organizations. Examples of these studies include The 1993 Robert Wood Johnson Foundation Family Survey and the University of Minnesota's Health Care Insurance and Access Survey conducted in 1990 and again in 1995.[1] In general, these periodic studies have larger sample sizes and provide more in-depth information about health care service provision and demographics than the annual surveys.

Since each of these studies employs a somewhat different methodology, the results from the surveys vary and *are not directly comparable*. For example, the CPS measured the rate of uninsurance in Minnesota as 8.0 percent for 1995, which differs considerably from the University of Minnesota Health Care Insurance and Access Survey's estimate of 6.0 percent in 1995. A direct comparison between the two surveys could yield conclusions that are not valid. However, because the various estimates of uninsurance in Minnesota are often released without caveats about comparing the results from different surveys, misinterpretation may occur.

As a result, the Minnesota Department of Health (MDH) uses a single monitoring mechanism for examining changes in health insurance coverage for Minnesota. The goal is to monitor trends in the rate of uninsurance in the state. While the periodic studies provide a wealth of information on the uninsured population, the sporadic nature of the studies makes them unsuitable for annual tracking of trends in uninsurance. Of the annual surveys conducted in the state, the Current Population Survey best fits the needs for ongoing analysis of trends. An annual or bi-annual Minnesota-specific survey with a large sample size would greatly aid the Department of Health in its ability to monitor the precise rate of uninsurance in Minnesota.

Minnesota's Rate of Uninsurance Remains Stable while the Nation's Rate has Increased

Because of year-to-year fluctuations that occur in data collection and estimation, the Census Bureau recommends that CPS data be averaged over a several-year period to reduce the effects of these fluctuations. In particular, it recommends using a two-year average for comparisons of a single state's information over time and a three-year average when comparing the uninsurance rates of a given state to those of another state or region.[2] Presented in Table 1 are two-year and three-year averages of uninsurance for Minnesota and the U.S.

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Table 1
Two-Year and Three-Year Average Rates
Percent of Population Lacking
Health Insurance
Minnesota and U.S.

	Two-Year Average		Three-Year Average	
Average Ending	MN	US	MN	US
1990	8.8%	13.8%	8.7%	13.6%
1991	9.1	14.0	8.9	13.9
1992	8.7	14.4	8.8	14.2
1993	9.1	15.0	9.2	14.7
1994	9.8	15.3	9.2	15.1
1995	8.8	15.3	9.2	15.3

Table 1 shows that Minnesota's rate of uninsurance has remained steady at approximately 9 percent during the 1990s. In contrast, the nation's three-year average rate of uninsurance has risen from 13.6 percent to 15.3 percent between 1990 and 1995. The changes in insurance coverage are not statistically significant in Minnesota, but are for the U.S. ***In other words, Minnesota's rate of uninsurance has remained steady while the nation's rate has increased.***

At this time, it is unclear what the "true" rate of uninsurance is in Minnesota. The University of Minnesota's Health Care Access survey found a considerably lower rate of uninsurance than did the CPS, BRFSS, or The Robert Wood Johnson Family Survey, and each survey has certain strengths and weaknesses.[3] However, MDH's goal is to monitor the trend in the uninsurance rate on an ongoing basis. Taken from that perspective, all of the surveys reached the same conclusion: ***Minnesota's rate of uninsurance has remained stable from 1990 to 1995.***

Issues surrounding the trend in uninsurance are complicated, as individuals in Minnesota and nationally receive insurance coverage from one or more of a number of sources. As a result, changes in general economic conditions, public program eligibility, and employer-based offering of insurance can have impacts which simultaneously increase and reduce the percentage of Minnesotans with health care coverage. The next section of this issue paper discusses some of these issues.

Recent Trends in Employer-Based Coverage Differ for Minnesota and U.S.

Most people receive their health care coverage through an employer.[4] Traditionally, Minnesotans have received coverage through an employer at a somewhat higher rate than the national average. For example, according to the March 1995 CPS, 71 percent of non-elderly Minnesotans received coverage through an employer in 1994, compared to 65 percent nationally.[5]

Trends in the percentage of individuals who receive health insurance coverage through an employer also differ somewhat for Minnesota and the nation. While the rate of employer-based coverage declined both in Minnesota and nationally in the late 1980s and early 1990s, the rate stabilized in Minnesota around 1992 while the national rate continued to decline. Therefore, while nearly all studies indicate that the percentage of workers with health insurance coverage through an employer has declined nationally, Minnesota's rate of coverage has remained steady. The University of Minnesota's recently completed Health Care Access Survey reached similar conclusions, finding that the percentage of Minnesotans covered through a group or employer-based health insurance policy remained the same between 1990 and 1995.

Factors Influencing Employer-Based Health Care Coverage Rates

There are a number of factors which influence the rates at which employers offer insurance to their employees. For instance, employer-based coverage may decline if the cost of insurance coverage becomes so expensive relative to profits and income that firms are no longer able to offer coverage to employees as a benefit.

Alternatively, if family incomes decline or employers require employees to pay a greater share of their insurance premiums—either of which raises the

relative cost of health insurance for employees—fewer employees may choose to remain enrolled in employer-sponsored plans.[6]

Shifting employment patterns may also play a role. One often-cited reason for decreased employer-sponsored insurance coverage is the general movement among employers to part-time or contract work, where insurance coverage is less likely. In Minnesota, for instance, 62 percent of part-time employees work for companies that offer insurance to employees, compared to 82 percent of full-time employees.[7] If Minnesotans who were previously working for employers offering insurance move to part-time or contract employment where health care benefits are less likely, employer-sponsored insurance rates will fall.

Economywide shifts in employment between industries may also have an impact on the number of people enrolled in employer-sponsored plans. If employment grows in industries where fewer businesses offer insurance, the percentage of the population covered by employer-based insurance will decline. In addition, job growth in smaller firms, which are less likely to offer insurance, has outpaced job growth in larger firms. Nationally, between 1987 and 1992, firms with fewer than 100 employees created over three times as many jobs as firms with over 1,000 employees.[8] This shift may lead to a lower rate of employer-based coverage.

Several recent studies have examined the relative importance of these explanations in their impact on overall rates of uninsurance. ***The general conclusion from the studies is that, nationally, rising health care costs and falling family incomes account for the majority of the decline in enrollment in employer-sponsored plans.*** While the studies note that there has been a shift in industry of employment and some movement toward part-time and contract work, the findings show that these changes do not explain much of the total change in enrollment. Rather, an overall decline in employer-sponsored coverage in all industries is a much more important factor.[9]

Minnesota Employer-Based Coverage Rates Stable

Minnesota's stable rates of employer-sponsored coverage in the 1990s, in contrast to declining U.S. rates, may in part be due to various insurance reforms enacted under the MinnesotaCare legislation. First, MinnesotaCare created the Minnesota Employees Insurance Program (MEIP). This program, designed to allow small businesses to pool their purchasing resources, has helped nearly 400 businesses purchase health coverage, 79 percent of whom had not previously offered insurance to their employees.[10]

Second, and perhaps more significantly, small employer group insurance reforms under MinnesotaCare have increased coverage and affordability in the small employer health insurance market. After the implementation of the small group insurance reforms in Minnesota, the number of small employer groups enrolled in the market increased 15 percent, meaning an additional 2,500 small businesses began offering health insurance to their employees.[11]

Finally, the cost-competitive environment for medical services that has developed in Minnesota in the 1990s has helped hold down premium rates and has made health insurance more affordable than it had been previously.

Public Program Enrollment has Increased

In the late 1980s and 1990s, both Minnesota and the nation saw an increase in public program enrollment. Nationally, Medicaid enrollment among the non-elderly population increased from 8.5 percent to 12.4 percent of the population between 1988 and 1993.[12] In Minnesota, trends in enrollment in public programs, which include Medicare, Medical Assistance, and General Assistance Medical Care, have been similar. Enrollment in public programs in Minnesota has increased from approximately 19 percent of the population in 1990 to about 23 percent in 1995.[13]

An important difference in public program enrollment between Minnesota and the U.S. should be noted. While Medicaid enrollment increased 56 percent nationally between 1988 and 1993, it increased at a more modest 40 percent for Minnesota over that time period. More importantly, Medicaid enrollment actually declined in Minnesota between 1994 and 1995. Some of the decline in Medicaid enrollment can likely be attributed to the MinnesotaCare program. Minnesota's Department of Human Services estimates AFDC enrollment would be 7

percent higher today had MinnesotaCare not existed, saving the state and federal governments approximately $24 million annually in AFDC costs.[14]

Enrollment in Individually Purchased Insurance Declining in Minnesota but Stable Nationally

Individuals who are not enrolled in a public program or who do not have access to insurance through an employer may choose to purchase individual coverage in the open market. The use of individual insurance policies as a primary source of insurance coverage has declined in Minnesota in the 1990s, while it has remained stable nationally. Nationally, between 11 and 12 percent of the population is covered through an individual or non-group policy.[15] Minnesota, on the other hand, has seen a decline in the percentage insured through private individual policies from 9.4 percent in 1990 to 5.0 percent in 1995.[16]

A Shift in the Composition of the Uninsured

The trend in uninsurance and sources of insurance coverage have differed for the U.S. and Minnesota over the first half of the 1990s. Table 2 shows their respective experiences.

Table 2
Change in Uninsurance Rates and Sources of Insurance Coverage
Minnesota and U.S.
1990-1994

	Minnesota	U.S.
Uninsurance Rate	Stable	Increase
Employer-Based Coverage	Stable	Decrease
Government Program Enrollment	Increase	Increase
Individually Purchased	Decrease	Stable

Because of the shifts in sources of coverage over the early 1990s, the composition of the non-elderly uninsured has shifted. In general, the population of uninsured have higher incomes and are somewhat older in both Minnesota and the U.S. in 1995 than in 1990. While stable employer-based coverage and increased government program enrollment have increased access for Minnesotans, the decline in individually purchased insurance offsets those increases.

Shifts in the source of insurance coverage for individuals have some predictable effects on the composition of those remaining uninsured. For instance, since government programs such as Medicaid and MinnesotaCare frequently concentrate on covering children and those with lower incomes, movement of individuals from uninsurance to public programs is likely to increase the average age and average income of the uninsured. Minnesota saw a decline in the percentage of uninsured who were children, consistent with what would be expected given coverage trends.

Similarly, people who purchase insurance through individual policies have higher average incomes and are older than people on public programs or those receiving insurance through employers.[17] Movements from individually purchased insurance to uninsurance raises the average income and age of the uninsured population.

MinnesotaCare Not Displacing Private Coverage

During the debates over the MinnesotaCare legislation, some expressed concern that passage of a subsidized insurance program would displace privately purchased insurance with a public program. However, the finding that the distribution of the uninsured has shifted toward somewhat higher income categories supports the premise that those who were previously uninsured are taking advantage of public programs, while those in higher income categories, who were previously insured through individually purchased sources, may be dropping their coverage, perhaps because of rising premiums. A study released last fall indicated that MinnesotaCare was reaching its intended audience and was not crowding out private insurance.[18] The data presented here are consistent with that finding. The decline in individual enrollment may be partially attributable to the increase in small group enrollment, as some employers who did not previously offer coverage may

now provide coverage for employees who can therefore drop their individual coverage.

Conclusion

The issue of the uninsured remains near the forefront of health care reform discussions. As Minnesota's health care market continues to evolve and change, the various factors influencing insurance rates will continue to change as well. The Minnesota Department of Health will continue to monitor the rate of uninsurance and the sources of insurance coverage, and will report periodically on changes or developments in the market using CPS and other data sources as they are available.

Notes

1. The 1990 Health Insurance and Access survey was funded by the State of Minnesota. The 1995 survey was funded by the Blue Cross Blue Shield Foundation.

2. See U.S. Bureau of Census, Current Population Survey, User Notes.

3. A number of these strengths and weaknesses are detailed in "Preliminary Estimates of the Number of Uninsured Minnesotans," Staff Report to the Minnesota Health Care Commission, 1994.

4. See Minnesota Department of Health, Health Economics Program, Minnesota Health Care Market Report 1995, p.34.

5. It should be noted that, starting in March 1995 (examining coverage in 1994), the Census Bureau revised the wording of the health insurance questions of the CPS. As a result, data from 1994 and 1995 is not directly comparable to previous years.

6. Several of these explanations are offered in, and examined by, Gregory Acs, "Explaining Trends in Health Insurance Coverage Between 1988 and 1991," and Steven Long and Jack Rodgers, "Do Shifts Toward Service Industries, Part-time Work, and Self-Employment Explain the Rising Uninsured Rate," both studies from Inquiry, Spring 1995.

7. See the Robert Wood Johnson Foundation Family Survey, 1993. Part-time was defined as less than 40 hours per week. Full-time is 40 hours or more per week.

8. See "The Changing World of Work and Employee Benefits," EBRI Issue Brief, Number 172, April 1996.

9. Acs, "Explaining Trends in Health Insurance Coverage between 1988 and 1991" and Long and Rodgers, "Do Shifts Toward Service Industries, Part-Time work, and Self Employment Explain the Rising Uninsured Rate."

10. Minnesota Department of Employee Relations. "Minnesota Employers Insurance Program: Report to the Legislature," August, 1995.

11. For a more detailed analysis of the small group insurance market reforms in Minnesota, see Minnesota Department of Commerce, "Study of Small Employer Insurance Reform," January 1995.

12. Holahan, J., C. Winterbottom, and S. Rajan. "The Changing Composition of Health Insurance Coverage in the United States." Paper presented at the May 1 meeting of the Council on the Economic Impact of Health Care Reform, 1995.

13. Health Economics Program calculations based on data from the Minnesota Department of Human Services, Reports and Forecasts division and the Health Care Financing Agency.

14. "The Impact of MinnesotaCare on AFDC Caseload," Memorandum from the Minnesota Department of Human Services, Reports and Forecasts Division, December 1995.

15. See Employee Benefits Research Institute Notes, January 1996, Vol. 17, Number 1.

16. University of Minnesota, School of Public Health, Institute for Health Services Research, "Minnesota Health Care Insurance and Access Survey, 1995," p. 15.

17. Ibid, p. 20.

18. Lurie, Nicole, Alfred, Pheley, and Michael Finch. "Is MinnesotaCare Hitting its Mark?" University of Minnesota School of Public Health, Institute for Health Service Research and Hennepin County Medical Center, October, 1995.

For further information about uninsurance in Minnesota, contact Scott Leitz, Economist, (612) 282-6324 or Lynn A. Blewett, Director, Health Economics Program at (612) 282-6361.

The Health Economics Program conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy. The information is used to inform policymakers, consumers, and other stakeholders in Minnesota. For more information or for a list of recent publications, please contact the Health Economics Program at (612) 282-6367 or via e-mail at mark.meath@health.state.mn.us.

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HEALTH REFORM IN MINNESOTA

Health Economics Program

Issue Brief 95-07

Distribution of Insurance Coverage in Minnesota

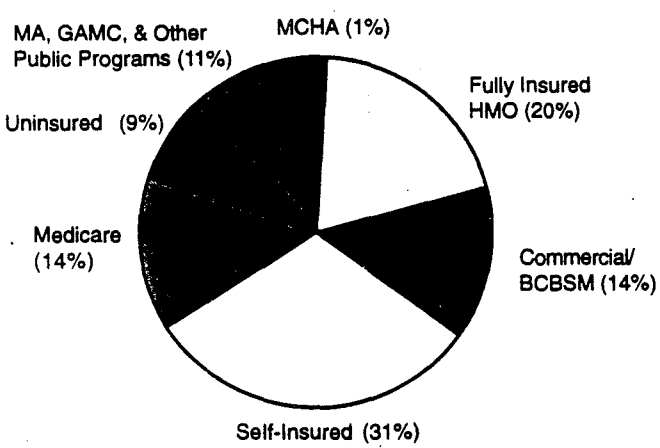
October 1995

Under MinnesotaCare, the Commissioner of Health is authorized to collect information from public and private payers regarding health care expenditures, revenues, and plan member enrollment. By combining this information with data from a survey of Minnesota families conducted during 1993, funded by the Robert Wood Johnson Foundation, the Health Economics Program of the Minnesota Department of Health has developed estimates of the distribution of insurance coverage among Minnesotans. This issue brief describes the distribution of insurance coverage among Minnesotans.

Source of Coverage

Figure 1 shows the sources of insurance for all Minnesotans. Self-insured products cover nearly one-third (31%) of all Minnesotans, and fully-insured products (HMO and Commercial/Blue Cross Blue Shield) cover another third (34%) of the Minnesota population. Public programs cover 26% of all Minnesotans, and approximately 9% of all Minnesotans are uninsured.

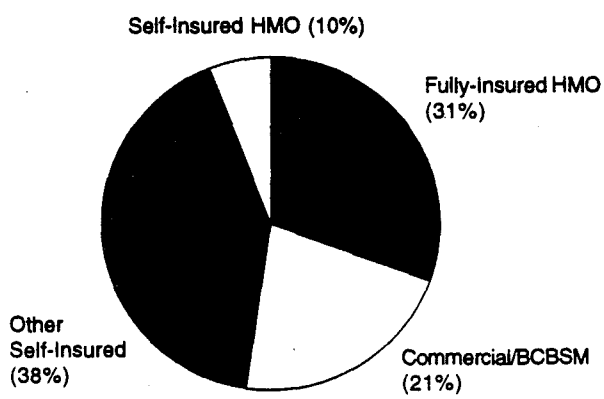
Figure 1
Distribution of Minnesota Population by Primary Source of Coverage, 1993
(n=estimated 4.5 million Minnesotans in 1993)



Private Payer Market

Health insurance coverage by private payers may be received through either a fully-insured or a self-insured plan or product. Fully-insured plans are offered by commercial (or traditional indemnity) companies, HMOs, and Blue Cross Blue Shield of Minnesota. Under these plans, insurance companies are paid premiums to assume the risk for insuring enrollees. Under self-insured plans, the employer pays covered medical expenses out of organizational assets rather than by purchasing insurance. Thus, the employer assumes the risk of losses directly, rather than transferring that risk through a third party. Figure 2 shows the distribution of Minnesotans covered by private payers.

Figure 2
Distribution of Minnesota Population Covered by Private Payers, 1993
(n=estimated 2.9 million Minnesotans in 1993)



- Enrollment in fully-insured and self-insured plans is split nearly 50-50;
- Of Minnesotans in private plans, nearly half (48%) are in self-insured plans;

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- Traditional indemnity insurers and BCBSM account for just over 20% of those insured through private payers;

- Fully-insured HMO products represent approximately one-third of the private market.

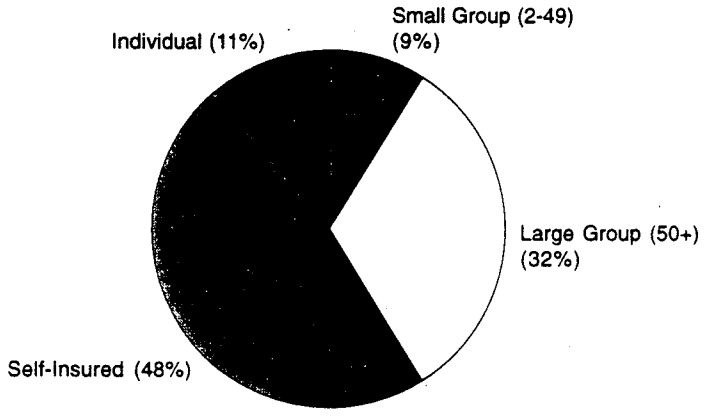
Several other points are interesting to note:

- HMO enrollment differs greatly between the metro and non-metro areas of Minnesota. HMOs cover 41% of the population of the 7-county metropolitan area, but only 6% of the non-metro population;

- Enrollment in self-insured plans has been increasing in Minnesota. In 1988, enrollment in self-insured plans was approximately 600,000. By 1994, self-insured enrollment was over 1.4 million.[1]

Figure 3 shows the distribution of Minnesotans insured through private sources by type of purchaser group. As shown, while nearly half of privately-insured Minnesotans receive coverage through self-insured plans, large groups (50 or more) cover over 30% of all privately-insured Minnesotans. Just over one in ten privately-covered Minnesotans receives coverage through individually purchased insurance policies.

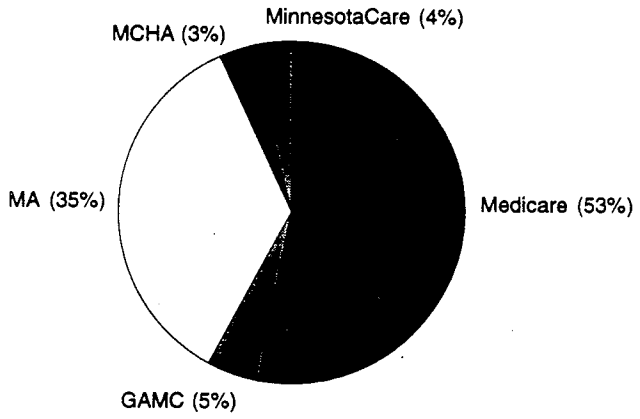
Figure 3
Distribution of Privately-Insured Minnesotans by Type of Purchaser Group, 1993
(n=estimated 2.9 million Minnesotans in 1993)



Public Payers

There are four primary public programs which provide health care coverage to Minnesotans: Medicare, Medicaid (called Medical Assistance, or MA, in Minnesota), General Assistance Medical Care, and MinnesotaCare. In addition, the Minnesota Comprehensive Health Association (MCHA) offers an insurance product for individuals who are unable to purchase health insurance at standard market rates or without restrictive clauses due to pre-existing conditions. Figure 4 shows the distribution of Minnesotans enrolled in these programs.

Figure 4
Distribution of Minnesota Population Covered by Public Programs, 1993
(n=estimated 1.2 million Minnesotans in 1993)



Medicare enrolls the majority of people who receive their insurance through public programs, while MA covers the majority of the remaining Minnesotans enrolled in public programs.

This issue brief provides a baseline source of information on Minnesotans' health care coverage sources. Minnesota's health care market has changed rapidly over the past several years, and as the market in Minnesota continues to evolve, we will be able to monitor changes and shifts in the distribution of coverage against the baseline information presented in this brief.

[1] Baumgarten, Allan. Minnesota Managed Care Review, 1994. Minneapolis, MN. September 1994.

Endnotes

1. Minnesota Health Care Market Report, 1997, in process, Minnesota Department of Health studies, 1996.

2. "Measuring Trends in the Number of Uninsured in Minnesota", Minnesota Department of Health, Health Economics Program, November 1996. Contact Scott Leitz at (612) 282-6324.

3. Minnesota Health Data Institute "You and Your Health Plan", 1995 Statewide Survey of Minnesota Consumers; MHDI, October 1995. Pages 5, 7, 9; A: Overall Satisfaction with Health Plan.

4. According to ReliaStar Financial Corporation (formerly Northwestern National Life Insurance), Minnesota regained the title as the nation's healthiest state, based on 1995 health statistics data.

5. Medical Alley, Fact Sheet 1996.

6. Bovbjorg, R.R., Griffin, C.C., Carroll, C.E.; 1993: U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s. Journal of Law, Medicine and Ethics, 21:2, 141-162.

7. Minnesota Health Care Market Report 1995; Minnesota Department of Health, Health Economics Program, June 1995. Contact HEP at (612) 282-6367.

8. Minnesota Department of Commerce study, 1996. Contact John Gross (612) 296-6929

9. "Distribution of Insurance Coverage in Minnesota", Minnesota Department of Health, Health Economics Program, August 1996. Contact HEP at (612) 282-6367.

10. More information is available from the Minnesota Health Information Clearinghouse at (612) 282-6314.

11. "Study of Small Employer Insurance Reform", Minnesota Department of Commerce, January 1995

12. Contact Minnesota Department of Health, Health Economics Program at (612) 282-6367.

13. Minnesota Department of Health, Health Economics Program, 1995.

14. "Minnesota Health Care Expenditures and Trends", Minnesota Department of Health, Health Economics Program, June 1995. Contact HEP at (612) 282-6367.

15. "Distribution of Insurance Coverage in Minnesota", Minnesota Department of Health, Health Economics Program, August 1996. Contact HEP at (612) 282-6367.

16. Minnesota Health Care Market Report, Minnesota Department of Health, Health Economics Program, 1995

17. U.S. Bureau of the Census, Current Population Survey, 1995.

18. "Minnesota Health Care Insurance and Access Survey, 1995" University of Minnesota Institute for Health Services Research, 1995. (612) 624-6151. Page 12.

19. "Distribution of Insurance Coverage in Minnesota", Minnesota Department of Health, Health Economics Program, August 1996. Contact HEP at (612) 282-6367.

20. "Distribution of Insurance Coverage in Minnesota", 1996; and Minnesota Health Care Market Report, 1995; both Minnesota Department of Health, Health Economics Program

21. Insurance Federation of Minnesota, 1996

22. Minnesota Health Care Market Report, Minnesota Department of Health, Health Economics Program, 1995

23. Minnesota Department of Commerce study, 1996

24. Miles, MD, Steven. Presentation June 27, 1996 for the "Choosing Well" forum. Studies were scored for: recent data, controlled population, peer review, multi-institutional, and authors not associated with payer organizations. The 21 studies which received four or five points were reviewed. Studies with fewer points are listed in a bibliography, available through MHCC.

25. Ware, MD, John. "Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems", Journal of the American Medical Association, October 2, 1996. Vol. 276, 13; 1039-1047.

26. Minnesota Health Data Institute "You and Your Health Plan", 1995 Statewide Survey of Minnesota Consumers; MHDI, October 1995. (Please see the MHDI report for further information about ratings for benefits, coverage, physician choice, continuity of care, access, and medical services.)

27. Ombudsman for Mental Health and Mental Retardation, Roberta Opheim, at (612) 296-3848; Ombudsman for Medical Assistance Programs, Ginny Prasek at (612) 297-1256.

28. Minnesota Council of Health Plans count using Minnesota Statute, 1996. Contact Michael Scandrett at (612) 603-2693.

29. Contact the Minnesota Department of Employee Relations, Gary Westman at (612) 296-8190.

30. Contact Virginia Weslowski, Health Economics Program, Minnesota Department of Health at (612) 282-6339.

31. Contact the Minnesota Health Care Commission at (612) 282-6332.

32. Signed by President Clinton on August 21, 1996; now known as Public Law 104-191 or HIPAA; originated as Senate File 1028 and House File 3103.

33. "Distribution of Insurance Coverage in Minnesota", Minnesota Department of Health, Health Economics Program, August 1996. Contact HEP at (612) 282-6367.

34. Contact Denese McAfee, Minnesota Department of Health, Health Economics Program at (612) 282-6349.

35. Contact Mary Stadick at the Minnesota Health Care Commission at (612) 282-6355.

36. Contact Kathleen Schuler at the Minnesota Department of Human Services at (612) 297-4668.