

Insurance Market Reform

Health Care Access Commission Working Group

Co-Chairs: Sen. Mary Olson and Rep. Diane Loeffler

A) Standardization of Health Benefit Design

The Minnesota Department of Commerce reviews over 1,000 health insurance products annually, with the Minnesota Department of Health reviewing an additional 200 related health maintenance organization filings. Although there is a need for choice in the market, the overabundance of options may cause consumers and purchasers to feel overwhelmed.

A major study found that reducing non-price barriers such as perceived difficulties locating information about insurance products spurred purchasing about as much as modest subsidies.¹ At the federal level, Congress mandated the standardization of Medigap plans, a reform that successfully enhanced consumers' understanding of their plan options and decreased abusive gimmicks.² By standardizing the options from health plans and insurance organizations (insurers) available to consumers and purchases, Minnesotans may be better able to make informed decisions about their coverage and make accurate comparisons between the products and prices of different carriers.

Minnesota Efforts

Minnesota has enacted the following laws relating to standard benefit sets:

- HMO benefit set (Minn. Stat. § 62D.02, subd. 7, and Minn. Rules, parts 4685.0700 and 4685.0801), enacted in 1973. This benefit set has been amended in recent years to permit higher copays, deductibles, and out-of-pocket limits, including cost-sharing required under federal law for high-deductible health plans (HDHPs) for use with health savings accounts (HSAs) (Minnesota Statutes, sections 62D.095 and 62Q.025).
- Qualified plan requirements (Minn. Stat. §§ 62E.05 to 62E.07), enacted in 1975. This is a requirement that an insurer must offer each of three types of "qualified plans" specified in law to an individual or employer before an unqualified plan may be sold. HMO plans are automatically deemed to be qualified, regardless of their level of cost-sharing. The three qualified plans all require at least 80 percent coverage after meeting a deductible, with an annual out-of-pocket limit of no more than \$3,000 per person and a lifetime maximum benefit of at least \$1,000,000. The three plans are identical, except that the annual per person maximum deductibles are \$150, \$500, and \$1,000. Features other than the annual out-of-pocket limit and the lifetime maximum need not be complied with if the Commissioner of Commerce approves other actuarially equivalent features as a substitute. This law does not prohibit the sale of unqualified plans, but requires only that each type of qualified plan be offered first.

¹ M. Susan Marquis, et al., *The Role of Product Design in Consumers' Choices in the Individual Insurance Market*, RAND Corp., Health Services Research (Aug. 2007), available at http://www.rand.org/health/feature/2007/070716_buntin.html

² Fox, P., Snyder, R. and Rice, T. 'Medigap Reform Legislation of 1990: A 10-Year Review'. *Health Care Financing Review*. Spring 2003. Volume 24, No. 2.

- Two standard small employer plans are required to be offered to small employers under Minnesota Statutes, section 62L.05, as enacted in 1992 MinnesotaCare Act. One of them bases out-of-pocket costs on a deductible and the other bases them on specified copays. These plans are rarely purchased.
- Universal standard benefit set required by 1994 MinnesotaCare Act (Minn. Stat. § 62Q.21, enacted in Laws 1994, ch. 625, art. 4, § 7), repealed in 1995 MinnesotaCare Act (This was to be a mandatory offer effective 1996 and the only coverage permitted effective 1997. The specifics were to be enacted by the legislature in 1995 based upon recommendations to be developed by the Department of Health, but the law was repealed instead.)
- Study by the Department of Commerce of the idea of developing standard benefit sets, required in 1992 and 1993 Minnesota Care Acts, and completed in 1994. (Minnesota Department of Commerce; Standardization of Health Insurance Policy Forms: Report to the Legislature; March 1, 1994)
- A law (Minn. Stat., Section 62L.045) enacted in 1999, permitting insurers to sell policies to small employers that did not include all mandated benefits, subject to Department of Commerce approval. Insurers and the department disagreed on interpretation of the law, and no policies were approved for sale under that law. It had been enacted with a three-year sunset and was allowed to expire.
- A law (Minn. Stat., Section 62L.056) enacted in 2005, permitting insurers to sell policies to small employers that exclude coverage of "any or all" mandated benefits, other than those required under federal law. This law is much more flexible for insurers than the 1999 law. To date, no insurer has filed a policy form for approval under the 2002 law.

1. Recommendation: Require the offering of a standardized set of "Minnesota Wellness Policies" to allow easy comparison by purchasers and consumers and create strong incentives for their use.

Requiring the offering of a standardized set of "Minnesota Wellness Policies" will allow "apples to apples" comparison by purchasers/consumers. These would be designed to be comprehensive (preventive care, chronic care management, mental health coverage, etc. similar to what major employers currently offer). Specialized policies do not decrease the overall health care costs, but instead increase cost shifting among various risk groups. There would be a limited number of standardized policies (under 5) differing primarily on the cost-sharing structure. These benefits would be the base for which Minnesota defines 'adequate' health coverage for all individuals. This would replace the current statutory "qualified plan" and other little value regulatory models.

To incent the use of these policies the State could:

1. Permit only the Minnesota Wellness standardized policies to be sold through an "Exchange" as discussed in the section on Improved Purchasing;
2. Make income based premium assistance available only to persons covered by one of the Wellness Policies. Standardizing may also allow possible use of federal SCHIP funds for premium assistance;
3. Base the adequacy of medical support in divorce on the benefit options; and

4. Be a basis for cross-employer subsidy via the Exchange for persons and households with more than one employer offering health care coverage.

2. Recommendation: Insurance products should be required to cover preventive care and early diagnostic tests, at 100% before the deductible.

One purpose of deductibles is to discourage patients from getting unnecessary or low value care. At the same time, preventing health problems or catching diseases early through screening tests for cancer and other diseases has been demonstrated to be cost effective. There should not be financial barriers to getting this care. The appropriate level of preventive care coverage should be designated in the policy by reference to a nationally or widely recognized evidence based standard.

3. Recommendation: Insurance products should be required to cover chronic care coordination and cost effective prescriptions at 100% before the deductible. The conditions and services to be covered would need to be further defined.

Demonstration projects have shown on-going management of chronic diseases can cost effectively maintain health and reduce the use of expensive emergency room care or hospitalization. One example is the congestive heart failure care system implemented at St. Mary's in Duluth. Some in the group expressed concern that limits should be placed on what is included under the term 'chronic conditions' and the prescriptions approved to treat them. An outside group should monitor what is included under this recommendation to ensure that best practices and evidence-based medicine are the basis for such treatments.

4. Recommendation: Establish a set of limited statewide health improvement and health outcome goals and encourage the use of them by insurers as the standardized basis of "pay for performance" models.

Providers have commented on the administrative burden placed upon them to collect and report different data to various insurers for their "pay for performance" systems. Insurers often have minor differences in the data collected for measuring progress on the same goal. Those differences are costly at the provider level. A standardized, limited set of measures would not only reduce costs but also allow the state to monitor the progress of public/private health promotion efforts. An implementation objective would be same definitions, same measures, and same forms for submitting data. These targets should be set in a public process that involves consumers and public health in addition to providers, purchasers, and insurers. The Commissioner of Health should convene the group and it should use the expertise of the many existing organizations addressing quality measurement including: Minnesota Community Measurements, ICSI, Stratis Health, Bridges to Excellence, and the Minnesota Hospital Association.

B) Cost Containment Through Insurance Regulation Changes

Incentives for employers relating to health insurance are both challenging to design from a policy perspective and may not withstand legal challenge due to the interaction with the federal Employment Retirement Income Security Act of 1974 (ERISA). ERISA prohibits states from regulating self-insured plans or requiring employers to purchase private health coverage. Preemption does not completely eliminate the state's ability to offer incentives to employers, such as tax credits for small businesses, purchasing pools, or subsidies for health insurance purchased by low-wage workers. Alternatively, federal preemption does not prevent the state from imposing a tax of general application that does not explicitly refer to ERISA plans.³ In all of these incentives, the state cannot "bind plan administrators to a particular choice" of coverage.⁴ This section looks solely at the issue of incentives for employers to offer health insurance.

5. Recommendation: Standardize all applications for employees and employers for health care coverage.

Testimony by one small employer on the working group emphasized confusion with the current system and administrative obstacles he faced when trying to obtain insurance quotes for his employees. Efforts to reduce the administrative burden are important to cost containment. Administrative barriers discourage individuals from seeking or re-evaluating coverage. The state and insurers should not be complicating the process of obtaining insurance, but instead assisting employers and individuals to locate appropriate coverage to meet their needs.

6. Recommendation: Consider increasing the small employer definition to more than 50 employees for purposes of health insurance purchasing.

The current definition of a small employer for health insurance purposes is an employer with 50 or fewer employees⁵. The group felt that the definition should be reviewed as the protections provided small employers may be appropriate for those of a larger size that are still not of sufficient size to avoid significant risk of outliers. The workgroup was not prepared to address what larger size to recommend without further study.

7. Recommendation: Require the Department of Commerce to study ways of reducing the total number of insurance filings annually.

The working group would require the Department of Commerce, with the assistance of other appropriate state agencies, to look into whether there are excessive insurance filings and make recommendations on how to address the issues. In addition, the Department should make recommendations to the Legislature concerning existing health care mandates that no longer serve their intended purpose. The working group heard about the two small employer policies insurers are mandated to offer, but few employers purchase these products.

8. Recommendation: Any adopted cost containment savings from other HCAC workgroups should be passed on to consumers in the form of reduced premiums.

³ Boyle v. Anderson, 849 F.Supp. 1307, 1313 (D. Minn. 1994).

⁴ Egelhoff v. Egelhoff, 532 U.S. 141, 147 (2001).

⁵ Minn. Stat., Section 62L.02, subd. 26(a)

Although the group did not have the opportunity to review the recommendations of other working groups, there was a consensus that any savings in the system should be passed on to consumers in the form of lower premiums.

9. Recommendation: Continue to allow and encourage the development of new purchasing strategies to promote competition in the marketplace and test out new models.

As innovative strategies are developed, the working group wants to be sure that there continues to be a focus on the development and testing of updated purchasing strategies that promote competition, improve outcomes and/or reduce costs. One example is efforts surrounding county based purchasing for publicly paid health programs. Any efforts must consider appropriate protections for the individuals and providers involved as well as the impact on the rest of the market.

10. Recommendation: Study the reserve requirements of insurers, including the appropriate levels of reserves, accountability for their use, and the possibility of requiring reserves generated by publicly funded coverage to be separately accounted for and managed.

While reserves are necessary for stability in the market, the appropriate level should be periodically reviewed. The NAIC Risk Based Capital Model Act disincentivizes plans from having their reserves at the floor, but there are no guidelines concerning the ceiling. The analysis of adequacy should compare the current reserves with the former measure of months of coverage.

11. Recommendation: Establish uniform expectations and reporting on the community benefits to be provided by non-profit entities in the health industry.

Common definitions and reporting were just established for hospitals focused on the provision of care to the uninsured.⁶ A clearer delineation of community benefit is needed for the non-profit insurers. For Minnesota's non-profit HMOs, the expectation might be the funding of the local public health based health promotion plan just recommended by the Commissioner of Health and the Statewide Community Health Advisory Committee and the continued funding of quality improvement organizations such as Minnesota Community Measurements and ICSI. The special role of the non-profit insurers in the Minnesota marketplace is based on enhanced value added and a clearer definition of that will increase consumer and purchaser confidence in the value of that preference.

⁶ MINN. SESS. Law 2007 Ch. 147, Art. 9, § 21.

C) Other cost containment approaches to explore further

12. Recommendation: Address affordable “transition coverage” and portability.

Minnesota Department of Health studies demonstrate that many people are unable to maintain continuous coverage, mainly due to affordability concerns during life changes (people who lose employer subsidized coverage but cannot afford COBRA, those whose income is too high to qualify for public programs, new graduates not yet employed, etc). The solution to this is likely linked to a publicly funded premium subsidy.

Moving the market toward standardizing policies and promoting access to them via an "Exchange" may allow for continuous coverage through life transitions and job changes.

13. Recommendation: Explore value-based purchasing.

The concept behind value-based purchasing (sometimes called Value-Based Insurance Design or VBID) is to reduce barriers to evidence-based care that saves money. It can be implemented through patient incentives based on differential cost sharing, payment based on a “unit of health improvement,” or financial rewards for certain outcomes or performance. Value-based designs seem worthy of further exploration and perhaps pilot implementation.

In one model, patients' cost sharing should reflect the variable needs of the patient, such that it encourages use of services that have high clinical value (clinical benefits exceed costs) and discourages use of services with low clinical value (costs exceed clinical benefits). Several major private companies have used insurance cost-sharing mechanisms to encourage employees to utilize high value medical care.

Some members raised concerns that the present outcome-based measures do not adequately risk-adjust for factors outside providers' control and therefore may unfairly penalize those delivering care to these groups.

14. Recommendation: Public program purchasing as the base for pilot programs.

The working group was intrigued by the idea of using the public programs (MA, GAMC, MNCare, etc.) as models to pilot and refine payment reform and cost containment strategies. Initiatives taken by the state for the population in public programs may have an effect on the private market. Given the financial situation of the enrollees and/or other unique characteristics they may not be an appropriate group for piloting certain approaches but may be for many others. For example, additional payment for previously uninsured, health care assessment upon enrollment, reward for bringing enrollees up to date on at least x % of key preventive care and screening tests, enrollment fee waived until served (make money by serving people, not by avoiding their health needs), and testing the effectiveness of various approaches to health promotion (health coaches, financial incentives, group education vs. one on one, etc).

D) Sharing Risk

Risk sharing refers to using regulatory processes or the grouping of people to spread risk across a larger group of lives and/or to limit the use of individual risk factors (age, gender, health history, etc.) in insurance product pricing. It can protect individuals and groups with disproportionate numbers of health challenged employees from significantly higher costs and/or high amounts of price volatility. It can also help assure a competitive marketplace and reduce swings in pricing by mediating the impact of adverse selection on any one insurer.

Past and Present Efforts

Since 1975, Minnesota has had the Minnesota Comprehensive Health Association (MCHA), which is a high-risk pool for people who get rejected for coverage in the individual market. All health insurers doing business in the state are required to be members of MCHA and to pay its assessments for the difference between the cost of MCHA coverage and the premiums charged to the enrollees. Insurers pass the assessments on to their customers, and the assessments are about two percent of the premiums paid by the customers. About half of MCHA's funding comes from the assessments on insurers, and the other half from the premiums charged to enrollees. Premium rates are required by law to be between 101% and 125% of the average rate charged in the private market to healthy people for equivalent coverage. The Commissioner of Commerce decides where within that range the premiums will be each year.

In the 1992 MinnesotaCare Act, the legislature created a system regulating how health insurance premium rates are set in the individual and small employer market, and that system has been in place since that time. It has two components: (1) specification of what factors an insurer can use in determining premium rates; and (2) limits on how much premium rates can vary for a product based on those factors. The factors that insurers are currently allowed to use are age, health status, claims experience, industry or occupation, duration of coverage, and geography. The limits on variations in premium rates are specified in terms of rating bands and index rates.

A rating band is a range of permitted premiums above and below an index rate, which is simply the midpoint of the rating band for a specific insurance product. Minnesota rating bands allow variations in premium rates up and down from the index rate of up to plus or minus 50 percent for age; plus or minus 25 percent combined for health status, claims history, industry or occupation, and (for small employers only) duration of coverage; and an actuarially valid adjustment for cost variations between geographic regions of no fewer than seven contiguous counties selected by the insurer.

Since July 1, 1993, Minnesota has had pure community rating in its Medicare supplemental insurance market. Pure community rating is a system in which premium rates are allowed to vary only based upon differences in the insurance product and the number of family members covered.

Beginning in 2003, Minnesota law has limited the renewal premium increase from one year to the next for a small employer to the percentage change in the index rate, plus any percentage change due to the number of individuals and families covered by the small employer, plus 15 percent. This has the effect of limiting to 15 percent an employer's possible premium change from one year to the next due to changes in the employees' health status, claims experience, or duration of coverage.

Minnesota has enacted several laws relating to purchasing of health coverage by groups of individuals or groups of employers, through associations, purchasing pools and similar arrangements. These laws include:

- A law providing that a group insurance policy may be issued to an association only if the association was formed by persons having some purpose in common other than purchase of insurance, has at least 100 members, is controlled by its members (and not by an insurance company), has dues, gets at least 80 percent of its revenues from sources other than sale of insurance, and does not offer insurance to members during their first 30 days of membership.⁷
- A law permits fraternal organizations to act as insurers for their members. This law is very narrowly written for certain fraternal organizations and does not permit many new groups to offer coverage due to its specificity.⁸
- The 1995 MinnesotaCare Act regulated the health insurance options for small employers with regard to the use of purchasing pools. The thrust of this law is to limit the ability of small employers to form a group to unfairly get coverage through the group in a way that allows them to do better than they could do on their own in the small employer market. The law does not prohibit selling coverage through a group of employers, but limits the ability to use that as an end-run around the rating bands, guaranteed issue, and other requirements of the small employer market.⁹ A law enacted in the 1994 MinnesotaCare Act permits the formation and operation of purchasing pools of individuals and employers, subject to various requirements. This law has not proven to be practical and has never been used.¹⁰ A law enacted in the 1994 MinnesotaCare Act, authorizing the formation and operation of health care network cooperatives, which would be insurance risk-bearing entities that would contract with health provider cooperatives to provide health care within a (probably rural) geographic area through local providers to the network cooperatives' enrollees. This law has never been used.¹¹
- A law enacted in 1997, permitting the formation and operation of community purchasing arrangements consisting of health care purchasing alliances, which would be groups of (probably rural) businesses, and accountable provider networks to market health care services under contracts with providers negotiated by the purchasing alliances. Accountable provider networks are permitted to bear insurance risk. This law has never been used.¹²

15. Recommendation: Modeling should be done on using adjusted community rating and rating bands to promote more affordability.

Adjusted community rating excludes health status and claims experience as factors in determining premium rates, usually permitting only age and geography used within rating bands. There was support for adjusted community rating along with the current rating bands already used by insurers to spread risk in the market. However, before any specific risk rating system

⁷ MINN. STAT. § 60A.02, subd. 1a (2007) and MINN. STAT. § 62A.10, subd. 1(2007).

⁸ MINN. STAT. § 64B (2007).

⁹ MINN. STAT. § 62L.045 (2007).

¹⁰ MINN. STAT. § 62Q.17 (2007).

¹¹ MINN. STAT. § 62R (2007).

¹² MINN. STAT. § 62T (2007).

could be implemented the group felt comprehensive modeling should be done to better evaluate the overall impact on the market. Any changes would need to be fully understood and phased in over time to carefully monitor their implementation.

Reducing or eliminating the impact of health status on pricing could be one approach to stabilizing pricing but could have other impacts that need to be carefully considered. Prohibiting health status as a rating factor without a phase-in would likely cause premiums to fluctuate for a period of time as premiums charged for healthy individuals' rise and those charged to unhealthy individuals fall to the average.

16. Recommendation: The Minnesota Comprehensive Health Association (MCHA) needs to be maintained until other mechanisms are in place to allow persons with significant health challenges to secure affordable coverage in the marketplace. Its financing mechanism of assessments on insurers should be reviewed in search of a broader and fairer base.

The Minnesota Comprehensive Health Association (MCHA) provides coverage to over 25,000 Minnesota residents who are uninsurable in the regular individual market. Unless the state requires guaranteed issue and makes coverage affordable in the individual market, there is no other source of coverage for these people.

MCHA's funding source of assessing its insurer members for about 50 percent of its costs is far from ideal. The federal ERISA law prevents assessments on self-insured employers, so the assessment burden falls on the individual, small employer, and large employer insured market; currently about two percent of premiums. This has provided one reason for large employers to self-insure. Small employers are generally unable to assume the risk of self-insurance and having to pay the MCHA assessment makes their coverage more costly and results in an unfair burden on them compared to their larger competitors. Efforts to provide a broader and fairer funding base should continue.

17. Recommendation: Study the potential benefits of merging the individual and small group markets in a mandated system for Minnesota.

Merging these two insurance markets requires insurers to offer individual coverage if they offer small employer coverage. More importantly, an individual's rating for premiums will be the same regardless of whether the policy is sold through the individual or small employer market.

Minnesota's private insurance market is quite different from other states and merging the two markets might have very different effects. For example, the Minnesota Department of Health reports that in 2005, only 443,000 people (8.7 percent) had a small employer policy and just 219,000 people (4.3 percent) had an individual market policy. In addition, premiums are growing at a slower rate in the Minnesota small employer market (5.1 percent increase in 2006) than in the private insurance market overall (7.2 percent increase).¹³ The individual market saw premiums increase by 6.7 percent in 2006.¹⁴ Expectations would depend largely on how such a merger is paired with other components of insurance reform. Modeling would better estimate the effects of merging the two markets.

¹³ MINNESOTA DEPARTMENT OF HEALTH, *Chartbook Section 4: Small Group and Individual Health Insurance Markets* (July 2007), available at <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section4.pdf>.

¹⁴ *Id.*

Merging the two markets and requiring guaranteed issue, while eliminating MCHA with no other changes to the system could cause individual market premiums to increase. Small group premiums may decrease on average, and previously MCHA covered enrollees would also likely see a drop in premiums on average.¹⁵ Again, without pressures forcing healthy individuals to remain in the market, premiums will ultimately increase even more for those remaining in the merged markets.

18. Recommendation: Review the ongoing study on the effectiveness of developing pools for individuals to band together for group purchasing outside of an employer based model

Groups are better able to spread risk and reduce sudden spikes in rates due to unexpected catastrophic costs in our current marketplace. There may be advantages to assisting with group formation by persons otherwise subject to individual underwriting. The challenge of this is to have a large enough group and a healthy enough mix to gain sufficient benefits, while avoiding adverse selection. Independent employer associations, geographical groupings, ethnic associations, etc. could be eligible to form such pools. Without required participation, there are doubts about whether this approach would work. A study on this approach is currently underway, as passed in the Health and Human Services 2007 Omnibus Bill.

¹⁵ These are very general estimates that require an actuarial analysis. MINNESOTA DEPARTMENT OF COMMERCE, *Report of 2005 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies, Nonprofit Health Service Plan Corporations and Health Maintenance Organizations* (June 2006); and MINNESOTA DEPARTMENT OF HEALTH, *Health Economics Program, Section 2: Trends and Variation in Health Insurance Coverage 7* (July 2007).

E) Improved Purchasing

Individuals and employers (especially small employers) often find it confusing and challenging to get comparable information on which to make an informed purchase of health coverage. Differing mixes of benefits and cost sharing provisions make an "apples to apples" comparison almost impossible. Smaller companies find it administratively difficult to offer access to the tax advantaged approaches for paying for care such as pre-tax premium payments and pre-tax accounts to pay for out of pocket health costs. A major study showed the complexity of the market a major barrier to the uninsured or employers not currently offering insurance.

It was acknowledged that purchasing challenges are not the only insurance challenge faced by individuals. Dealing with consumer service issues was not a charge to our group from the Health Care Access Commission. Nevertheless we did briefly touch upon this important issue. More information would be needed before comprehensive recommendations could be made. Individual members named concerns with getting good information about quality providers and obtaining access to them, consumer's difficulty challenging coverage and care decisions, and holding insurers accountable for delays, mistakes, inequitable decisions and their consequences. These issues may contribute to the real costs of health care borne by patients and, in some instances, diminish the quality of care that is provided.

19. Recommendation: Review the forthcoming study of the 'Health Insurance Exchange' by the Department of Health. It should have public oversight of its operation.

A health insurance exchange is a mechanism to bring buyers and sellers of health coverage together, ideally including both the private and public sectors. Its specific functions would be specified in legislation. A health insurance exchange would facilitate comparisons of health plan prices and options. Other states that have implemented this option have included regulation regarding the offerings and transactions related to the purchase of private insurance through the exchange. The exchange model can be combined with a variety of state subsidies, tax policies, or preventive care incentives designed to lower overall costs in the health care system.

The Minnesota Department of Health is currently developing a report to the Legislature that would better evaluate Exchange options and implementation issues. The group felt that any detailed discussion of the components of the Exchange should await the results of that study. There was agreement that any proposed "Exchange" should have public oversight. Until more specifics were available, members were unwilling to recommend moving forward with implementing an "Exchange".

20. Recommendation: There should be more transparency in cost and quality of the health care delivered.

Information currently available in Minnesota is inadequate to assist the public in how to better identify high value providers and products. Pennsylvania has one of the most advanced reporting systems on costs and quality. The state publicly reports the cost of hospital-acquired infections and the variation in cost and quality of cardiac care in the state. Minnesota should move in the direction on increasing transparency by working with providers, hospitals, plans and other organizations to better collect and report similar data.

21. Recommendation: Require full disclosure of maximum total costs for all health insurance policies, require suitability tests and counseling for the sales of high deductible

policies, and require health sales agent training so they can effectively assist purchasers and understand the complexities of the changing health market.

Too many people focus on premium price when purchasing health coverage without understanding the risks of the cost sharing components (out of pocket, co-pays, lifetime limits, deductibles). Standardized disclosure will assist in this. Some of the health related personal bankruptcies are related to persons buying inappropriate coverage – paying premiums for policies that will not adequately cover their ongoing chronic health needs. Better disclosure and counseling at the point of purchase may assist in improved purchasing.

F) Moving Toward Universal Coverage

Studies show persons with coverage are less likely to put off needed care and more likely to appropriately use medical services (clinic v. emergency room us, preventative care, etc.). Increased costs have led to more cost sharing through co-pays and deductibles. Escalating premiums are causing many individuals and businesses to seriously consider dropping their health coverage. In recent years, the movement to ensure that all Minnesotans have access to affordable, comprehensive health care coverage has received growing supporting from a myriad of parties and is the charge of the Health Care Access Commission.

Past Efforts

In 1992, Minnesota enacted an individual mandate, requiring every Minnesota resident to have and maintain health coverage from a public or private source, beginning July 1, 1997. It was repealed in 1995 before it would have gone into effect.

Efforts by other States

In 2006, Massachusetts enacted an individual mandate for all individuals 18 years and older, which went into effect July 1, 2007.¹⁶ Their mandate did not include a subsidy schedule or a definition of affordability, which are two reasons the mandate has yet to be enforced.¹⁷ State income tax returns will require proof of health insurance coverage, and those that fail to comply will face tax penalties. The state has recently indicated that 60,000 residents will not face penalties for being uninsured, because the state cannot afford to extend subsidies to them and coverage would be unaffordable to them without a subsidy.

By comparison, instead of enforcing its individual mandate immediately, Vermont's mandate will not go into effect unless the state's uninsurance rate remains above 4% in 2010.¹⁸ The state continues to promote health coverage through social marketing, outreach efforts, and market reforms in the meantime. Proponents of this method may favor waiting to see if other factors drive more individuals into the market and using a mandate as a threat. Opponents still argue that without a mechanism to force healthier uninsured individuals, premiums will increase for those already in the market. The success of this approach is unclear.

23. Recommendation: Overall affordability must be the basis for moving forward with insurance reforms and increasing the number of persons with adequate coverage.

The workgroup felt it important that the message of further progress to getting everyone covered must be focused on affordability and accessibility. Those with coverage must have reasonable access to care where they live at a price they can afford. That includes affordability for those currently who have insurance (and the underinsured) so that they can maintain adequate coverage.

¹⁶ MASS. GEN. LAWS, ch. 111M § 2 (2007); Haislmaier, E. and Owcharenko, N., *The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs*. 25 HEALTH AFFAIRS 6, 1580-1590 (November/December 2006).

¹⁷ Holahan, J. and Blumberg, L. 'Massachusetts Health Care Reform: A Look At The Issues'. Health Affairs. September 2006. <http://content.healthaffairs.org/cgi/content/full/hlthaff.25.w432v1/DC1>

¹⁸ VT. STAT. ANN. tit. 2, § 902(a)(3)(D) (2007). A Joint Legislative Commission will determine the needed analysis and criteria for implementing a health insurance requirement by January 2011 if less than 96 percent of Vermonters have health insurance by 2010.

24. Recommendation: Voluntary efforts linked to the achievement of interim coverage and cost containment goals should be the focus while more sophisticated risk sharing and market reform provisions are analyzed and developed.

To achieve these goals, the state should use social marketing, outreach at a variety of venues, and other tactics to reach out to all uninsured Minnesotans. The effectiveness of various approaches should be measured, best practices implemented widely, and accountability for progress emphasized. Special efforts with measurable goals should be targeted at key groups of the uninsured such as small businesses and their employees, the self-insured, low income persons eligible for public programs of coverage, older pre-Medicare low income persons, etc. Implementation of recommendations to aid in purchasing and cost containment should proceed and contribute to progress.

25. Recommendation: Overall systemic changes need to occur in the health care system, addressing affordability, developing key supportive insurance regulation components and strongly pursuing voluntary efforts that provide everyone with accessible, quality health care coverage. Taking the Vermont approach, an individual mandate could only be triggered by a failure to meet certain measurable goals by a certain date that go beyond the simple measure of percentage of the population insured to include other measurable targets involving affordability and cost containment.

Because our present healthcare system does not provide quality care that is affordable for and accessible to everyone in Minnesota, the committee could not recommend a mandate to purchase coverage from the market as it is presently structured. Our group did review and discuss a mandate as one component arguably needed to achieve universal coverage, but would have needed the opportunity to review and evaluate other reform initiatives before it could have determined whether the "reformed" plans addressed existing healthcare model inadequacies and inequities, including those related to cost and access, to the degree necessary to justify consideration of a mandate. It was not possible to evaluate this issue in a vacuum, prior to completion of and an opportunity to review the recommendations of the other working groups.

To the extent reform initiatives produce a model that would provide all Minnesotans quality care that is affordable and accessible, the group strongly preferred the Vermont approach to a mandate, which sets certain measurable goals to be achieved through voluntary efforts; a mandate would only be imposed if these goals are not met by a specified date. The working group was not comfortable suggesting specific goals without a clearer timetable of when various reforms would be implemented and without understanding the impact of the affordability and cost containment plans being developed by other working groups. The group did feel Minnesota's goals should go beyond Vermont's simple measure of the percentage insured, by focusing as well on affordability and accessibility.

Although not prepared to fully endorse an individual mandate, the working group was more comfortable taking the Vermont approach. This approach used an individual mandate as a threat that would not go into effect unless certain measurable goals have not been achieved by a certain date. Minnesota's goals should go beyond Vermont's simple measure of the percentage insured but also include other goals in affordability and in cost containment. Learning from other states' experience, it will take a few years to establish a system capable of supporting an individual mandate. Also, changes at the federal level may be enacted within the next few years that will ultimately impact efforts at the state level.

The state should establish robust goals for which an inability to meet would trigger a mandate to go into effect. The workgroup was not comfortable suggesting specific goals without a clearer timetable of when various reforms would be implemented and understanding the impact of the affordability and cost containment plans being developed by other workgroups.

Before a mandate is triggered, the following components must be in place:

- An affordability standard
- Income-related premium scales and/or subsidies
- Guaranteed issue/renewal in the market
- Assistance to individuals and small employers in purchasing health care
- Risk sharing mechanisms that adjust for high risk populations
- Definition of what level of coverage satisfies the mandate
- Enforcement mechanisms

An affordability standard

The Massachusetts mandate did not originally define affordable coverage. This is a key component to any Minnesota reform effort. The Cost Containment: Restructuring the Health Care System Workgroup (Berglin/Thissen) is focusing its attention on this issue.

Income-related premium scales and/or subsidies

It is important that income-related premium scales and/or subsidies be available for both individuals and small employers in order to meet affordability standards. Some individuals may not qualify for public programs, but cannot afford products offered in the market without assistance. The level of a subsidy/scales will depend on the accepted definition of 'affordable' and the cost of the qualifying minimum benefit set.

Guaranteed issue and renewal in the market

Guaranteed issue/renewal requires insurers or health plans to accept everyone who applies for coverage regardless of health status, income, or age and guarantees the renewal of that coverage as long as the premium is paid. Minnesota already has guaranteed renewal, but not guaranteed issue, in the individual market. Minnesota currently has both guaranteed issue and renewal in the small employer market.

By enacting guaranteed issue, high risk and high cost individuals could access insurance in the private market. Without accompanying guaranteed issue with an individual mandate or appropriate risk sharing mechanisms, healthier individuals will likely leave the market due to cost increases from the inclusion of high-risk individuals, many of whom are currently enrolled in MCHA.

Assistance to individuals and small employers in purchasing health care

Standardized policies, trained agents, full disclosure of maximum costs, and the establishment of other consumer supports should assist with informed purchasing.

Risk sharing mechanisms for both individuals and health plans

Risk sharing will be needed so that a single insurer is not overly burdened with high-risk enrollees and so that persons with significant health challenges continue to have a variety of insurer choices in the marketplace. Sophisticated modeling and analysis should be done prior to

implementation. The Transformation Taskforce is expected to do some modeling of an individual mandate.

Definition of what level of coverage satisfies a mandate

While the group does recommend incenting the use of a limited number of standardized Minnesota Wellness Policies, this group did not define what acceptable minimum coverage would include. This definition will depend on the standard of affordability set by the Commission and the goals for cost effective coverage.

Enforcement mechanism to ensure compliance with a mandate

The group did not discuss methods of enforcing compliance with an individual mandate, but did recognize its importance. Massachusetts elected to have the mandate enforced through tax penalties. Something similar could be designed for Minnesota.

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