

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).

