SENATOR LINDA BERGLIN, 61
Senator Paul E. Koering, 12
Senator Tony Lourey, 08
Senator John Marty, 54
Senator Julie Rosen, 24

REPRESENTATIVE TOM HUNTLEY, 07A
Representative Jim Abeler, 48B
Representative Steve Gottwalt, 15A
Representative Diane Loeffler, 59A
Representative Paul Thissen, 63A

85TH LEGISLATIVE SESSION

THE LEGISLATIVE COMMISSION ON HEALTH CARE ACCESS

Work Force Shortage Working Group Recommendations

The Work Force Shortage Working Group was charged with reviewing issues and solutions for health care work force shortages in Minnesota by focusing on the following:

I. Identifying current and anticipated health care workforce shortages, both by provider type and geography;
II. Evaluating the effectiveness of incentives currently available to develop, attract and retain a highly skilled health care workforce; and
III. Studying alternative incentives to develop, attract and retain a highly skilled health care workforce and recommend whether to replace, enhance or supplement current incentives with new ideas, including payment reform.

The working group consisted of a diverse group of 24 people, including six legislative members, 18 public members, and legislative staff.[1] It met six times between September 23 and December 8. While the time was far too short, the engagement and enthusiasm of the members was remarkable.

I. Current and Anticipated Health Care Workforce shortages, by provider type and geography.

There is broad agreement that Minnesota faces severe workforce shortages in a number of professions, geographic areas and for certain populations, and that the shortages will continue to worsen. These shortages will impact the ability of Minnesotans to access appropriate health care and will also impact Minnesota's economy.

The health care industry is a major Minnesota employer, with about 344,000 public and private sector jobs, or 13.4 percent of total state employment for 2009. According to the Minnesota Department of Employment and Economic Development (DEED), over 103,000 new jobs will be created and additional thousands of replacement health care workers (including those in the social assistance sector) will be needed between 2009 and 2019. In 2009, the professions with the highest job vacancy rates were psychiatrists, occupational therapy assistants, occupation therapists and physical therapy assistants. The largest numbers of vacancies in 2009 were for health aides, nursing aides, orderlies and attendants, and registered nurses. [2]

[1] A list of working group members may be found in Appendix A.
[2] Minnesota Department of Employment and Economic Development, "An Overview of the Health Care Industry in Minnesota," June, 2010.

Ann Lynch

According to the state Office of Geographic and Demographic Analysis, between 2005 and 2035, the population over age 65 will grow by 125 percent, or almost 770,000 people. By 2035 the proportion of the population 65 or older will go from about 12 to 22 percent.[3] This older population will likely need more health care services. At the same time, many Baby Boomers will be retiring from jobs in health care, which will create many vacancies and greatly increase the demand for health care providers.

In addition to an aging workforce and a growing senior population, practice choices of medical students, students of other health professions, and new providers contribute to workforce shortages in rural and inner-city areas, particularly in primary care specialties. The working group identified the following:

- Practice related factors, such as lack of familiarity with a geographic area, lack of professional support, and limited availability of collaborative relationships.
- Financial factors, including the high cost of professional education, high debt loads, and relatively lower salaries in primary care specialties and health care shortage areas.
- Lifestyle factors, including desire for work-life balance and fewer or more predictable work and on-call hours; and community opportunities for education, support, recreation and culture.

The Minnesota Department of Health (MDH) developed a similar analysis of future workforce shortages. The analysis concentrated on licensed primary care providers, including physicians, nurses, and physician assistants. It concluded that Minnesota's rapidly aging population will create a sharp increase in age-related health care needs, which will increase the demand for health care services just as significant numbers of health care providers are retiring. The MDH report notes that Minnesota's educational system has seen some increases in class size for health professionals but is not increasing the production of health professionals rapidly enough to keep pace with demand. A preliminary estimate of the effects of federal health care reform predicts that the supply of new providers trained under federal workforce initiatives may be sufficient to care for those newly eligible under federal reform, but it will not reduce future underlying workforce shortages.[4]

The Minnesota Department of Health (MDH) designates health professional shortage areas (HPSA) for dental care, primary care and mental health providers using criteria established by the federal government. Currently, there are both urban and rural HPSAs for dental and primary care. There are also rural HPSAs for mental health care providers. Although there are no designated HPSAs for providers of mental health care in urban areas, the working group noted there are serious unmet mental health needs in urban areas, too. For example, there is a significant need for child psychiatrists all over the state.

The shortage of nurses is complex because nurses practice at different levels (i.e. advanced practice nurses, RNs and LPNs) and in many different practice settings. In some parts of the Twin Cities metropolitan area, nurses have a difficult time finding jobs, while nurse shortages exist in many rural areas. Disparities can be found among professional settings, too, regardless of geographic area. For example, hospitals generally do not have trouble staffing nurse positions, while long-term care nursing facilities struggle to fill vacant positions and retain staff.

The working group identified the following areas that are especially burdened by current and projected workforce shortages and are in urgent need of attention to ensure patient access to care: (1) long-term care facilities are understaffed and experience high turnover due, in large part, to the inability to offer competitive wages because of low reimbursement rates; (2) rural areas of the state are unable to attract and retain providers to serve large areas, which affects patients' access to care and places additional burden on urban facilities; and (3) there is an acute need for more mental health care providers across the state.

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[3] Minnesota Office of Administration, State Demographic Center; http://www.demography.state.mn.us/projections.html.
[4] Minnesota Department of Health, Office of Rural Health and Primary Care, information presented and provided to the Work Force Shortage working group, 2010.

II. Incentives currently available to develop, attract and retain a highly skilled health care workforce.

The working group heard presentations from several current programs working to develop, attract and retain a highly skilled health care workforce. While these are not "incentives," as set forth in the charge to the working group, they illustrate successful approaches to building capacity in Minnesota's health care system. Additionally, there was consensus among the working group members that Medical Education and Research Costs (MERC) funding is vital to efforts to provide needed clinical training to health care professionals.

AHEC – The Area Health Education Centers is a national initiative that receives federal funding. The Minnesota AHEC program was established in 2002 and is a collaboration among the University of Minnesota Academic Health Center's six health professions schools, a statewide program office, and rural and urban regional centers, all administered through the University of Minnesota. Minnesota's AHEC programs include initiatives to: build the state's health care workforce pipeline through programs for students in kindergarten through high school; provide support to health professional students working in rural and urban underserved communities; and provide support and information to health care professionals and underserved communities.[5]

HealthForce MN - HealthForce Minnesota is a virtual collaborative network housed at Winona State University and administered through Minnesota State Colleges and Universities (MnSCU). It is funded with state dollars as one of four Centers of Excellence in Minnesota. It is a collaborative partnership of education, industry and community that was created to increase the number and expand the diversity of health care workers; to integrate health science education practice and research; and to build capacity for education and industry to collaborate to enhance patient care.[6]

TCCP - The Clinical Coordination Project increases the capacity of clinical education programs to provide clinical experiences to students. It acts as a bridge between clinical sites and health care education programs to schedule clinical time more efficiently and effectively so that current capacity needs are met while simultaneously planning for future capacity needs. TCCP began as a pilot in 2006 and was funded by MnSCU. It is currently funded by MnSCU and federal Department of Labor grants but future funding is uncertain. A 2009 evaluation reported a 75% decrease in time spent scheduling, planning and tracking clinical experiences, as well as an increased ability to provide and secure clinical space.

MERC - The Medical Education and Research Costs (MERC) Fund was established to help offset lost patient care revenue for teaching facilities and to help ensure continued excellence of health care research in the state.[7] Though funding sources have changed since its establishment, MERC is currently funded by cigarette tax revenues, a carve-out of medical education funds from the Prepaid Medical Assistance Program/Prepaid General Assistance Medical Care Program, and federal Medicaid matching funds obtained by the Department of Human Services.

MERC funding has been an important incentive and support to the training of health care professionals. More than 500 training sites receive MERC funds for all provider types across the state, and more than three thousand trainees benefit annually from this funding. Training health professionals is a four to ten year commitment.

Loan Forgiveness - MDH testified that their studies show the state's current loan forgiveness programs are effective, in that they are a factor in participants' decisions on where to practice. Applications for participation in these loan forgiveness programs outstrip the available funding, which indicates unmet demand for these incentives.

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[5] Minnesota Area Health Education Center Network, http://www.mnahec.umn.edu.
[6] HealthForce Minnesota, http://www.healthforceminnesota.org.
[7] Minnesota Statutes, §§ 62J.691-62J.693.

III. Recommendations

The Work Force Shortage Working Group makes the following recommendations to the Commission on Health Care Access:

Recommendation 1: Establish a consistent source of direct funding for training health care professionals in primary care.

The working group identified barriers that limit capacity growth for the primary care workforce, including dentistry, mental health and long-term care. The primary barrier to training health care providers is access to clinical instructors and training sites. Clinical instructors must be able to train students without being expected to absorb financial harm to their practice. Without funding dedicated for this purpose, providers will be less and less willing to take on additional time and financial pressures in order to provide on-site training.

Additionally, in order to meet current capacity needs by scheduling clinical training more efficiently and effectively, the work of TCCP, described above, must be appropriately funded. The modest funding required for this program is not certain in the near future.

A strong consensus exists in the working group that MERC funding must be preserved at least at its current level in order to meet Minnesota's pressing need to train health care professionals. An adequate and stable funding stream dedicated to the education of health care professionals is critical to meeting Minnesota's health care workforce needs.

Recommendation 2: Support and reinforce multidisciplinary team-based settings to better utilize the training and skills of all providers and to serve patients more effectively.

The working group believes that the health care of the future will be delivered not so much by individual practitioners but by health care teams. These teams will consist of practitioners from a variety of disciplines, and even in different locations, who will collaborate to provide effective, efficient, and affordable care to patients. The team approach to health care will require training in team settings so that practitioners learn to work with and rely upon colleagues in a variety of disciplines.

The working group recommends utilizing collaborative practice settings to make the best use of the skills and training of each of the health care disciplines. Improved utilization of providers' training and skills in team-based settings will build capacity of the current workforce across disciplines and care settings. Rural practices will especially benefit from providers working within multidisciplinary collaborations and utilizing innovations such as telemedicine, which would allow access to specialists at the point of care.

Dedicated training funds are critical to training health care professionals in multidisciplinary team-based settings. Training funds should be made available to certified health care homes.

The working group considered some proposals to expand or clarify the scope of practice of advance practice nurses and other health care professionals. While such changes may impact the future availability of some services in areas of shortage, the proposals are controversial and could not be fully vetted in the short time available to this working group.

Recommendation 3: Increase funding to expand loan repayment programs, pursue every opportunity to obtain federal funding, and support higher education institutions in applying for federal funding.

Consensus exists among members that loan repayment programs are effective tools to draw providers into practice in underserved geographic areas. Expanding these programs by increasing funding and making it available to more professions would be beneficial. Student loan repayment for faculty in health care programs is also needed. Numerous opportunities for additional workforce funding are available under the Patient Protection and Affordable Care Act (ACA); these should be pursued.[8]

Recommendation 4: The State should establish one statewide council to establish, promote and monitor a statewide plan for addressing health care workforce issues.

One ongoing council with a comprehensive and multidisciplinary membership (including, but not limited to, representatives of public health; all levels of dentistry; pharmacy; long-term care; all levels of nursing and state agencies) should be established under the auspices of the state to bring these groups together to establish, promote, and monitor a statewide plan for addressing health care workforce issues.

Multiple groups are working on health care workforce issues in Minnesota, including, but not limited to the following: working groups at the University of Minnesota; the Governor's Workforce Development Committee (GWDC); and HealthForce MN's Healthcare Education-Industry Partnership (HEIP). The HEIP council has been meeting for 14 years and consists of health care industry leaders, education leaders, labor representatives and state government representatives. The working group agrees that the HEIP council provides valuable information and collaboration, and recommends that the statewide council work with existing groups and broaden participation.

The working group has identified health care workforce issues that are complex and, in some cases, continuous. The following issues should be among those addressed by the statewide council:

(1) Development of competency-based guidelines to address clinical training experience necessary for mental health practitioners and others to ensure eligibility for reimbursement of their services;
(2) Consider whether modifications to state practice regulations would be helpful or appropriate in order to expand access to rural and other underserved populations. For example, development in cooperation with MMA and MNA of compromised recommendations to the Legislature regarding independent practitioner status and prescription authority for advanced practice registered nurses; the recommendations must use the *Consensus Model of APRN Regulations* as a baseline and consider clarifying the definition of "collaborative management" as it pertains to patient care and APRN oversight;
(3) Better utilization and compensation for mental health care providers working within an integrated care approach; ~~and~~
(4) These and all issues considered by the council should be examined on a continuous basis to ensure adequate patient access to safe, effective, and affordable services.

Adopted

Dave Sieck

4. The need for addl funding thru MERC w/ rr monies
5. The use of simulation centers and other tech based resources to ~~reduce~~ expand ... training sites.

[8] See Appendix B.

APPENDIX A

WORK FORCE SHORTAGE

Legislative Members:

Senator Ann Lynch, Chair
Senator Sharon Erickson-Ropes
Senator David Tomassoni

Representative Tina Liebling, Chair
Representative Patti Fritz
Representative Jeff Hayden

Public Members:

Ann C.F. Olson, Associate Professor & Certified Nurse Practitioner, Winona State University-Rochester Health Services
Bruce Nelson, Chief Executive Officer, ARRM
Deb Tauer, President, Minnesota Licensed Practical Nurses Association
Heather Bidinger, Founding PA Program Director, St. Catherine University
Jon Marchand, Programs Administrator, Greater Minnesota Family Services
Laura Beeth, System Director Talent Acquisition, Fairview Health Services
Linda Slattengren, Past President, Minnesota Nurses Association
Macaran Baird, Professor and Head of Family Medicine and Community Health, University of Minnesota Medical School
Mary Alice Mowry, Director, Pathways to Employment & Manager of Disability Services, DHS
Mary L. Chesney, Director, Doctor of Nursing Practice Program, University of Minnesota School of Nursing
Mary Rosenthal, Director, Health Care Reform, SEIU Health Care MN
Meghan M. Goldammer, Health Policy Analyst, Sanford Health Plan
Phil Kibort, Vice President of Medical Affairs and Chief Medical Officer, Children's Hospitals and Clinics
Randy Rice, Physician & Partner, Gateway Family Health Clinic
Robert Lohr, Medical Director, Mayo Health System
Sheila Riggs, Chair, Department of Primary Dental Care, University of Minnesota School of Dentistry
Shelley Vogt, RN, BSN, PHN, Sound Objective Solutions LLC & Good Samaritan Society
Trisha Stark, Director of Professional Affairs, Minnesota Psychological Association
Troy Taubenheim, Executive Director, Metro Minnesota Council on Graduate Medical Education

Staff:
Senate Counsel and Research: David Giel
House Research: Emily Cleveland
Tasha Truskolaski, Laura Herman

APPENDIX B

The working group supports the recommendation to leverage every opportunity available to support higher education institutions by seeking federal funding. In an effort to understand the new and existing federal funding for available workforce development, the working group asked the following institutions to complete a document that would indicate available and received grants under the Patient Protection and Affordable Care Act (PPACA):

- University of Minnesota
- Minnesota Department of Health (MDH)
- Minnesota Department of Human Services (DHS)
- Department of Employment and Economic Development (DEED)
- Minnesota State Colleges and Universities (MnSCU)
- Minnesota Private Colleges

The group received information from DEED, MDH, The College of St. Scholastica, and MnSCU. DHS confirmed that they do not have the ability to apply for such grants given their designation. The University of Minnesota is working on a submission in a format requested by the working group.

NEW AND EXISTING FEDERAL FUNDING FOR WORKFORCE DEVELOPMENT GRANTS, LOAN FORGIVENESS, ETC.

Reporting Organization: **Governor's Workforce Development Council (DEED)**

Contact Person: Bryan Lindsley, 651-259-7572, bryan.lindsley@state.mn.us

1. Funding Under The Patient Protection And Affordable Care Act Available to This Organization

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
The State Health Care Workforce Development **Planning Grant** is authorized under Section 5102 of the Affordable Care Act (P.L. 111-148)	(A) $149,599 (R) $149,599	The program authorizes funds for States to **plan** activities leading to health care workforce development strategies at the State and local levels. These activities are expected to lead to a ten percent to twenty-five percent increase in the primary care health workforce over a ten year period, and applicants will be expected to address how the activities will lead to the expected increases in health workforce.	One-time planning grant	Requirement to provide an amount, in cash or in kind, that is not less that 15 percent of the amount of the grant, to carry out the activities supported by the grant. The matching requirement may be provided from funds available under other Federal, State, local or private sources to carry out the activities.	9/30/2010 through 9/29/2011	Minnesota was eligible to apply for a Planning Grant **or** an Implementation Grant (see below). Because Minnesota did not already have a comprehensive plan, and because 30 planning grants and only 1 implementation grant were to be awarded nationally, Minnesota chose to apply for the planning grant. The Department of Employment and Economic Development is the fiscal agent for the grant. HealthForce Minnesota will be providing project management for the grant. It is unknown at this time if there will be additional federal funds available for implementation at this time.

The State Health Care Workforce Development **Implementation Grant** is authorized under Section 5102 of the Affordable Care Act (P.L. 111-148)	(NAF) 3,000,000	The program authorizes funds for States to **implement** activities leading to health care workforce development strategies at the State and local levels. These activities are expected to lead to a ten percent to twenty-five percent increase in the primary care health workforce over a ten year period, and applicants will be expected to address how the activities will lead to the expected increases in health workforce.	One-time implementation grant	Requirement to provide an amount, in cash or in kind that is not less than 25 percent of the amount of the grant, to carry out the activities supported by the grant. The matching funds may be provided from funds available from other Federal, State, local, or private sources to carry out such activities.	9/30/2010 through 9/29/2012	Minnesota was eligible to apply for a Planning Grant (see above) **or** an Implementation Grant. Because Minnesota did not already have a comprehensive plan, and because 30 planning grants and only 1 implementation grant were to be awarded nationally, Minnesota chose not to apply for the implementation grant.

2. Funding Under The Patient Protection and Affordable Care Act Available to Another Entity

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
None known.						

3. Funding Under Other Federal Programs Available to This Organization						
Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
None known.						

4. Funding Under Other Federal Program Available to Another Entity						
Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
None known.						

NEW AND EXISTING FEDERAL FUNDING FOR WORKFORCE DEVELOPMENT GRANTS, LOAN FORGIVENESS, ETC.

Reporting Organization **Minnesota Department of Health** Contact Person Barb Juelich, 651-201-3947, barb.juelich@state.mn.us

1. Funding Under The Patient Protection And Affordable Care Act Available to This Organization

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
None. MDH is not eligible for any direct PPACA workforce-related funding.						

2. Funding Under The Patient Protection and Affordable Care Act Available to Another Entity

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
Primary Care Residency Expansion Program, HRSA/HHS CFDA 93.510 Awarded to Hennepin County Medical Center	R - $1,918,827	Increase the number of residents trained in general pediatrics, general internal medicine, and family medicine.	Two additional residency slots added each year.	Unknown	2010 - 2015	

3. Funding Under Other Federal Programs Available to This Organization						
Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
National Health Service Corps State Loan Repayment Program CFDA 93.165	A - $100,000 R - $100,000	Improve access to primary care by helping underserved communities recruit and retain primary care medical, mental health and dental providers. Eligible providers include: family practice, internal medicine, pediatric and OB/GYN physicians; nurse practitioners; physician's assistants; certified nurse midwives; psychiatrists; clinical psychologists; licensed independent clinical social workers; licensed professional counselors; psychiatric nurse specialists; marriage and family therapists; dentists; and dental hygienists who serve the targeted populations living in Health Professional Shortage Areas (HPSA).	5 per year. Providers serve a two-year commitment.	One to one state match required	9/1/2010 – 8/31/2011 Renewed annually	
Grants to States to Support Oral Health Workforce Activities	A- $994,542 R - $994,542	1.) Improving infrastructure to support dental hygienists and dentists practicing with collaborative agreement.	1.) 25 - 30 hygienists and dentists trained; increasing the capacity of these providers.	40% state match required.	10/1/2010 - 9/30/2011. Grant expected to continue through	Symposium, for 50 dental educators planned in 2012.

CFDA 93.236		2.) Collaborating with the University of Minnesota School of Dentistry to develop an Early Decision Program for Rural Dentistry Track for first year college students. 3.) Ensuring that young people across the state are exposed to dental careers via the development of the "Careers in Oral Health Inter-active Website" in cooperation and coordination with the University of Minnesota's Academic Health Center (AHC). 4.) Expanding the externship program of the pediatric dentist residency training program at Rice Memorial Hospital located in Willmar, Minnesota. 5.)Promoting, developing and implementing school prevention dental (sealant) programs in federally qualified dental health professional shortage areas and other underserved and rural areas of the state. 6.) Collect and analyze data on Minnesota's Oral Health Workforce. 7.)Dental Therapist and Advanced Dental Therapist	2.)Two current students in early decision track, total of three by the end of the grant. 3.)Website estimated completion date - 12/31/2010 4.) 11 dental residents participating through the end of the grant. 5.)Training for up to 25 dental hygienists and 10 "mini grant" recipients.		8/31/12.	

		Teaching Laboratory funding at a community dental clinic 8.) To improve primary care prevention infrastructure through upgrades to aging fluoridation equipment in the state. 9.) Public Health Nurses Primary Caries Prevention Project.	7.)Supporting training of approx. 20 new midlevel providers in next two years. 8.)Prevention/population health project 9.)20 Public Health Nurse agencies			

4. Funding Under Other Federal Program Available to Another Entity

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes

NEW AND EXISTING FEDERAL FUNDING FOR WORKFORCE DEVELOPMENT GRANTS, LOAN FORGIVENESS, ETC.

Reporting Organization: **The College of St. Scholastica** Contact Person: Marty Witrak, Ph.D., R.N., FAAN

1. Funding Under The Patient Protection And Affordable Care Act Available to This Organization

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
CFDA No. 93.513 Affordable Care Act - Advanced Nursing Education Expansion (ANEE)	$1,330,560 (A), (R)	Rural Advanced Nursing Education Expansion (Rural ANEE) Collaboration	56 new nurse practitioners will graduate within a five-year time frame	None	September 30, 2010	This grant will provide substantial financial assistance to RNs, thus allowing them to pursue nurse practitioner certification.
						In response to the acknowledged role that nurse practitioners play in delivering high value care, this project involves a unique collaboration between The College of St. Scholastica, National Rural Health Resource Center (NRHRC), and Essentia Health to increase the number of rural nurse practitioners.

2. Funding Under The Patient Protection and Affordable Care Act Available to Another Entity

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes

3. Funding Under Other Federal Programs Available to This Organization

Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes
Information Technology Professionals in Health Care: Program of Assistance for University-Based Training grants, funded under section 3016 of the Public Health Service Act, as added by the American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5	$1,547,750 (R)	*UP-HI: University Partnerships for Health Informatics Training* is a private-public partnership that builds on the strengths of existing HIT programs to increase the number of Minnesota graduates entering careers as: Clinical/Public Health Leaders; Health Information Management and Exchange Specialists; Health Information Privacy and Security Specialists; Research and Development Specialists; Programmers and Software Engineers; and Health Information Technology Sub-Specialists.	12 nursing informatics certificates, 5 master's degrees in health information management/health information exchange, and 60 graduate certificates in HIM/HIE. The time for completion of the masters degrees is two years from this fall and the certificates in HIM/HIE will be completed in 1-1.5 years, depending on start date. The nursing informatics certificate completion date will be approximately one year from the start date of January 2011.	None	September 1, 2010	This public-private partnership between the University of Minnesota (Minneapolis and Crookston campuses) and The College of St. Scholastica represents a high level of resource-sharing that will positively affect healthcare and workforce development. The key variables that stimulate students to pursue these degrees and certificates are the tuition and stipend packages. Qualified and interested students are now able to pursue the education needed to manage the HIT challenges and enhancements in healthcare. The need for and desirability of these programs is evident in the fact that most of the slots, intended for a three-year time frame, will be filled in the first year of offering.
						The majority of these programs will be delivered online and are therefore accessible to urban, rural and other students for whom travel is difficult.

American Recovery and Reinvestment Act of 2009, Title XIII - Health Information Technology, Subtitle B—Incentives for the Use of Health Information Technology, Section 3012, Health Information Technology Implementation Assistance Health Information Technology Extension Program: Regional Centers Cooperative Agreement Program	$19 million (R) plus $1.4 million small and rural hospital supplement (R)	*REACH: Regional Extension Assistance Center for Health Information Technology* will help healthcare providers improve the quality and value of care they deliver through adopting and meaningfully using health information technology (HIT). The project focuses on rural and small urban practices for medically underserved patients and areas.	10-15 new HIT field staff positions, 2-4 years Opportunities for internships for other federally funded programs	10 percent in years 1-2 90 percent in years 3-4	2/8/2010 9/2010 (hospital supplement)	Key Health Alliance (KHA)—Stratis Health, National Rural Health Resource Center, and The College of St. Scholastica are partners, with Stratis serving as the lead organization. This project is an example of partnerships across public and private organizations as well as between non-profits with complementary missions.
4. Funding Under Other Federal Program Available to Another Entity						
Program Name and Federal Cite	Dollar Amount Applied for (A), Received (R), or Available but Not Applied For (NAF) (Please indicate (A), (R), or (NAF))	Program Description and Purpose	Anticipated Number of New Practitioners and Timeframe (annually, onetime, etc.)	Matching and MOE Provisions	Funding Effective Date, Including Anticipated Response Date for Funds Not Yet Awarded	Notes

Minnesota State Colleges and Universities

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, PL 111-148. The law puts into place comprehensive health insurance reforms that will hold insurance companies more accountable and will lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans.[9] With the understanding that increasing coverage will result in an increasing demand for appropriately trained healthcare professionals, the PPACA provided for regulatory changes and additional funding to increase supply and improve distribution of healthcare workers. These funding opportunities have a strong focus on primary care provided by physicians, physician assistants, and advanced nurse practitioners; access to healthcare services through community health centers; and direct financial support for practitioners through loan forgiveness, traineeships, and National Health Service Corps expansions.

A review of www.grants.gov results in a range of grant opportunities representative of the scope of the PPACA and its goals. To illustrate this, a handful of the opportunities is included in the table below. The rows highlighted in blue indicate MnSCU applications/partnerships submitted.

Name/Description	CFDA	#	$	Close Date	Agency	Notes
Health Benefit Exchanges	93.525	51	$51,000,000	7/29/10	Consumer Info. and Insurance Oversight	Governor to appoint 1 applicant per state
Medicaid Rebalancing (HCBS; 'money follows the person')	93.791	20	$22,500,000	1/7/11	CMS	1 applicant per state
Infrastructure to Expand Access to Care	93.502	1	$100,000,000	10/4/10	HRSA	Public education with dental and medical school
Enhance public health programs through building epidemiology, laboratory, and health information systems capacity	93.521	58	$35,900,000	8/27/10	CDC	MN is one of the 58 eligible applicants
New Community Health Centers	93.527	350	$250,000,000	11/17/10	HRSA	
Consumer Assistance Program	93.519	56	$29,000,000	9/10/10	Consumer Info. and Insurance Oversight	
Health Profession Opportunity Grants to Serve TANF Recipients and Other Low-Income Individuals	93.093	17	$51,000,000	8/5/10	Admin for Children & Families	MN applied as a single applicant; HealthForce partner
Health Profession Opportunity Grants for Tribes, Tribal Organizations or Tribal College or University	93.093	3	$7,500,000	8/3/10	Admin for Children & Families	Eligible: Tribes, Tribal orgs., Universities; participants: TANF and low-income
Nursing Assistant and Home Health Aide Program	93.503	10	$2,500,000	7/22/10	HRSA	RCTC applied with SE Tech and MnWest
Maternal, Infant, and Early Childhood Home Visiting Program	93.505	56	$90,000,000	8/18/10	HRSA	Governor determines single applicant

[9] www.healthcare.gov

Name/Description	CFDA	#	$	Close Date	Agency	Notes
Primary Care Residency Expansion Program	93.510	105	$168,000,000	7/19/10	HRSA	Accredited residency programs
Expansion of Physician Assistant Training Program	93.514	40	$32,000,000	7/19/10	HRSA	Physician Assistant programs
Advanced Nurse Education Expansion	93.513	40	$30,000,000	7/19/10	HRSA	Stipends for students; Metro, MSU Mankato, MSU Moorhead, & WSU
State healthcare workforce development implementation	93.509	1	$3,000,000	7/19/10	HRSA	MN applied for the planning grant
State healthcare workforce development planning	93.509	30	$2,000,000	7/19/10	HRSA	MN applied through GWDC; HealthForce & MnSCU as partners

In March 2010, the National Conference of State Legislatures released a report entitled "Summary of the Health Workforce Provisions in the Patient Protection and Affordable Care Act: H.R. 3590". This report listed workforce-specific grants which were identified in the PPACA. A summary table of these grants, including an update on release date and known MnSCU applications is shown below. As shown, many of the grants have not yet been released and many are not applicable to MnSCU.

Item	Released	#	$ in Millions	Notes	MnSCU	
					Eligible	Status
Allied Health Workforce Recruitment and Retention	Unknown			Grants for eligible individuals Authorizes $60M in FY10	No	
Training Opportunities for Direct Care Workers	Unknown			Grants for accredited educational provider with partnership with long-term care Authorizes $10M for FY2011-2013	Unknown	
Federally Qualified Health Centers	8/25/10	350+	$1,277	Funds for community health centers Authorizes $2,988,821,592 in FY10; more in subsequent years	No	
Community Health Workforce	Unknown			Supporting CHWs Authorizes appropriations as necessary	Unknown	
School-Based Health Clinic-Capital	6/30/10	1,000	$50	Must operate a SBHC	No	
School-Based Health Clinic-Operations	Unknown			Must be an SBHC Authorizes appropriations as necessary	No	
Training in General, Pediatric, and Public Health Dentistry 1) Support and development of training programs 2) Faculty loan repayment	4/28/10	60	$20	Released in conjunction with ARRA funds and tagged as ARRA funding Primary focus on dentistry	Yes	Yes-Normandale applied under this group of grants
Alternative Dental Healthcare Providers Demonstration	Unknown			Up to 15 grants; $4M for 5 years; authorizes appropriations as necessary Geared toward underserved and rural communities and includes dental therapists, advance practice, independent, and supervised dental hygienists and others	Likely	
US Public Health Sciences Track	Unknown			Tuition and stipends for service as Commissioned Corps Officers	Unlikely	
Commissioned Corp and Ready	Unknown			Establishes Commissioned Corps and	NA	

Item	Released	#	$ in Millions	Notes	MnSCU	
					Eligible	Status
Reserve Corps				Ready Reserve Corps		
Workforce Diversity				Amends criteria for nursing workforce diversity grants already offered	NA	
Centers of Excellence				Reauthorizes Authorizations appropriations of $50M for FY2010-2015 Requires minority enrollment thresholds be met to apply	Unlikely	
Health Professions Training for Diversity				Authorizes changes in loan repayment and increases scholarship funding for disadvantaged students who commit to working medically underserved areas and loan repayments for fellowships	NA	
Interdisciplinary Training				Amends program Authorizes funds as necessary	NA	
Co-locating Primary and Specialty Care in CB Mental Health Settings	Not yet released		$50	Community mental health programs are eligible	No	
National Health Care Workforce Commission	N/A	N/A	N/A	Being formed; Mark Schoenbaum and Laura Beeth have applied to be on the Commission; appointments made by 9/30/10	NA	
National Center for Workforce Assessment State and Regional Centers Longitudinal Evaluation	Est. 9/30 Est. 9/30 Unknown		$1 $4.5 Unknown		Unknown	
Demonstration Projects to address health professions workforce needs	6/21/10 6/17/10	17 6	$51 $5	Health Professions Opportunities for TANF and Low-Income Individuals – GWDC applied with MnSCU partnership Personal and Home Care Aide State Training Program	No	DHS applied w/MnSCU partnership
Continuing Educational Support	Unknown			Outreach and support for continuing	Unknown	

Item	Released	#	$ in Millions	Notes	MnSCU	
					Eligible	Status
for professionals in underserved communities				education for isolated, rural providers Authorizes $5M for FY2010-2014		
Area Health Education Centers	4/26/10	26	$11.2	Amended program Eligible entities are academic health centers Unclear if new funds have been appropriated	No	
Nurse Retention	Unknown			May be included in the nursing grants below Appear to be either changes in, or additions to, existing annual HRSA grant funds which various MnSCU institutions apply for	Likely	
State Health Care Workforce Planning	6/17/10	20	$3	GWDC applied with MnSCU as partner	No	GWDC; HealthForce Minnesota to operation-alize if funded
State Health Care Workforce Implementation	6/17/10	1	$3	MN chose to apply for planning grant with hopes of securing implementation grant in the future	No	
Mental and Behavioral Health Education and Training	Unknown			Recruitment and support of students education in social work, psychology, and child and adolescent health	Yes	
Pediatric Specialty Loan Repayment	Unknown			Loan repayment	No	
Public Health Service Act Nursing Programs	Unknown			Authorizes funding for Public Health Service Act nursing	Unlikely	
Nurse Faculty Loan	Unknown			Raises limits on existing program which requires education institution to provide 1/9 cash match; program funds approximately 20 awards per year	Yes	
Advanced Nursing Education	NA			Amends existing program to include	Yes	Metro,

Item	Released	#	$ in Millions	Notes	MnSCU	
					Eligible	Status
				midwifery MnSCU institutions often apply for this annual grant round		Mankato, Moorhead and WSU were funded
Geriatric Education	Unknown			Extends program through FY2014 Existing program	Yes	
Nursing Student Loan	NA			Raises limits on student loan amounts	NA	
Nurse Managed Health Centers	6/17/10	10	$15	For nurse-managed clinics	Yes	No; no nurse-managed clinics in MnSCU
Medical Residency Training	NA			Modifies IME and DGME	No	
Distribution of Additional Residency Positions	NA			Redistributes unfilled residency slots	No	
Pediatric Specialty Loan Repayment	Unknown			For pediatric specialists	No	
Primary Care Residency	Unknown 6/17/10	 105	 $168	Support new or expanded primary care residency programs at teaching health centers Authorizes $25,000,000 in FY2010 $80,000 per resident	No No	
Primary Care Extension Program	Unknown			Establishes extension program to support primary care providers Requires state Medicaid program, sate health dept., and health professions schools	Unknown	
Natl Health Service Corps	NA			Funds for the NHSC	NA	
Primary Care Student Loan	NA			Student loans for primary care physicians	NA	
Primary Care Training and Enhancement	4/26/10	Un-clear	Unclear	For broad enhancements in primary care education	No	
Capacity Building in Primary Care	Unknown			Preference for physician training	Not Likely	
Public Health Workforce Loan Repayment	NA			Authorizes $195,000,000 for FY2010	NA	

Item	Released	#	$ in Millions	Notes	MnSCU	
					Eligible	Status
Fellowship Training in Public Health	NA			CDC fellowships	NA	
Geriatric Education Center	Unknown			Variety of geriatric education initiatives Requires physician training	No	
Geriatric Career Incentive	Unknown			Partners with Geriatric Education Center	Unknown	
Geriatric Academic Career Awards	4/14/10	72	$5	Medical School Faculty are eligible to apply	No	

Emily

December 14, 2010

Draft-with the changes that were voted on at the last exchange working group meeting

Health Insurance Exchange Working Group Recommendations

Adopted

Background

The Patient Protection and Affordable Care Act (ACA) requires each state to establish an American health benefit exchange (exchange) to facilitate the purchase of qualified health plans and to provide for the establishment of a small business health option program (SHOP exchange) that will assist small employers and their employees to enroll in qualified health plans offered in the small employer market. The purpose of an exchange is to help consumers and small businesses shop for coverage in a way that permits easy comparison of available health plan options based on price, benefits, services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, exchanges should create more efficient and competitive markets for individuals and small businesses. Exchanges will also assist eligible individuals in receiving premium credits and cost sharing subsidies making coverage more affordable or in enrolling in other federal or state health care programs. By providing one stop shopping, an exchange will make purchasing health insurance more convenient and more accessible.

Each state must have a health benefit exchange operational by January 1, 2014, that meets all the exchange requirements of ACA. By January 1, 2013, the Secretary is required to certify whether the state will have an operational exchange by this date. If the Secretary determines that the state will not meet this requirement, the federal government will establish and operate an exchange for the state, either directly or through an agreement with a nonprofit entity.

In order to begin planning the development of a health benefit exchange in compliance with ACA the Health Care Access Commission convened the Health Insurance Exchange Working Group and charged the group with identifying and exploring the options available to the state. The working group consisted of legislators and representatives of health care stakeholder groups, including health plans, health providers, medical centers, employers, brokers, the University of Minnesota, Center for the American Experiment, and Legal Aid. A list of the working group's membership is attached. During the past several months, eight meetings were convened. During these meetings, the working group concentrated on familiarizing its members with the issues associated with establishing a state exchange and began the groundwork necessary for the possible development of an exchange. A number of meetings were devoted to understanding the state's current health insurance market, including how coverage is obtained through the public health care programs and the commercial market, underwriting rules and regulations for the individual and small employer markets, reinsurance and risk adjustment options, and the current role of brokers in the procurement of commercial health coverage. The working group also began to identify and analyze the major decisions and tasks the state will need to address in order to comply with ACA and establish a health insurance exchange by January 1, 2014.

Linda Boroian

While the working group has begun to lay the foundation necessary to begin making these decisions, there was a general acknowledgement by the group that its work over the past few months is just the beginning. The working group recognizes that there are a number of strategic policy decisions yet to be made and that the state cannot effectively make these decisions until HHS and other federal agencies develop the necessary regulations and guidelines. It is anticipated that HHS will begin to issue regulations for public comment in early 2011 with additional regulations scheduled for publication later in 2011 and in 2012. Over the next three years HHS intends to publish a series of guidance documents to provide information to states as they begin the process of developing a health insurance exchange. However, the working group recognizes that it is necessary to begin the planning process now in order to completely understand the available options before strategic decisions have to be made To begin this process, the working group has agreed on several general recommendations in order to establish a working framework for an operational and functioning state health insurance exchange.

Recommendations:

Establishment of a State Health Insurance Exchange

Under ACA, an exchange must be available in each state by January 1, 2014. If a state chooses not to establish an exchange, a default exchange will be created by HHS. If a state chooses to establish a health insurance exchange, a state may elect to establish one exchange to provide both exchange and SHOP exchange services or may choose to establish separate exchanges. Furthermore, a state may choose to join with a number of other states to form a regional or interstate exchange, or it may choose to establish its own exchange, either as one statewide exchange or a number of subsidiary exchanges throughout the state, each serving a distinct geographic area.

The first issue discussed by the working group was whether the state should establish a health insurance exchange or instead allow the federal government to create a default exchange for the state. In considering this decision, the working group spent time evaluating whether the creation and control of a state exchange would be more beneficial for the state than ceding control to the federal government. The group recognized that if the state chose to create its own exchange, it would have the opportunity to create an exchange that met the specific needs of Minnesota. The federal default exchange structure may, for example, use a "one size fits all" philosophy without regard to the needs of Minnesota or without recognizing the nuances of the health care markets in this state. The working group also recognized the importance of keeping the exchange under state control to ensure that there will be state coordination between the state's public health care programs and the subsidy programs that will be offered through the exchange. Furthermore, the group acknowledged that the state will continue to regulate insurers outside of the exchange. Since some insurers may offer products both inside and outside of the exchange, it may be easier and less confusing if the state maintained regulatory control over products offered in the exchange. Finally, there was support for the idea that the risk adjustment and risk-pooling requirements within the exchange be based on the Minnesota insurance market. There was some concern that if the federal government set up a default exchange, the risk adjustment and risk

pooling for the products offered in this exchange could be based on other state populations thereby creating higher premiums for the exchange products than would be the case if pooling was only based on Minnesota's markets.

Recommendation: Based upon the consideration of these issues, the working group recommends that the state proceed expeditiously, meeting all federal deadlines, to establish a state health insurance exchange rather than allow the federal government to manage the required exchange functions through a federal default exchange. The working group also recommends that the state establish a single statewide exchange to provide the required exchange services rather than join a regional exchange with neighboring states or establish a number of subsidiary exchanges throughout the state. Finally, the working group recommends that an actuarial assessment be completed in order to determine whether or not to establish a single risk pool for the individual and small employer market.

Exchange Entry Point for Eligibility and Enrollment

Under ACA, the exchange is required to establish an enrollment system that: (1) ensures that applicants are screened for eligibility for all available health care subsidy programs, including the premium tax credits and cost-sharing subsidies available to qualified individuals through the exchange, Medicaid, CHIP, and other state public health care programs; and (2) enrolls individuals in public health care programs if determined eligible. This requires the coordination of efforts across available health care subsidy programs in order to create an efficient enrollment process and seamless transaction between the available health care programs.

Several options are available to the state in order to meet these enrollment requirements. First, the state could require the exchange to perform all eligibility determinations for exchange plans and Minnesota health care programs (MHCP). Second, it could require the exchange to perform exchange and MHCP eligibility determinations that come through the exchange and require the state and counties to perform exchange and MHCP eligibility determinations that come through their agencies. The third option is to require the exchange to perform determinations for the exchange plans and for MHCP that come through the exchange and have the state and counties only perform MHCP eligibility determinations for applications coming through their agencies.

Recommendation: The working group recommends that the state create an application process and a single entry point for all health care subsidy programs, including the premium credits and cost-sharing subsidies available through the exchange, Medicaid, CHIP, and other state public health care programs and that the exchange perform all eligibility determinations for exchange plans, as well as for the Minnesota health care programs. This would entail aligning eligibility rules, processes, systems and benefits to the extent possible; developing a secure, electronic data exchange interface to facilitate eligibility/subsidy determination; and obtaining technical and financial assistance in order to establish on-line eligibility determination and enrollment for individuals who will be eligible for premium tax credits, subsidies, and public health care programs. Counties would continue to be responsible for MHCP eligibility determination and enrollment for the elderly, blind, and disabled. To the extent appropriate, the Department of Human Services enrollment activities for exchange eligible populations should be integrated with exchange enrollment activities.

Qualified Health Plans Participation in the Exchange

Under ACA, HHS is required to establish minimum criteria that health plans will be required to meet in order to be certified as qualified health plans. A state may require health plans to meet additional criteria. Once these regulations are established, the exchanges are required to certify health plans that meet these criteria and make these plans available through the exchange. Only qualified health plans may be offered through the exchange. Within this general framework a state must make a number of policy choices regarding the structure of the exchange and exercising its regulatory authority over plan participation. For example, a state may maximize plan participation by minimizing certification requirements or it may use its certification authority to limit exchange participation to only high-value health plans.

While the state contemplates the available options as to how it structures its exchange and establishes its regulatory authority it is important for the state when making these decisions to establish requirements that will minimize the risk of adverse selection. Adverse selection will occur if a disproportionate number of individuals who are in poorer health and have high health expenses enroll in health plans through the exchange while healthier, lower cost individuals disproportionately enroll in health plans offered outside the exchange. If this occurs the cost of exchange health plans will be higher than the cost of health plans offered outside the exchange and the effectiveness and viability of the exchange will be in jeopardy.

ACA contains several provisions to help guard against adverse selection. (i.e. premium credits available only in the exchange; uniform premium rate rules and benefit standards; temporary use of risk corridors and reinsurance; same premium for the same plan; risk adjustment and single risk pool requirements) It also provides states with flexibility in order to further limit the risk of adverse selection. For example through the state's authority to regulate the individual and small group markets, the state can ensure that the rules for the insurance markets outside the exchange are consistent with the rules that apply inside the exchange. Furthermore, under PPACA health plans are not required to participate in the exchange and health plans offered outside the exchange do not have to meet the same standards as plans offered in the exchange. However, the state has the option to require all health plans who wish to offer products outside of the exchange to also offer coverage in the exchange and to offer the same products at the same price both inside and out. Another option for the state to consider is to merge the individual and small group markets over time increasing the chance of a more balanced risk pool and thereby reducing the risk of adverse selection occurring.

Recommendation: The working group recommends that the state should continue to explore regulatory options such as the ones described above or other market mechanisms to ensure a healthy marketplace and to encourage value based decision making by consumers and employers. Participating health plans should be encouraged to establish integrated health care delivery systems that use high-quality, low-cost providers and reward efficiency in coordination with health care reform efforts that are currently being implemented. Opportunities should also be provided to consumers and employers to share in savings when they choose high quality value-based products and participate in measurable health and risk factor improvements. For example, incentives such as lower cost sharing requirements or premium rebates or offering

additional benefits or services could be developed to encourage consumers to choose higher-quality, lower cost coverage and to make lifestyle decisions that will improve their health and reduce costs.

Application of Planning Grants

Beginning in 2010, HHS has made grants available to states to aid in the planning and the establishment of a state health insurance exchange. Grants will continue to be available on a rolling basis throughout the next three years. States will have to meet certain milestones in order to be awarded grants in 2011 and the size of the grants may be related to the number of milestones met. States that are not able to meet certain milestones by the spring of 2011 may apply for grants later in the year.

Recommendation: The working group recommends that the Minnesota Department of Health or other state agencies apply for state planning and implementation grants as soon as possible and for other grants consistent with these recommendations as they become available. One goal of these grants should to be to obtain funding that focuses on actuarial analysis assistance to permit the state to make an informed decision on whether to merge the individual and small group insurance markets. Another important focus for these grants should be to obtain technology support in order to establish an electronic verification and on-line eligibility system.

Continuation of a Working Group

Recommendation: The working group recommends the continuation of a health insurance exchange working group in order to continue to the develop key issues, to evaluate strategic options as they become available to the state, and ensure that the health insurance exchange that is established operates efficiently and effectively and focuses on improving the delivery of health coverage in this state. Membership of the working group should continue to be bipartisan and to represent a broad cross-section of stakeholders. This working group could continue to be organized by the Health Care Access Commission or as a task force established by the incoming administration but it is essential for the state to recognize the importance in continuing to provide time and resources for the strategic and operational planning of a statewide health insurance exchange.

December 14, 2010

Adopted as amended by Berglin

Payment Reform Working Group Recommendations

A. Background

The U.S. health care system is often criticized for providing care that is fragmented, and for paying many providers for this care under a fee-for-service system that rewards volume, rather than high quality care. This contributes to rapidly increasing health care costs and a system in which the quality of care does not always reflect the high level of expenditure.

In recognition of these concerns, the Minnesota Legislature in 2008 passed legislation that attempts to provide financial and other incentives for the provision of coordinated, high-quality care. These initiatives include provisions to certify health care homes and provide payment for care coordination, make quality incentive payments to providers, and allow consumers to compare providers based on the cost and quality of care (see M.S. chapter 62U). The 2010 Legislature directed the Commissioner of Human Services to implement a demonstration project to test alternative and innovative health care delivery models for Minnesota health care program enrollees, including accountable care organizations that provide services based upon a total cost of care or a risk-gain sharing payment arrangement (see Minnesota Statutes, § 256B.0755).

The federal Patient Protection and Affordable Care Act (ACA) contains many provisions intended to encourage providers to coordinate the care provided to patients and to reward providers for providing care efficiently. One of these provisions establishes a shared savings program under Medicare for accountable care organizations. In addition, the Minnesota Department of Health and the Minnesota Department of Human Services were recently selected to participate in the federal Multi-Payer Advanced Primary Care Demonstration, to implement health care homes and care coordination payments for both Minnesota health care program enrollees and privately insured enrollees. Finally, many Minnesota health plans, health systems, and health care providers are conducting their own payment reform and care coordination initiatives to reward the provision of efficient, coordinated care and improve health care quality.

Given the interest in, and importance of, payment reform and care coordination initiatives at both the national level and in Minnesota, the Health Care Access Commission convened a Payment Reform Working Group. The membership of the working group consisted of legislators and representatives of various health care and consumer groups (see membership list below).

During the Summer and Fall of 2010, the working group held six meetings (August 18, September 8, September 27, October 14, October 27, and December 2). The meetings included presentations and discussion on: the status of state grant applications related to payment reform, payment reform and care coordination principles, and Minnesota public and private sector payment reform and care coordination initiatives, with a focus on the establishment of accountable care organizations.

The recommendations that follow grew out of the working group discussions of those topics. The goals of the recommendations are to: (1) encourage, and allow the state to facilitate, the many promising approaches to payment reform and care coordination that are being conducted by Minnesota health plans, health systems, and providers; (2) provide the state with an ongoing means of monitoring and evaluating the success of payment reform initiatives; and (3) apply promising initiatives to state health care programs, in order to improve patient care and to reduce the rate of increase in state health care spending.

B. Membership of Working Group

Senator Tony Lourey, Co-Chair
Senator Rick Olseen
Senator David Senjem
Senator Linda Higgins
Senator Kathy Sheran
Representative Tom Huntley, Co-Chair
Representative Jim Abeler
Representative Julie Bunn
Representative Matt Dean
Representative Maria Ruud

Anne Edwards, Chair of Pediatrics, Park Nicollet Health Services
Charlie Fazio, Chief Medical Officer & Senior Vice President, Medica
Cindy Morrison, Vice President of Health Policy, Sanford Health
Daniel L. Svendsen, Executive Director, Generations Health Care Initiatives, Inc.
Don Jacobs, Chairman & Chief Executive Officer, Hennepin Faculty Associates
Douglas Wood, Chair, Division of Health Care Policy, Mayo Clinic
George Schoephoerster, Geriatrician, Geriatric Services of Minnesota
Heidi Holste, Associate State Director of Advocacy, AARP
James Wuellner, Vice President and Chief Financial Officer, St. Luke's Hospital of Duluth
Jim Przybilla, Chief Executive Officer, PrimeWest Health
Jonathan Watson, Director of Public Policy, Minnesota Association of Community Health Centers
Julie Sonier, Deputy Director, State Health Access Data Assistance Center, University of Minnesota
Lisa Fink, Staff Attorney, Legal Services Advocacy Project
Meg Hasbrouck, Vice President, Payer Relations and Contracting, Allina Hospitals and Clinics
Michael Scandrett, President LPaC Alliance, Minnesota Safety Net Coalition
Terry Carroll, Senior Vice President, Transformation and CIO, Fairview Health Services
Jim Reimann, Payer Relations Chair, Minnesota Medical Group Management Association
David Abelson, President and Chief Executive Officer, Park Nicollet Health Services

C. Recommendations

1. Develop Improved Methods of Risk Adjustment and Risk Assessment

Many payment reform initiatives require participating providers to bear some degree of financial risk, as an incentive to efficiently provide high quality services. For example, payments to a provider for a defined set of services provided as needed to a patient may be fixed, or the level of aggregate payment to a provider may vary with whether the provider meets a target tied to service utilization. In these cases, providers with a patient base that is healthier than average (relative to other providers) will be more likely to benefit financially, since expenditures and service utilization for that patient base will be more likely to be lower than average. This can give providers and health plans and systems a financial incentive to seek healthy enrollees ("cherry-pick"), and a financial disincentive to establish programs that would serve and attract patients with high-cost health care conditions. In addition, small providers may be reluctant to participate in payment systems that involve risk sharing, since any losses on patients with greater than average health care needs must be recouped over a smaller overall patient base.

Risk adjustment is one method of reducing the likelihood of providers being penalized for serving a greater-than-average proportion of patients with significant health care needs. Risk adjustment is the process of adjusting payments to health plans, health care providers, and other entities, to reflect differences in the risk characteristics of enrollees or patients. Risk adjustment can also be used to control for patient characteristics as part of measuring and comparing the cost and quality of care. Minnesota rules governing the statewide quality reporting and measurement system define risk adjustment in this context as "a process that adjusts the analysis of quality measurement by accounting for those patient-population characteristics that may independently affect results of a given measure and are not randomly distributed across all providers submitting quality measures. Risk adjustment characteristics include severity of illness, patient demographics, or payer mix" (Minnesota Rules, part 4654.0200, subpart 17).

Risk adjustment usually relies on a risk-assessment model to compare the risk characteristics of individuals or groups to a population average. These characteristics, which are typically obtained from enrollment or claims data, can include demographic factors such as age and gender, health status information, payor information, and information on medical condition and treatment. Risk assessment can be used to risk-adjust payments to health plans and providers when they are paid through capitation or some other non-fee-for-service payment method. Risk assessment can also be used to identify high-cost patients for purposes of disease management or care coordination, measure provider efficiency, and compare provider performance while controlling for patient health status and other relevant characteristics.

The working group discussed the limitations of current methods of risk assessment. Several working group members raised concerns about the fact that current methods do not generally incorporate factors such as race/ethnicity, language, or income/poverty that may influence health outcomes and health care utilization independently of other factors included in the models (e.g. age, gender, diagnoses).

Assessing the need for improvements to risk adjustment is a necessary and important step for implementing payment reform for two reasons. First, if providers do not trust the risk adjustment methods, many of them – especially small providers – will be reluctant to participate in payment reform initiatives. Second, inadequate risk adjustment could lead to financial incentives that penalize providers serving higher-risk populations and reward providers that serve lower-risk populations. This could ultimately reduce access to care for higher-risk populations.

Recommendation: The working group recommends that the state work with the private health care sector to assess the need for improvements in risk adjustment models, to develop the necessary data infrastructure (e.g. data collection on additional factors to be included in risk adjustment), and to develop and implement improved methods of risk adjustment. This process should result in a set of agree upon standards for risk adjustment and risk assessment models. The standards could, for example, address issues such as: the demographic and health-related factors that should be included in a risk-assessment model; the extent to which health indicators should be based on diagnosis or treatment; and the extent to which a risk adjustment model should be prospective (based on health spending indicators from a previous period) or concurrent (based on health spending indicators from the current period).

The standards should, among other things, encourage smaller or specialized health care providers and health plans to participate in payment reform initiatives that require some risk-sharing. An appropriate risk adjustment method for these providers will likely require special features given the small patient base of these providers, since current risk assessment tools tend to do a better job of explaining variations in health care costs between larger patient populations, as opposed to smaller ones. An appropriate risk adjustment method for these providers would also likely require including in the risk assessment model a wide range of variables, including non-clinical, socio-economic factors related to race, ethnicity, language, and poverty and homelessness.

2. Ensure the Full Participation of All Provider Types in Payment Reform

In order to have a significant effect statewide in reducing health care spending and improving the quality of care, payment reform and care coordination initiatives must include participation by a wide range of providers, who in the aggregate serve a large and diverse patient population across all areas of the state, both rural and urban. Participation in payment reform initiatives should be feasible and attractive not only for large, urban group practices but also for solo-practitioners and other small (often rural) providers, safety net providers such as community clinics, and specialty providers that serve defined populations, such as those with specific health conditions or certain cultural, ethnic, or socio-economic groups.

These small, safety net, and specialty providers may not have the resources necessary to evaluate whether to participate in a payment reform initiative, negotiate successfully with health plans and health systems, and modify their organizational procedures and payment systems as necessary to allow them to participate in payment reform initiatives. The health information technology and electronic health record systems required to participate in payment reform initiatives may be unaffordable to these providers, and these providers may require technical assistance in selecting

and maintaining these systems. Finally, these providers may only be able to accept limited financial risk as part of a payment reform initiative.

At the same time, many of these providers have experience in providing care to hard to serve populations using cost-effective and innovative payment and care delivery methods. This specialized expertise may be useful to health plans and large health care providers as they develop payment initiatives to serve low-income or culturally diverse or specialized populations.

Recommendation: The working group recommends that the state take steps to ensure that private sector payment reform initiatives, and those administered by the state for state health care program enrollees, are flexible in design and include a range of models, in order to incorporate the full range of health care providers and serve a diverse patient base. These steps could include, but are not limited to:

1. encouraging and coordinating efforts to provide technical and financial assistance to small, safety net, and specialty providers, to allow them to evaluate and participate in payment reform initiatives;

2. seeking any applicable federal grants that would support infrastructure development by small, safety net, and specialty providers, and assisting these providers in applying for relevant grants;

3. providing a means of communicating best practices to all providers, including but not limited to those best practices used by small, safety net, and specialty providers to reach hard-to-serve populations;

4. ensuring that financial risk arrangements do not preclude participation by small, safety net, and specialized providers; and

5. ensuring that risk adjustment methods are appropriate for small, safety net, and specialized providers (see also recommendation #1).

3. Facilitate Transparency and Coordination

Many payment reform initiatives require increased transparency – i.e. greater sharing of price and quality information between health care providers, and with consumers. Effective implementation of payment reform initiatives may also require health care providers and health plans to work together to coordinate care using uniform procedures. State and federal data privacy, antitrust, and fraud and abuse laws may limit the extent to which information can be shared, and the ability of providers to work together to establish uniform procedures for care coordination. These laws may also hinder efforts to allow consumers to choose providers or health care systems based on comparisons of cost and quality.

The ACA, in order to promote the development of Medicare accountable care organizations, provides federal agencies with waiver authority related to fraud and abuse laws, and also gives those agencies the authority to designate new regulatory exceptions and safe harbors.

Recommendation: The working group recommends that:

1. the state assist efforts by the private health sector to cooperatively develop uniform procedures and standards for payment reform initiatives, by convening groups of patients rights and consumer protection organizations, health care providers, and health plans when some form of state protection from antitrust laws is necessary;

2. state agencies assist provider groups and health plans interested in developing payment reform initiatives, by issuing timely decisions or issuing advisory opinions, after input from consumers, and when necessary, assisting providers and plans in obtaining clarification from the federal government;

3. the state monitor the extent to which data privacy and anti-fraud laws hinder the implementation of payment reform, and when necessary recommend appropriate changes in state and federal laws and any necessary federal waivers; and

4. the Minnesota Department of Health, in consultation with the Department of Human Services and providers and plans, develop improved patient reported outcome measures that can be used to measure delivery system performance and the effectiveness of payment reform initiatives.

4. Design and Implement Payment Reform in the Broader Context of Societal Determinants of Health

While much of the discussion of payment reform focuses on the actual provision of and payment for health care services, other factors also have a significant impact on population health outcomes. For example, the county health rankings model assigns weights to the various health factors that influence health outcomes. The model assigns a weight of 20 percent to clinical care, with the remaining 80 percent assigned to three sets of non-clinical factors – health behaviors (30 percent), social and economic factors (40 percent), and physical environment (10 percent). [Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, County Health Rankings: 2010 Minnesota, www.countyhealthrankings.org/minnesota]

Since the ultimate goal of the health care system is good health and positive health outcomes, payment reform initiatives should be developed in the context of these broader societal determinants of health, and in coordination with the public health system.

Recommendation: The working group recommends that payment reform initiatives for enrollees of state health care programs:

1. incorporate preventive services;
2. provide incentives for patients to adopt and maintain healthy lifestyles;
3. take into account racial, ethnic, and cultural factors;
4. respect patient preferences and decision-making; and
5. use measures of population health status as well as individual health status, including the health status of specific racial, ethnic, and low-income populations, when evaluating effectiveness.

The working group also recommends that the state encourage private sector payment reform initiatives to satisfy these criteria.

5. Continue the State's Focus on Payment Reform and Cost Containment

The development and implementation of payment reform initiatives is an ongoing process. Many payment reform models have only recently been implemented and have not been fully evaluated. Given the potential impact of payment reform on health care costs and quality, the state should maintain a means of reviewing the progress of payment reform, evaluating the effectiveness of payment reform initiatives in lowering health care costs, and providing a forum for discussing relevant issues with stakeholders.

Recommendation: The working group recommends that the state continue to focus on payment reform and cost containment, whether through a working group of the Health Care Access Commission, a commission appointed by the governor (perhaps similar to the Governor's Health Care Transformation Task Force of 2007), or by another means. Membership in the working group should continue to be bipartisan and represent a broad cross-section of stakeholders.

In addition to focusing on the recommendations listed in this report, the working group or other entity may also want to consider:

1. promoting and further developing the health care payment and quality reforms authorized by the 2008 Legislature, e.g. by continuing to transition payment reform from bundled payments and shared savings approaches to total cost of care models;

2. continuing to promote the development of health care homes, in both private and public sector programs, and monitoring health care home initiatives such as the Multi-Payer Advanced Primary Care Practice Demonstration for which participation by Minnesota was recently approved;

3. monitoring the development of ACOs in Minnesota, including the health care delivery systems demonstration project authorized under Minnesota Statutes, § 256B.0755, and based upon this monitoring, determining whether state regulation of ACOs is necessary;

4. evaluating the effectiveness of private sector payment reform models and payment reform initiatives authorized by the ACA, and whether successful initiatives should be incorporated into state health care programs;

5. evaluating what an appropriate definition and level of reimbursement should be for total cost of care, in order to both evaluate the effectiveness of payment reform and obtain a baseline for assessing ongoing provider concerns about the adequacy of reimbursement. In defining total cost of care, the working group should consider not just medical costs incurred by a provider for the provision of patient services but also the impact on costs (cost-shifting) for other providers, payers, government entities, and nonprofit organizations; and

Benefit moves and other ~~tier~~ cost sharing arrangements. (PASS)

6. promoting state collaboration with the newly established Center for Medicare and Medicaid Innovation, through communicating effective strategies to the center and seeking any necessary federal approval for state payment reform initiatives.

SMALL GROUP HEALTH INSURANCE MARKET WORKING GROUP

Laws of 2010, Chapter 370, SF1905/HF2163

Currently, Minnesota's Small Employer regulations permit a small employer with 2-50 employees to purchase a health plan, guaranteed issue, if the employer pays 50% or more of the employee's premiums and insures at least 75% of their eligible employees. Premiums are subject to rate bands and caps on rate increases.

The Working Group met eight times, from July 29th to November 4th, and reviewed the following topics:

- Options, concerns and costs in expanding the small group definition to 100 employees
- Migrating from fully-insured to self-insured
- Section 125 Plan
- Uniform application
- Impact of federal health care reform requirements.

The Working Group hoped to identify the effect on insurance premium costs with employers if the definition of a small employer was changed to, 2-50 and 51-100 employees or 2-100 employees. However, actuaries were not able to predict the exact effect on insurance premiums costs. What is hard to predict is the impact of self-funded and uninsured groups that would enter this new employer market, or currently insured employers who would drop coverage or self-insure.

The Working Group voted to recommend that Minnesota wait to expand the definition of small group or employers to 100 employees until the Federal Health Reform definition changes to 1-100 employees in 2014, under the Affordable Care Act. The Affordable Care Act also requires the creation of an Exchange which will assist individuals and small employers in looking for coverage, provide subsidies for individuals and enroll individuals in the public health programs. Additionally, the National Association of Insurance Commissioners (NAIC) will be doing an analysis on a national basis of the effect of expanding the small employer definition and will be developing a model law for states to adopt.

The Working Group learned that approximately 11% of employers with less than 100 employees self-fund. If the fully-insured small employers market is expanded to 100 employees along with rate band protection and guaranteed issue, this could create anti-selection. Employers with sick employees and dependents would purchase coverage to cover costly ongoing health conditions, but could become self-insured if the group was healthy.

The Working Group learned that Section 125 Plans are used by employers that offer group health insurance to their employees but concerns were raised about MN Statute 62U.07 mandate that applies to employers (employer with 11 or more employees must set up a Section 125 Plan) that do not offer health insurance. There are legal and Affordable Care Act concerns about setting up Section 125 Plans inappropriately, especially with individual health plans. Because of the cost and complexities of setting up a Section 125 Plan, a CPA, tax expert or

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knowledgeable insurance agent should assist the employer in setting up the Plan and annually review it for compliance. The Group recommended repealing 62U.07 and incorporating education and compliance information related to the offering of a Section 125 Plans in the design of an Exchange.

The Working Group determined that developing and implementing a uniform application form may be early due to changes in the new federal health care reform laws and because Minnesota insurance agents/producers have created an electronic application for the small employers market. Federal reform will require the Exchange to have a uniform application in 2014 that will enroll individuals in both public health programs and private insurance policies. Additionally, NAIC will be developing a national uniform application in 2011-2012.

SMALL GROUP HEALTH INSURANCE MARKET WORKING GROUP

REPORT TO THE MINNESOTA HEALTH CARE ACCESS COMMISSION

In accordance with the Laws of 2010, Chapter 370

NOVEMBER 15, 2010

Table of Contents

I. INTRODUCTION:

This report is in response to Chapter 370, Laws of 2010[1] which created a Small Group Health Insurance Market Working Group (Working Group) to study options available to increase rate predictability and stability for groups of 100 or fewer employees. Minnesota's current small employer law applies to employers with 2 to 50 employees. The report, due to be submitted to the Legislative Health Care Access Commission by November 15, 2010, must address specified topics outlined in the law.[2]

The legislation required the commissioner of the Minnesota Department of Commerce (COMM) to provide assistance in research and administrative support to the Working Group composed of representatives of prescribed organizations. The Working Group members appointed to carry out the terms of this statute are:

Minnesota Council of Health Plans:
Nancy Nelson, Vice President & Chief Actuary, Blue Cross and Blue Shield of Minnesota
Joe Pupkes, Vice President of Underwriting & Product Development, PreferredOne

Minnesota Association of Health Underwriters:
Tom Aslesen, Accord Benefit Resources, Inc.
Christopher Schneeman, Registered Health Underwriter, Seven Hills Benefit Partners

Insurance Federation of Minnesota:
Bob Johnson, President, Insurance Federation of Minnesota

Minnesota Chamber of Commerce:
John Sjoberg, Controller, Shaw-Lundquist Associates, Inc.

National Federation of Independent Businesses - Minnesota:
Mike Hickey, Minnesota State Director, National Federation of Independent Businesses - MN

Minnesota Senate:
Sen. Linda Scheid (DFL-Brooklyn Park)
Sen. Mike Parry (R - Waseca)

Minnesota House of Representatives:
Rep. Diane Loeffler (DFL-Minneapolis)
Rep. Denny McNamara (R-Hastings)

Employer Representatives:

- Sandra King, Vice President – Operations, West Central Initiative (Employers whose businesses employ 50 employees or less)
- Charles Terry, Terry's Hardware, Inc. (Employers whose businesses employ 50 employees or less)
- Julie Pawlowski, Director of Human Resources, Command Tooling Systems (Employers whose businesses employ 51-75 employees)
- Alex Neutgens, Controller, Ecologic Analytics (Employers whose businesses employ 51-75 employees)
- William Gullickson, CEO, MGK (Employers whose businesses employ 76-100 employees)

- Suzette Frith, Human Resources Manager, TSE, Inc. (Employers whose businesses employ 76-100 employees)

Employee Representatives:

- Terese Pilaczynski, Director of Human Resources, Lancet Software Development (Employees of businesses that employ 50 employees or less)
- Scott Walker, Carpenters Union Member, St. Paul Linoleum and Carpet Company (Employees of businesses that employ 51-100 employees)

Minnesota Department of Commerce:

- John Gross, Director, Health Care Policy

In addition to the committee members, the following presenters provided expert information for this report:

- Glenn Wilson, Commissioner, Minnesota Department of Commerce
- Greg Datillo, President, Datillo Consulting, Inc.
- David Reid, E.A.S.E., LLC
- Samantha DiMaggio, Senior Loan Officer, Minnesota Department of Employment and Economic Development
- Thomas R. Pender, J.D., Legislative Analyst, Minnesota House of Representatives Research Department
- Manny Munson-Regala, J.D., Deputy Commissioner, Minnesota Department of Commerce
- Cindy Sheffield, President, SOMI
- Dan Strusz, Executive Vice President, HCC Life Insurance Company
- Stefan Gildemeister, Assistant Director, Health Economics Program, Minnesota Department of Health
- April Todd-Malmlov, State Health Economist, Health Economics Program, Minnesota Department of Health
- Melane Milbert, Research Analysis Specialist Senior, Minnesota Department of Commerce

The cost of preparing this report is $7500. This includes staff time, printing and supplies.

II. EXECUTIVE SUMMARY

The economic reality that many small employers face makes it difficult for them to provide their employees with health insurance. Minnesota assists small employers with 50 or less employees in offering health insurance by assuring them access to the market through guaranteed issue and limits on dramatic rate increases. The Working Group was charged by law to explore a variety of issues related to helping small businesses more easily access and understand the health insurance market and analyze implementation issues related to expanding the definition of small employer under Minn. Stat. Chapter 62L, with an overall charge to study and report on the options available to increase rate predictability and stability to employers with 100 or fewer employees.

The full charge of the working group included addressing the following topics:

1. analyzing implementation options in expanding the small group definition to 100 employees;
2. underwriting concerns and rating requirements and the implications of change in small group market size on the entire health insurance market, and limitations on renewal, enrollment methodologies, and processes;
3. costs for employers, employees, brokers, and health plans;
4. how to assist employers in understanding the implications of employers migrating from fully insured to self-insured and associated risks;
5. a uniform application form;
6. education and compliance issues related to the offering of Section 125 plans under Minnesota Statutes, section 62U.07; and
7. assuring compliance with federal law, including expeditious implementation of federal health care reform requirements.

This report is structured with separate sections that provide detail on each of the above topics. (See Table of Contents for Page Numbers)

The Working Group considered options for implementation of changes in the small employer health insurance market including:

1. Following the federal default which will change the existing small employer definition to include employers with 1-100 employees in 2014;
2. Expanding the definition of small group to include employers with up to 100 employees earlier than 2014;
3. Creating a separate pool for employers with 51-100 employees, and
4. Adding sole proprietors (single employee groups) to the existing small group market.

The Working Group faced challenges in evaluating the options due to lack of data, concurrent market changes, budget limitations, time constraints and the number of unknowns with Federal Health Reform regulations still being developed.

The Working Group hoped to quantify the impact on rates of employers with 2-50 employees and employers with 51-100 employees if the definition of small group was expanded to 2-100. Without knowing which groups will transition into or out of the fully-insured small employer market and completing an actuarial analysis, the exact effect on insurance premium costs cannot be identified. The Working Group learned that the information and actuarial analysis needed to estimate the impact on existing employers in the fully-insured market would take more time than the Working Group had to complete its report and would require additional funding and collection of detailed group specific information from the health plans. Even with group specific information and detailed actuarial analysis to obtain the cost impact of pooling existing groups in the fully-insured market, actuaries would not be able to predict the behavior and assess the impact of self-funded and uninsured groups that could enter the fully-insured small group market or fully-insured groups that could decide to drop insurance or self-fund.

The Working Group discussed the context in which any state change in definition of small employer would be taking place, including both state and federal changes and the impacts on health plan resources as they implement the changes which have already been enacted.

The Working Group learned about the history of Minnesota Small Group Law including changes enacted this past legislative session. Minnesota Laws 2010, Chapter 384, Section 24 provides the option for health plans to offer flexible benefits plans to groups of up to 100 employees beginning January 1, 2012. These flexible benefits plans can modify or exclude Minnesota mandated health care benefits (except maternity and other benefits required by federal law) and use other cost control measures such as co-pays, deductibles, and cost-sharing arrangements. This is a new option available to assist small employers with 100 or fewer employees looking for lower cost health insurance options. These flexible benefit plans, when offered to groups of 2 to 50 employees, will have to comply with existing rate band statutes that apply to groups of that size.

Federal Health Reform under the Affordable Care Act (ACA) was also discussed since the definition of small employer is set to change to include employers with 1-100 employees effective in 2014, unless the state elects to set the upper limit for small group size at 50 employees until 2016. The change to defining small employer as an employer with 1-100 employees, if done in 2014, would coincide with implementation of other provisions of the Affordable Care Act, including the requirements for an Exchange to assist individuals and small employers looking for coverage. The Exchange will have mechanisms to provide subsidies for individuals and allow employers to provide defined contribution plans.

Given the federal changes, Minnesota will not be the only state interested in assessing the impact of expansion of the small employer definition but is currently the first state to consider making the change early. Additionally, the National Association of Insurance Commissioners (NAIC) anticipates having the NAIC Regulatory Framework Task Force review the impact of expansion of the small employer definition to 1-100 prior to 2014 when states would have to make decisions about whether to follow the federal default or elect to set the upper limit for small group size at 50 employees until 2016.

The Medical Loss Ratio recommendations presented by the NAIC to the U.S. Department of Health and Human Services (HHS) in October, as required by ACA, presume that the definition of small employer will remain at 50 or fewer employees until 2014. Since federal regulations about Medical Loss Ratios and corresponding rebates have not been issued, it is unclear what the impact would be of having a state definition of small employer that is different from the definition used to calculate medical loss ratio and rebates under federal health reform.

The Working Group discussed the issue of sole proprietors since the federal law is set to both increase group size in the small group market to include employers with 100 employees and reduce group size to include businesses with a single employee. The Working Group determined that it was not the charge of the Working Group to make a decision on single employee groups. Other committees of the Heath Care Access Commission (HCAC) will be looking at merging the individual and small group market into one Exchange. Single employee groups will be part of the small group definition in 2014 under federal health reform. The Working Group identified that there will be potential for adverse selection with individuals in single employee groups since that individual employee will have the choice of shopping for insurance in the individual or small group market. This will be an issue for the Exchange group to consider.

The Working Group had a specific charge to look at the issue of developing a uniform application and found that there was extreme interest in having a uniform application from employers, employees and agents. Some agents already purchase a system that allows them to utilize one application to apply to multiple companies. While there was interest in a uniform application, the Working Group did not feel the timing was right to begin development of a uniform application for private insurance in the small group market. As part of federal health reform, the Exchange will also be requiring a uniform application in 2014. The NAIC will be leading this effort on a national basis. Any uniform application that Minnesota would develop ahead of 2014 would be temporary since the uniform application for the Exchange will need to incorporate the ability for individuals to enroll in both public health programs and private insurance plans, as well as collection of information necessary to assess eligibility for subsidies.

The Working Group also had a specific charge related to Section 125 plans and the requirements of Minn. Stat. 62U.07. The Working Group determined that Section 125 plans are commonly used by employers that offer health insurance to their employees but concerns were raised about the 62U.07 mandate that applies to employers that do not offer health insurance. There are potential legal consequences for the employers if the mandated Section 125 Plans are set up inappropriately, especially when employees are assisted in purchasing individual health plans. There are also questions about the future of Section 125 plans under federal health reform. While employers that offer their employees health insurance through a group plan can continue to offer a Section 125 plan under the Affordable Care Act (ACA), the ACA precludes using Section 125 plans for Exchange-based individual insurance. For these reasons, the Working Group recommends repealing 62U.07 and incorporating education and compliance information related to the offering of Section 125 Plans in the design of an Exchange.

MAJOR FINDINGS

- **Growth in Small Business:** There is significant growth in the number of sole proprietorships and small businesses in the state. Overall companies of 2-50 employees represent 80% of the firms in Minnesota, while firms of 51-100 employees represent 4%.
- **Disproportionate Decrease in Health Insurance for Employers with 50-99 employees:** While there has been some reduction in the number of companies offering insurance to their employees, most small employers do provide health insurance to their employees. The percent of Minnesota employers offering health insurance declined only slightly between 1996/1997 and 2008/2009 from 54.5% to 52.2%. However, the percentage of Minnesota employers with 50 – 99 employees offering health insurance coverage declined from 87.0% to 79.5% in the same time period. A greater trend is in employers responding to rate increase proposals by increasing employee cost sharing or dropping employer contributions to dependent coverage.
- **Satisfaction of Employers with 2-50 Employees:** Small employers reported that they appreciate the guaranteed issue and guarantee renewability protections so that they cannot be forced out of the market due to a major illness or accident in the lives of one or two employees. They also appreciated the rate protection of the rating bands. However, small employers are concerned that rate increases will cause healthier employees to consider dropping coverage and the employer could lose the small group protections if they can't meet the 75% participation requirements. Losing the small group protections through the addition of a 51st employee would make some hesitate to add new employees if their health insurance costs would become less manageable.
- Purchasing insurance and understanding the market is difficult for employers without dedicated human resource professionals. They rely on agents for their information.
- Federal health reform requires all states to go to small group sizes of 1-100 in 2014 unless the state elects to delay the expansion beyond 50 employees until 2016.
- Insurers currently are undergoing significant challenges and demands related to understanding and reacting to proposed implementation regulations and the complex federal health reform law.
- While self-insuring used to be limited to larger size firms, more small firms are now doing it. Firms utilize stop loss insurance to manage the risks of self-funding.
- Limited information prevented the Working Group from analyzing or modeling the impacts of changes in the market. Therefore the committee had no information to predict the effects of alternative implementation options or transition options for expanding small group size. A survey that Minnesota Department of Health is conducting could provide additional information on these markets but isn't due until after the November 15 due date of this report. The data is due December 13 and has to be analyzed. It will be discussed and reviewed when it is available.

- The current requirement that companies with 11 or more employees offer Section 125 plans for tax advantaged payment of premiums can be problematic due to court rulings and IRS interpretations since the enactment of that law, particularly if employees purchase individual health plans.
- The burden of having employees fill out multiple health histories in order for an employer to get quotes from multiple insurance companies has been addressed by some agents acquiring and using software that combines the different health history questions of multiple insurance companies into a single application.

RECOMMENDATIONS

The Working Group was split on the following issue:

Expansion of the Small Group Definition to include groups from 51-100: The Working Group voted to recommend that Minnesota not expand small group size up to 100 prior to the federal default outlined in the Affordable Care Act which would change the small employer definition to include groups with 1-100 employees effective in 2014. This was a split decision (9-5) by the working group.

There was a minority of the group that wished to set up a separate risk pool for employers with 51-100 employees sooner than 2014. The risk pool for employers with 51-100 employees would be modeled after Minn. Stat. Chapter 62L which provides guarantee issue, rate bands and other protections to small employers with 2-50 employees. This recommendation was defeated (7-6) by the Working Group.

There was consensus by the Working Group on the following recommendations:

Expansion of Definition to Include Self Employed (Group of One): The Working Group recommends that incorporation of sole proprietorships or "small groups of one" into the small employer definition in Minnesota should await the effective date of the corresponding federal change under the Affordable Care Act (ACA). The ACA will change the definition of small employer to include single employee groups in 2014.

Uniform Application: The Working Group determined that developing and implementing a uniform application form may be premature at this time due to the changes in the new federal health care reform laws and the fact that the benefits it would yield would be for a limited time frame. An on-line uniform application will be developed as part of the Exchange.

Section 125 Plans: The Working Group recommends repealing Minn. Stat. 62U.07 (the requirement to offer Section 125 plans even if there is not an employer sponsored health insurance benefit) and incorporating education and compliance information related to the offering of Section 125 Plans in the design of an Exchange.

III. LEGISLATIVE BACKGROUND

A. Small Employer Definition

Under Minnesota Law[3], a "small employer" is a business that employed an average of 2 to 50 current employees during the past calendar year, has at least two current employees on the first day of the current plan year, and has at least two eligible employees who have not waived coverage. Two or more related businesses that are treated as a single employer under the Internal Revenue Code are treated as a single employer. An employer that has more than 50 current employees, but has 50 or fewer employees under federal ERISA and HIPAA laws, is treated as a small employer. Federal law does not allow an employee to also be an employer and therefore may have fewer employees than under Minnesota law. In addition, employees whose health coverage is determined separately under a collective bargaining agreement do not count in determining whether the employer is a "small employer".

An employer that qualifies as a "small employer" is eligible for guaranteed issue and guaranteed renewal coverage in the small employer market if at least 75 percent of the small employer's eligible employees who have not waived coverage participate, and if the employer pays at least 50 percent of the premium for each of those participants. The employer is not required to contribute toward the cost of covering dependents.

B. History of Minnesota Small Employer Health Insurance Laws

The committee was provided an Overview of Minnesota Legislation related to the Small Group Health Insurance Market, specifically related to the history of Minnesota's small employer health insurance laws (Minnesota Statutes, Chapter 62L).

1991 The first version of the current small employer legislation in Minnesota passed the legislature in 1991 and was in a bill that was vetoed by the Governor because of a lack of funding for other aspects of the bill.

1992 A different version of this legislation was enacted in May 1992. This version used a provider tax to fund various programs and included the implementation of the small employer law effective July 1, 1993.

1993 The scope of the Minnesota Small Employer Market was defined as 2 to 29 current employees.

1995 The small employer definition was increased to 2 to 49 current employees.

1997 The small employer definition was increased to 2 to 50 current employees

C. Flexible Benefit Plans

1992 State law related to flexible benefits plans was initially enacted in Minnesota in 1992 and codified in Minnesota Statutes 62L.05. These plans provided for a benefit set that does not fully comply with other statutory requirements for small employer health insurance by allowing reductions in coverage and increased cost sharing, such as co-pays and deductibles.

1999 At this time, a flexible benefits plan pilot project was enacted and allowed to sunset in 2003. The law allowed sale of these plans to small employers only by health plan companies that had less than 3% of the Minnesota health insurance market, which excluded participation by the four largest health plans in the Minnesota marketplace. The Minnesota Attorney General's office took the position that the exclusion of maternity benefits permitted for these plans would be gender discrimination in violation of the Minnesota Human Rights Act.

2005 Flexible benefits plan legislation was enacted that allowed health plans to exclude any state health coverage mandates except those specifically required by federal law and the law was clarified to provide that these products were not in violation of the Human Rights Act.

2010 Effective in 2012, legislation was enacted that allows the flexible benefit plans to be marketed to employers with from 2 to 100 employees and to individuals. (See Appendix C with exact legislation language)

IV. STAKEHOLDER CONCERNS

A. Employers and Employees

The employer and employee members of the Working Group expressed concerns regarding the cost of health insurance. It is a significant expense for these employers and costs are shared by the employees. Since rate increases can be difficult to predict, particularly if there has been a change in employee health status, this can create budget issues for the small employer. Members of the Working Group shared stories of employers that were afraid to hire their 51st employee for fear of moving into the large employer market because they knew that they had group members with significant health conditions and were benefiting from the cap on rates in the small employer market.

Since the cost of employee health insurance is a significant expense for these small employers, most shop the insurance market every year, and look at alternatives such as self funding[4]. Shopping for insurance takes time away from running their business and may require their employees to complete applications for each different insurer that the employer asks for a quote.

For groups that have employees with health conditions, particularly those with a number of low income workers, participation levels can drop as rates paid by the employees increase. This can create problems for the employer to get a quote and shop the market. In order to obtain the guarantee issue and rate band protections of the small employer market for those employers with 2-50 employees, the group must maintain 75% participation. Many insurers in the larger group market, which includes employers with 51-100 employees, also require 75% participation in order to quote a group. If a larger group falls below the 75% participation level due to employees not being able to afford rate increases, the group may not be able to shop other carriers in the market. The other carriers may reject the group due to the percentage of employees electing to participate.

B. Insurance Companies

Insurance companies expressed concerns that increasing the group size for the small employer market would have a cost impact on their operations and for many groups in the existing 2-100 market. Some groups will benefit while others will see rate increases as costs from groups with the highest claims are shifted and built into the rates of other healthier groups.

Insurance companies also expressed concerns about timing and resources. Carriers are facing many changes due to federal health reform. New federal law changes are required each year until 2014. Implementing the required federal changes will strain their resources. Carriers are concerned that the addition of state law changes, even if those law changes call for early implementation of federal law changes, will place an unnecessary burden on their resources.

Federal changes under provisions of the Affordable Care Act (ACA), already require that the definition of small employer be modified in 2014 to include employers with 1-100 employees unless the state elects to set the upper limit for small group size at 50 employees until 2016. Other provisions of the ACA that take effect before 2014, such as provisions relating to Medical Loss Ratio, presume that the definition of small employer will not include employers with more than 50 employees until 2014. If Minnesota changes its definition of small employer to 100 prior to 2014, it will create special implementation obstacles for carriers that operate in other states as well as Minnesota. These carriers will have to have a special process and implementation schedule for Minnesota that is different than the other states where the carrier does business.

C. Agents

Insurance agents expressed concerns similar to other stakeholders. In addition, the agents expressed concerns that the value of their role in assisting small employers and employees to make health coverage decisions will be overlooked as the state implements federal health reform.

V. ITEMS CONSIDERED

A. Implementation Options in Expanding the Small Group Definition to 100 Employees

The Small Employer Health Insurance Market Working Group identified options in implementing an expansion of the small employer definition.

Pooling of Risk: The Working Group discussed the fact that the existing small employer market is set up with rate bands. When rating for health status, groups can be rated +/- 25% from the base rate due to health conditions. The addition of groups with 51-100 employees to the existing small employer pool of groups with 2-50 employees has the potential to impact the rates for all employers from 2-100 employees. One option to avoid an impact on small employers in the existing pool of employers with 2-50 employees would be to set up a separate pool for employers with 51-100 employees. Such a pool for employers with 51-100 employees could provide a rate range similar to the existing small employer market or a wider range (for example, a range of +/- 33% from a base rate).

Inclusion of Self-Employed/Groups of One: The group discussed sole proprietorships and the issues that they face in obtaining health coverage. Sole proprietors need to apply for coverage in the individual market. If rejected in the market due to health conditions, sole proprietors are eligible for coverage under the Minnesota Comprehensive Health Association, our state high risk pool, or possibly the federal high risk pool, the Pre-Existing Condition Insurance Plan, if they have been without coverage for six months or more. Since self-employed individuals can apply for coverage in the individual market, those that would be most likely to attempt to get a group policy are those for which the group policy is cheaper than their options in the individual market. This is most often those with existing health conditions. The Affordable Care Act expands the definition of small employer to include sole proprietorships in 2014, with no option for waiver on a state level. The Working Group recommended that this change should await the effective date of this provision of the Affordable Care Act.

Transition in Group Size: The group discussed the issues that face groups as they hire new employees and move from the small to the large group market and heard stories of employers that were afraid to hire their 51st employee out of concerns for the impact on health insurance premium if the group changed from a small to a large group. The small employer definition could be expanded to allow groups that were originally rated as a small group to maintain their small group status within reasonable limits of growth. Insurance companies were concerned about anti-selection issues. Groups that grew to be more than 50 employees would only elect to stay in the small group market if rates were cheaper. Likely the unhealthy groups would want to stay and be rated as a small group and the healthy groups in this scenario would ask to be rated as a large group. This adverse selection would result in higher premium rates for the entire small group pool.

Timing of Implementation: The group discussed the timing of any expansion in small group definition. Insurance companies explained that they would need time to develop and file rates, file changes to forms, and implement other process changes. Carriers did not anticipate being able to make the

change until 2012 or 2013. Carriers expressed that they are already working to implement changes required under the Affordable Care Act (ACA). If the state does not act to change the small employer definition earlier, the definition of small employer is set to change in 2014 due to the ACA.

B. Underwriting Concerns and Rating Requirements and the Implications of Change in Small Group Market Size on the Entire Health Insurance Market, and Limitations on Renewal, Enrollment Methodologies, and Processes

Effect of Adding Employers with 51-100 employees to the existing small employer market: The Working Group asked the Department of Commerce to try to obtain information that would help the Working Group determine the impact on rates if employers with 51-100 employees were added to the existing pool of employers with 2-50 employees. The actuarial staff from the Department of Commerce interviewed a number of the largest carriers in Minnesota's small group market to obtain information. The interviews were conducted independently with each carrier. For each interview, the company's lead actuary or delegate was asked a structured set of questions.

The actuaries identified that there are many problems in predicting the behavior of groups with 51 to 100 employees if the small employer definition is changed to provide employers of that size with guaranteed issue and rating bands. Some groups in that size category that are currently self-insured or uninsured may enter the fully-insured market. There is no available information on how many groups will enter the fully-insured market from self-funding or uninsured status. There is also not any information available regarding claim cost distribution for employees of such groups.

Other groups of 51-100 employees that are currently insured in the fully insured market may elect to self-fund if groups of this size were put in the small group market. Actuaries do not have any way to estimate that exact movement. However, when asked to provide their professional judgment, the actuaries consistently and independently identified that at least 10% of groups that are currently fully-insured would be expected to leave the fully-insured market. Additionally the actuaries noted that many of the size 51-100 groups may move to self-insurance in the future to avoid the federal requirements of community rating and minimum loss ratios, even if state law does not impose rating bands and guaranteed issue on that size.

In the large group market (currently defined as employers with 51 or more employees), rates vary for a number of reasons besides current health status of the employees. For example, large group rates can vary based on all of the following factors:

- Age,
- Retiree Status,
- Industry,
- Benefit Differences,
- Claims Experience, and
- Agent commissions.

While the choices in plan design for small employers are limited, there are still over 200 small group plans available in Minnesota. In contrast, carriers allow large groups much more latitude to customize their benefits to differ from the carrier's standard package (adjusting deductibles, coinsurance & co-pays; adding or removing benefits; adding or removing exclusions; including wellness programs; etc.) creating a virtually unlimited number of benefit differences. This creates a problem when looking at the claims experience for groups in the 51 to 100 size category. Each group would have to be adjusted manually by an actuary to get a valid comparison of demographic and benefit differences.

Similarly, the presence of catastrophic claims makes it difficult to compare among groups. There is no standard methodology to adjust the experience.

Another challenge in determining the impact on claims cost if employers with 51-100 employees were added to the existing pool of small employers is that it is difficult to obtain totals on the number of people covered by such plans. Carriers that insure groups with 51 or more employees do not have an accurate count of the employees in those groups. The carriers just verify that the group has more than 50. Most carriers in the small group market have some fully-insured groups in the 51-100 size category, but the total number of members appears to be significantly lower than the total in the small group block. This may have to do with the overall number of larger groups in Minnesota, or it may have to do with the number that are self-insured.

For the reasons indicated, it is not possible to predict the effect on employers with 2-50 employees and employers with 51-100 employees if the existing small employer market was expanded to 2-100 based on information available.

Since the Affordable Care Act will expand the definition of small employer nationally to include employers with 1-100 employees by 2014, the National Association of Insurance Commissioners (NAIC) is anticipating completing an analysis on a national basis of the effect of this expansion of the small employer definition and will be developing a model law for states to adopt. Since an NAIC will be taking up the issue of expansion of small employer definition, one option would be to delay state action until the NAIC has completed its analysis. The state will have to make a decision by 2014 about whether to accept the federal default definition of small group or elect to set the upper limit on small group size at 50 employees until 2016. The NAIC analysis should be available prior to the time that decision is needed.

Effect of Creating a Separate Pool for Employers in 51-100 employer market: The Working Group looked to evaluate the effect of applying rating bands and guarantee issue requirements to employers with 51-100 employees as their own separate pool so as not to impact groups in the existing small group market of 2-50 employees. The consensus of the actuaries at the companies is that, if rating bands and guaranteed issue were applied to existing groups in the 51-100 employee market as their own pool, and if none of those groups leave the market, the overall impact would be slight, perhaps 1-6% increase in overall cost to make up for the high-cost groups whose premiums would be capped at 125% of an index rate. More employers would be expected to experience rate

increases than would experience rate decreases and there would be a subset of groups that are currently paying less than 75% of that index rate that would experience extremely significant rate increases to bring them within the band. This would negatively affect rate stability and predictability.

Declinations: The Working Group was concerned that employers in the large group market face declinations. The consensus of the actuaries on declinations among the size 51-100 groups is that outright "decline" decisions are very rare. Typically a company can rate for bad experience, and the group either chooses the lowest rate from among the carriers in the market, or the group can't afford to provide coverage to its employees because the lowest rate is still unaffordable.

For groups that are currently fully-insured, the incumbent carrier is required to offer them a renewal. Agents explained that, for groups with historically poor experience, they often are unable to get any carrier other than the incumbent carrier to quote the group. The incumbent carrier often has issued a blended rate so that the premium quoted for the 51-100 employee group, while possibly a significant rate increase, does not reflect the full cost of expected claims. If an agent seeks a competitive bid from another carrier, that carrier may require a premium that it knows exceeds the quote of the incumbent carrier and will therefore decline to bid.

MDH Survey: The Minnesota Department of Health (MDH) conducts a survey of health carriers. The survey was revised this year to include questions to assist in providing additional detail for small groups. The timing of the MDH survey and the due date of this report did not permit inclusion of the data with this report. The survey may provide additional data regarding small employer groups including:

- Further Size Breakdown of employers in the existing small employer market,
- Average Premium per member per month,
- Average Claims per member per month,
- Number of groups by Size,
- Number of covered members,
- Percentage of index rate for groups in the existing 2-50 market, and
- Premium Range in the 51-100 market

Unfortunately, this survey is still limited in the ways identified in the actuarial interviews. They may provide a partial picture of the claims and rates in the small group market but cannot adjust for benefit and demographic differences, particularly in groups of 51-100 employees currently in the large group market.

Recommendation: The Working Group recommends that Minnesota not expand small group size up to 100 prior to the federal default outlined in the Affordable Care Act which would change the small employer definition to 1-100 in 2014.

C. Costs for Employers, Brokers and Health Plans

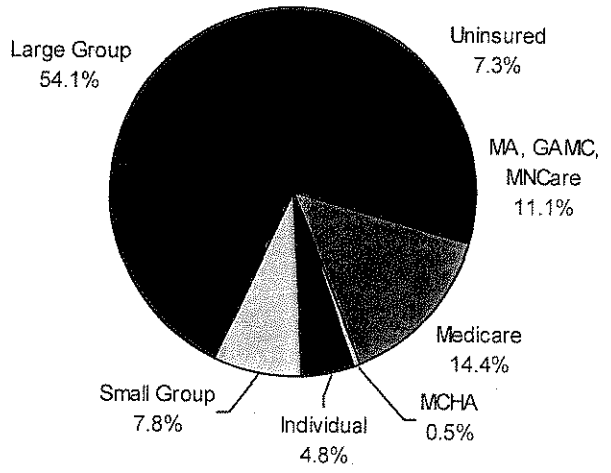
Trends in the Number of Private Establishments in Minnesota, by Firm Size[5]

Overall the number of businesses in Minnesota grew by 5.2% during the period from 1999 to 2009 with an average annual growth rate of 0.5%. The best growth rate occurred in 2006 with a 2.9% increase in the number of businesses and the lowest growth rate occurred in 2009 with a decline of -4.6% businesses overall. There were 141,418 businesses in Minnesota in 2009 compared to 134,399 in 1999. Of these total number of businesses, 113,054 were in the firm size range with 1-50 employees in 2009 compared with 110,042 of this firm size in 1999; and there were 6,082 firms with 51-100 employees in 2009 compared to 5,669 in 1999.

Minnesota Small Group Health Insurance Market Statistics [6]

Source of Coverage: The primary source of health coverage for the 5.2 million people in Minnesota in 2008 was job based coverage. A total of 61.9% of Minnesotans had health coverage through an employer. The next largest source of health insurance coverage in Minnesota was Medicare at 14.4%, followed by State Public Programs (Medical Assistance, GAMC[7] and Minnesota Care) at 11.1%, Individual coverage at 4.8%, and the state high risk pool (Minnesota Comprehensive Health Association - MCHA) at 0.5%. As of 2008, Minnesota had a 7.3% rate of the uninsured.

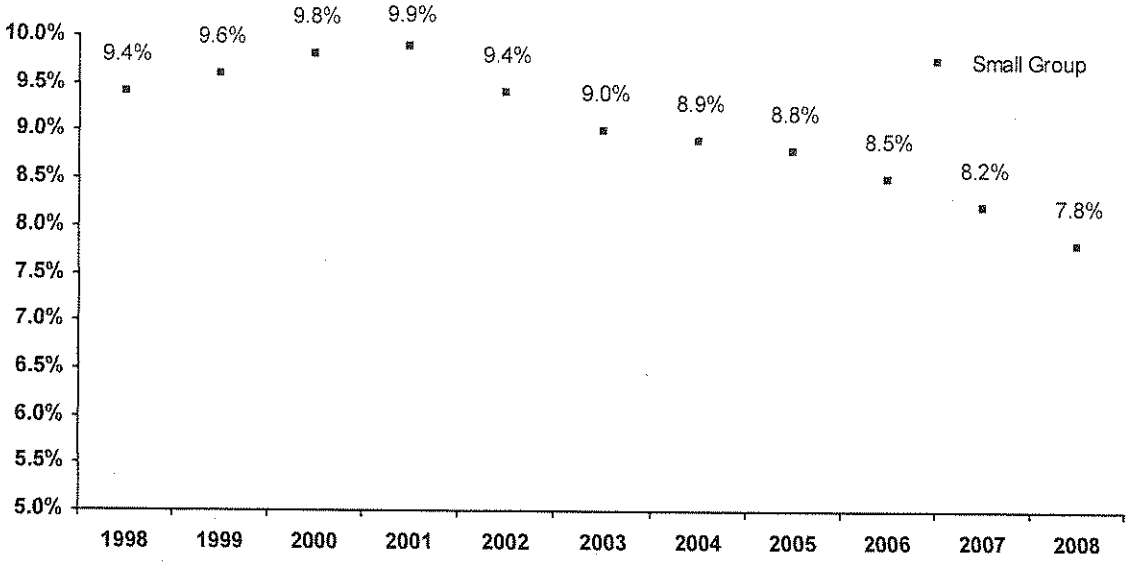
Distribution of Minnesota Population by Primary Source of Insurance Coverage, 2008



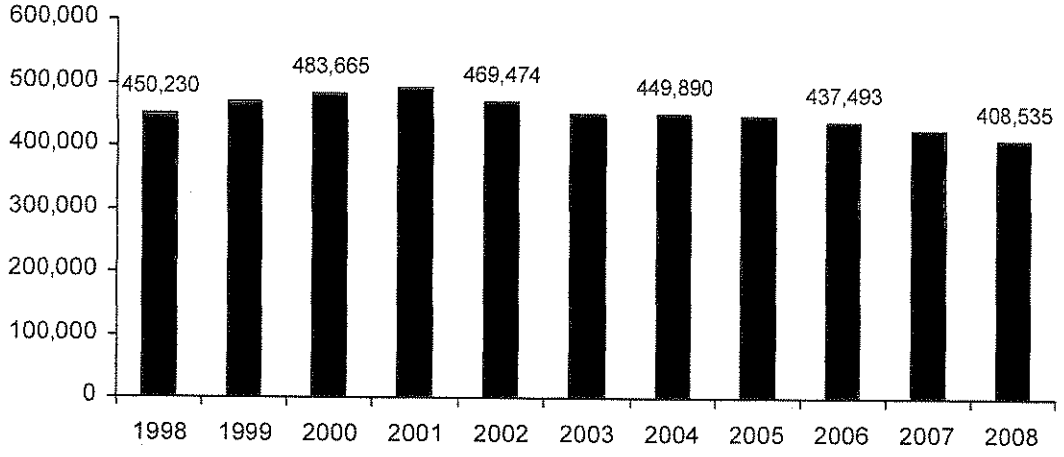
Source: MDH Health Economics Program; population estimates are from the U.S. Bureau of Census, July 2009
MA is Medical Assistance, MNCare is MinnesotaCare, GAMC is General Assistance Medical Care

Of the 61.9% of the Minnesota population with job based health insurance coverage, 54.1% of the population received coverage in the large group market which is defined as employers with 51 or more employees and 7.8% of the population received coverage in the small group market which is defined as employers with 2 – 50 employees.

Enrollment in Small Group Plans as a Share of the Population: Between 1998 and 2008 the small group market declined from 9.4% to 7.8% as a share of the Minnesota population.

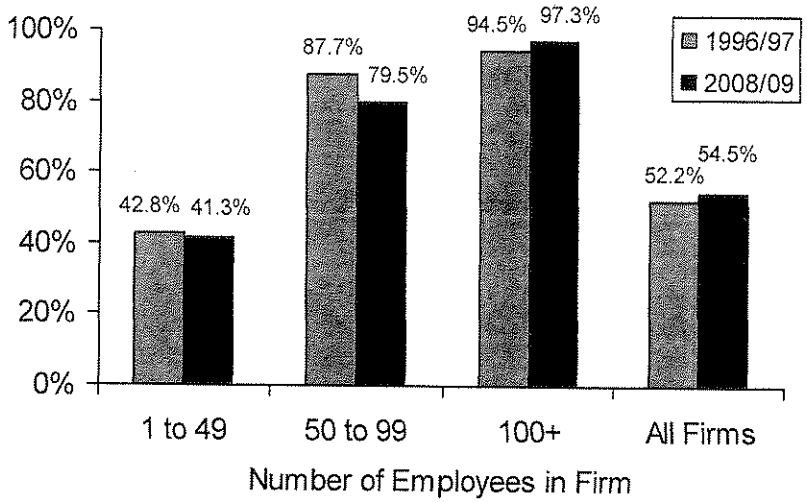


Trends in Minnesota Small Group Health Enrollment, 1998 to 2008: In 1998 there were 450,230 enrollees in the fully insured Small Group market compared to 408,535 in 2008. During this period of time, the number of small employers remained virtually the same at approximately 80,000 establishments in firms with 2 – 50 employees.



Fully insured market only.
Source: MDH, Health Economics Program; estimates based on data from various sources.

Percent of Employers Offering Health Coverage, by Firm Size: The percent of Minnesota employers offering health insurance coverage by firm size declined between 1996/1997 and 2008/2009 from 42.8% to 41.3%. The percentage of Minnesota employers with 50 – 99 employees offering health insurance coverage declined from 87.0% to 79.5% in the same time period. The percentage of employers with 100 or more employees offering health insurance coverage increased from 94.5% to 97.3%.



Source: MDH analysis of data for private employers from the Medical Expenditure Panel Survey/Insurance Component (years are pooled to improve the statistical validity of the estimates. Preliminary data; difference between estimates have not been tested for statistical significance.

Percent of Employees Eligible for Health Insurance Coverage: The percent of employees eligible for health insurance in firms offering coverage during the same period of time declined from 80.9% to 75.5% for the small employer market with 1 to 49 employees and from 77.4% to 68.9% for employees working in firms with 50 to 99 employees. There was an increase in the percentage of employees working in firms with over 100 employees who were eligible for health insurance. This percentage increased from 79.6% to 80.2%. [8]

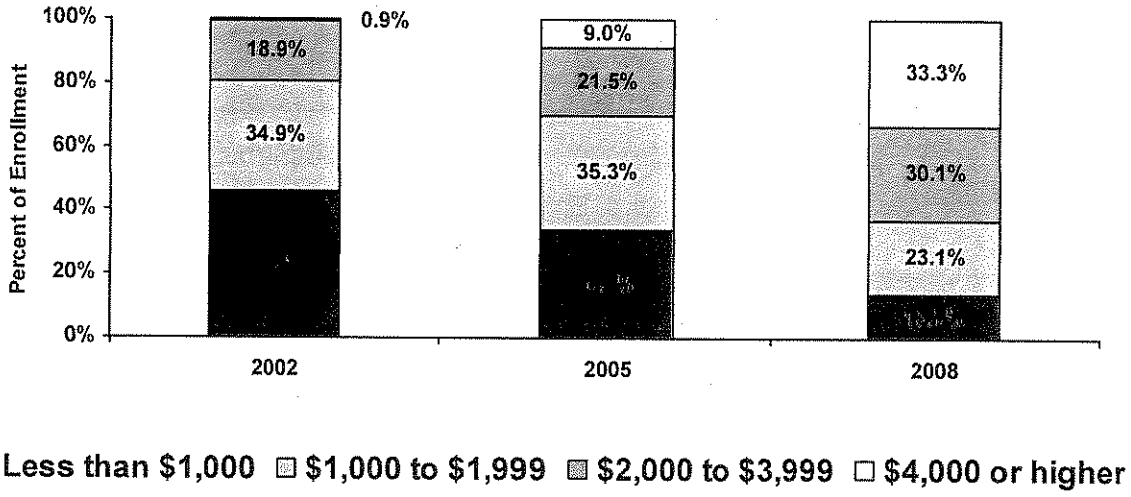
Average Health Insurance Premium/Single Coverage: During the time period from 1996/97 to 2008/09, the average annual health insurance premium in Minnesota for Single Coverage increased from $1,757 to $4,563 in firms of 1 to 49 employees; from $1,835 to $4,704 for firms with 50 to 99 employees and from $2,012 to $4,481 for firms with 100 or more employees. The average employee contribution to single coverage by firm size for the period remained substantially the same for firms with 1 to 49 employees at 15.7% to 15.9%, but increased from 15.9% to 26.5% for employees working at firms with 50 to 99 employees and from 15.9% to 21.9% for employees working at firms with 100 or more employees. [9]

Average Health Insurance Premium/Family Coverage: During the time period from 1996/97 to 2008/09, the average annual health insurance premium for family coverage increased from $4,588 to $11,231 in firms with 1 to 49 employees; from $4,994 to $13,375 in firms with 50 to 99 employees; and from $5,208 to $13,910 for firms with 100 or more employees. The average

employee contribution to family coverage by firm size increased from 26.6% to 35.4% for firms with 1 to 49 employees, but decreased from 31.8% to 31.2% form firms with 50 to 99 employees. For firm sizes of 100 or more employees there was a slight increase in the average employee contribution to family coverage from 23.1% to 23.9%.[10]

Family Deductibles: The most striking difference in the distribution of family level deductibles in the small group market between 2002 and 2008 is the number of employees with deductibles of $4,000 or higher. In 2002, there were only 0.9% of employees in the small group market with family level deductibles of $4,000 or higher. This increased to 33.3% in 2008.

Distribution of Family Level Deductibles in the Small Group Market, 2002 to 2008



Office Visit Copayments: Office visit copayments in the small group market of $25 or more increased from 6.1% to 59.0% from 2002 to 2008. Family level out of pocket limits in the small group market of $6,000 or more increased from 0.9% to 15.7%. The number of employees paying from $4,000 to $5,999 in family level out of pocket costs increased from 37.6% to 64.4% from 2002 to 2008. The availability of unlimited lifetime limits on benefits in the small group market decreased by 51.2% to 25.2% from 2002 to 2008.

Premium Volume by Carrier: The total premium volume in Minnesota in 2008 in the small group market was $1.54 billion. The companies with the largest market shares are Blue Cross Blue Shield of Minnesota with 45.6%; Medica with 27.2%; Health Partners with 19.8% and Preferred One and Federated Mutual Insurance Company with 3.2% each. Time Insurance company (formerly Fortis) had 0.4% market share and Principal Life Insurance Company had 0.2% market share. The other 3 companies operating in the Minnesota marketplace had combined market share of 0.4%.

Loss Ratio Experience[11]

A loss ratio is a rough measure of how much of the premium revenue was spent on medical care. Revenue not used to pay medical expenses is used for health plan administration, marketing, taxes, other expenses, and net income.

For 2009, the loss ratios for health plan companies in the small group market ranged from 62% to 136%. The loss ratio overall for all health insurance companies in the small group market for 2009 was 87%.

Additional Change Brings Additional Cost

Insurers have raised concerns about an early expansion of the small employer definition form 2-50 employees to 2-100 employees at a time when there are so many other changes in the health insurance marketplace due to federal health care reform that was enacted on March 23, 2010. On the six month anniversary of enactment, or September 23, 2010, many new benefits were mandated by the new law including allowing parents to keep dependents up to age 26 on their policies, guaranteed issue for children under age 19 with preexisting conditions, and elimination of lifetime and annual maximums. The newly mandated benefits have associated costs that may pressure increases in health insurance rates, particularly when added to medical trend.

Increases in health insurance premiums have been shown to cause some employers to attempt to decrease or neutralize cost increases by changing their benefit plans to increase the cost sharing of their employees such as providing for increased out of pocket costs in the form of higher deductibles and co-pays. Other employers may choose to drop health insurance coverage for their employees causing their employees to become uninsured if they cannot afford COBRA or to seek other coverage options such as MCHA, Minnesota Care, GAMC or other public assistance programs that are paid in whole or in part by other ratepayers or state and federal taxpayers.

It should also be noted that another change resulting from federal health care reform will increase medical loss ratios (MLR) to 80% for small groups and 85% for large groups effective January 1, 2011, subject to rebates paid to consumers for failure to comply. The definition of small group for purposes of the MLR calculation is 2 – 50 employees until 2014.

Another concern raised about early adoption of the small employer definition is that healthy groups may choose to self insure to avoid premium increases leaving unhealthy groups in the fully insured market causing additional pressure for rate increases to the other small groups in the risk sharing pool currently defined as small employers.

Insurers are already incurring implementation costs for federal health reform and appealed to the Working Group to avoid adding additional administrative costs associated with implementing an early change in the small employer definition during this time of change in the health insurance marketplace. The change in the small employer definition is scheduled to take effect in 2014, when the national health insurance mandate is scheduled to go into effect. This will bring more healthy

individuals and groups into the health insurance marketplace and increase the size of the risk sharing pool. Additionally, an Exchange is required to be up and running by 2013 for testing by HHS.

Insurers will also have costs associated with revising applications and policies, underwriting rules, rates, and filing fees for any proposed policy changes. These additional early adoption costs will be borne only by plans doing business in Minnesota. According to the National Association of Insurance Commissioners (NAIC) no other state has enacted legislation to increase the small employer definition to 100 employees. The NAIC is in the early stages of forming an advisory group to study the impact of this change in federal law and to recommend model legislation for adoption by the states to expand the small employer definition to 1 – 100 employees in order to bring state law into compliance with federal law effective 2014.

D. Ways to Assist Employers in Understanding the Implications and Risks of Migrating from Fully-Insured to Self-Insured

The Working Group discussed self-funded plans, sometimes referred to as self-insured plans, and the risks and benefits in transitioning between the self-funded and fully-insured market. The Working Group was given an overview of self-insurance to gain familiarity with terms such as:

Self-Funding: In a self-funded arrangement, the employer funds employee claims rather than buying traditional health insurance. The employer often delegates administrative responsibilities to a third-party administrator (TPA), insurer or HMO. Employer can manage its exposure to catastrophic claims expense by purchasing stop loss insurance. Self-funded groups are subject to federal law only and do not need to comply with state mandates.

Fully-Insured: This is traditional health insurance where employers pay a premium to an insurance company and the insurer accepts the risk of paying claims. Groups that are fully insured are subject to both federal and state law.

Stop Loss Insurance: Coverage purchased by employers in order to limit their exposure under self-funded (self-insured) health plans. This coverage is available in two types:

Specific stop loss – The type of coverage that protects against catastrophic claims on a single individual covered under the group plan. The stop loss carrier reimburses the employer for claims on individuals whose annual eligible expense exceed the specific deductible.

Aggregate stop loss – The type of coverage that protects against higher than expected total claims under the employer's self funded plan. The stop loss carrier reimburses the employer when total eligible claims for the group exceeds the aggregate attachment point, often set at 125% of expected claims.

Stop loss insurance is sometimes also referred to as excess risk insurance. Stop loss policies are subject to Minn. Stat. 60A.235 and 60A.236.

The Working Group discussed concerns that the healthiest small groups may exit the fully-insured small group market in favor of self-funding if the change in small group definition causes an increase in rates in the fully-insured small group market. There is no way of measuring and projecting this effect. The more groups that exit for self-funding, the higher the rates needed for groups remaining in the fully-insured small group market.

The Working Group discussed that approximately 11% of employers with less than 100 employees self-fund. [12] If the fully-insured small employer market is expanded to include groups with 51-100 employees and these groups are given the same protections currently afforded to groups with 2-50 employees in the existing fully-insured small group market, such as guarantee issuance and rate bands capping the rating that can be applied for health status, this would contribute to more anti-selection. Market forces would incentivize groups with 51-100 employees to apply to the fully-insured small employer market when they have employees or covered dependents with costly ongoing health conditions to take advantage of guarantee-issue and rate caps. The healthiest groups in this size range would be incentivized to self-fund so that they would not have to pay extra to fund claims of the sicker groups in the pool.

Groups that self-fund need to manage risk. Currently most self-funded groups manage risk through the purchase of stop loss coverage. Stop loss carriers have been offering riders that self-funded employers can purchase at contract inception that provide self-funded employers with certain guarantees on renewal, including riders that offer the following:

1. Guarantee that the stop loss carrier will offer a renewal.
2. Guarantee that the stop loss carrier will not apply a higher specific deductible to any individual person covered as part of the group due to a catastrophic health condition
3. Guarantee that the stop loss carrier will not offer renewal increases in excess of a specific percentage outlined in the contract.

Some employers that chose to self-fund elect to purchase such riders as a way of protecting against renewal increases.

Under Minn. Stat. 60A.235 and 60A.236, there are specific requirements on stop loss policies sold to self-funded groups of less than 50 employees. Stop loss policies purchased by small groups of less than 50 employees must include a contract period no less favorable to the small employer than coverage of all claims incurred during the contract period regardless of when the claims are paid. The Working Group learned that an "Incurred" contract basis such as the type of contract required by Minn. Stat. 60A.236 can be beneficial to groups trying self-funding for the first time. If the small employer decides that they want to go back to the fully-insured market, an "Incurred" contract provides coverage for large claims that were incurred during the time that the employer was self-funding but were not paid until after the self-funded plan is terminated.

The Working Group learned that "Incurred" contracts like those required to be provided to small

employers with fewer than 50 employers are not the most common type of stop loss contracts. Larger groups that have been self funding for a while often purchase contract terms that reimburse the group based on when the claim is paid, regardless of when it is incurred.

If the definition of small employer is changed, this will impact stop loss coverage requirements for groups in the 51-100 market because Minn. Stat. 60A.236 references the small employer definition. If groups in the 51-100 market that have been purchasing their stop loss coverage based on when claims are paid were newly required to purchase coverage based on when claims are incurred because of a change in the definition of small employer, there would be a transition period where the employer would have to purchase both stop loss contracts to protect against old claims that have not yet been paid as well as covering all new claims based on the requirements of Minn. Stat. 60A.236. If the definition of small employer is changed, Minn. Stat. 60A.236 could be changed so that it continues to apply only to groups of 50 or fewer employees to avoid consequences on groups with 51-100 employees that have been self-funding and have purchased paid contracts.

No recommendation was made by the Working Group specific to stop loss and self funded groups. Since the Working Group did not recommend a change in small employer definition at this time, the Working Group felt that there was no need to make specific recommendations related to the impact of the small employer definition change on self-funded groups and stop loss.

E. Uniform Application Form

The Working Group reviewed the need to create a Uniform Application Form to be used by all carriers conducting business in the small group market One purpose of a Uniform Application Form would be to improve the ability to shop multiple insurance carriers with a single form.

The Working Group debated the viability of developing and implementing a new form that may not have all of the attributes required on the federal version; and information necessary to manage subsidies for insurance premiums offered through the new federal health reform laws.

Recommendation: No Adoption of a Uniform Application at this time.

The Working Group recognized that there is considerable interest in a "Uniform Application"; however, it recommends that the development and implementation of a uniform application form, at this time, is premature and may overlap or duplicate uniformity efforts required by the new federal health reform laws.

By January 1, 2014, the Affordable Care Act requires all Qualified Health Benefit Plans that sell through the newly created Exchange to utilize uniform application forms that shall be used by employers and individuals for both private and public insurance programs. Since there will be national requirements, the NAIC Consumer Information Working Group is in the process of developing a Model Uniform Application national prototype for use in the Health Insurance

Exchanges.

The Working Group wanted to avoid costly and duplicative effort that would occur if insurers were required to revise and create a uniform application form for use in Minnesota's small group market and then had to update their systems again due to federal health reform changes. Although there are electronic "uniform" applications currently available in the private insurance marketplace, both public and private insurance options have not been integrated into these forms in 2014 under the ACA.

Minnesota's Current Market – Universal Application

In deciding to delay the implementation of a uniform application form, the Working Group considered the benefits and availability of systems that allow for uniform applications in Minnesota.

The Benefits of electronic universal application include:

- The ability for employers to shop for the best deal through multiple companies without filling out a lot of duplicate paperwork for each insurer,
- Less loss of productivity because employees can complete the application quickly online or even at home,
- Streamlined process for employees, with the convenience of applicable data (name, birth date, dependent information, etc) being transferred to other lines like dental insurance, and
- Quality controls for the carriers and agents that ensure that enrollment applications are complete because the system will not allow enrollees to skip questions.

In the absence of a state-developed "Uniform Application", various alternatives are in use and offered by private vendors. The Working Group invited one of the four vendors that currently offer uniform application systems to the broker community to present how such systems can improve the efficiency of the application process. These systems can replicate each carrier's application forms by mapping out similar and unique carrier requested fields that each applicant must fill out. Applicants only have to complete fields that are shared by all carriers once. Applicants can also bypass questions that do not apply to them. For example, if an enrollee isn't pregnant, they answer no and no further questions regarding maternity will be asked.

Agents and brokers like the electronic universal application product because it saves them a lot of follow up calls looking for missing information. Average paper application process cost is estimated to be $40 to $75 while the electronic application cost is less, around $3. This difference is attributed to asking additional questions if the originally paper application is not properly completed. This fee is paid by the broker.

When uniform application systems first came onto the market, there were issues with web pages timing out and employees having to redo their applications. These issues have largely been

resolved, however not all agents or groups are interested in using these systems. The Working Group discussed reasons why some groups and agents may elect not to use one of the uniform application systems.

- **Lack of personal face to face interactions:** Many agents do sit with the clients and fill out the forms for the clients. That's a matter of personal business style for the agents and what they feel best meets their clients' needs.
- **Internet access issues for smaller employers who are perhaps rural or unable to provide employees with access to the internet:** The website forms are available in multiple languages, so access for non-English speaking enrollees is good. Most employees have computers at home, however many agents will make computers available to the enrollees. Overall, most people are enrolling at work between 10 am and 2 pm.

The Working Group discussed data safety and privacy with these systems. The vendor that presented to the Working Group indicated that his software had been in use for 18 months with no issues. Vendors that offer these systems are required to comply with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.

The uniform application software does not completely eliminate requests from insurance companies for more specific information on a particular plan participant. However, any additional questions are usually needed to accurately determine the risk and correct premiums. For example, if an applicant indicated they had cancer, but it was later determined it was a mild form basal cell skin cancer, the estimated losses and premiums quote would be reduced.

F. Education and Compliance Issues Related to Offering Section 125 Plans under Minn. Stat. 62U.07

The Section 125 Plan legislative initiative in Minnesota (MN Statute 62U.07) was designed to encourage employers who made no financial contribution to their employees' health insurance and offered no group health plan to make available a mechanism for individual health insurance purchased by their employees more affordable.

Beginning July 1, 2009, Minnesota law required employers that do not offer health insurance benefits to their employees and had 11 or more full-time equivalent employees to establish and maintain a Section 125 plan to allow their employees to purchase health coverage with pre-tax dollars. Employers were not required to offer or contribute to health insurance benefits. Employers could "opt out" of this requirement by certifying to the Commissioner of Commerce that they have received education and information on the advantages of Section 125 plans and chose not to establish a 125 Plan. Commerce received 28 notices from small employers that they were going to opt out.

For employers, there are financial benefits to establishing a Section 125 plan. Employers do not pay Medicare, Social Security, or unemployment insurance taxes on the amounts that employees choose

to have withheld from their paychecks on a pre-tax basis. However, given the complexities, a CPA, tax expert or knowledgeable insurance agent should help in setting up the Section 125 Plan which should be regularly reviewed for compliance. To help with this complexity and expense, small employers (those with 2 to 50 employees) could have applied for a grant of $350 from the state to offset the cost of establishing a Section 125 plan. However, only six (6) employers applied.

Concerns have been were raised about a mandate that applies to employers that do not offer health insurance. There are significant legal consequences for the employers if the mandated Section 125 Plans are set up inappropriately. Health insurance policies that are individually purchased are subject to the insurer's medical underwriting and risk rating, both the eligibility for coverage and individual premiums could differ based on each employee's health status. If an employee purchases and pays for their own individual health plan, but if those premiums are paid through a Section 125 Plan pre-taxed dollars method (employer doesn't pay for the premiums but deducts them from the employee's salary), there is a potential that this could constitute an employer contribution to the employee's health insurance. Given this legal uncertainty, many insurers and benefit advisors have backed away from using Section 125 Plans to pay for individual health insurance.

There is increased administrative work associated with handling the employee premiums that are turned over to the employer for the Section 125 Plan. The employer has to be able to produce evidence that the premium was actually paid and that there was actual coverage for the employees and their dependents. Sometimes employers will say it is just too much administrative work and an accommodation for the employee only. It is not workable and particularly when the employer does not make a contribution and has no health plan.

While employers that offer their employees health insurance through a group plan can continue to offer a Section 125 plan under the Affordable Care Act (ACA), the ACA precludes using Section 125 plans for exchange-based individual insurance. The ACA provides fairly strong arguments that non-exchange-based individual insurance policies may be purchased through a section 125 plan, but it fails to state so explicitly.

Minnesota Statute 62U.07 places a burden on business that is non-revenue work. There is no compensation for the administrative work and record keeping. Every employee comes with an incredible amount of work so that the business cannot grow. The employer should be compensated for that work as an incentive to comply with what the government is asking the business owner to do. These additional requirements are an obstacle to doing business and cause small businesses to avoid employing new employees. Small employers are competing with large employers that have advantages that the small employers do not have.

Recommendation: The Working Group recommends repealing Minn. Stat. 62U.07 (the requirement to offer Section 125 plans even if there is not an employer sponsored health insurance benefit) and incorporating education and compliance information related to the offering of Section 125 Plans in the design of an Exchange.

G. Impacts of Federal Law

The Affordable Care Act was signed into law by President Obama on March 23, 2010. Federal agencies have begun to issue guidance required for implementation of the ACA but many of the details are still to come in the form of regulations that have yet to be promulgated.

Recently initiated programs include:

- The Pre-Existing Condition Insurance Plan (PCIP), a temporary federal high risk pool for uninsured individuals, that is being administered by the federal government in Minnesota;
- The Early Retiree Reinsurance Program (ERRP) that encourages provision of retiree health benefits by reimbursing a portion of those claims; and
- The Small Employer Health Plan Tax Credit that provides for tax credits for qualified small employers starting for tax years starting 1/1/2010. To qualify, small employers must pay at least 50% of the employee health premium, have no more than 25 full time equivalent employees, and have average eligible employee wages that do not exceed $50,000.

The impact of federal law will be different from state to state. The PPACA provisions are similar in several respects to existing insurance market provisions in Minnesota law.

The overview focused on:

- the insurance market reforms, the coverage requirements and
- The provisions of the Health Insurance Exchange found in the new federal law.

In July 2010, the Minnesota Department of Commerce issued a Minnesota Amendatory Endorsement to assist health insurers in complying with various insurance market changes in the new law effective for plan years on or after September 23, 2010, that apply to both the fully-insured and self-insured market, such as:

- No lifetime benefit limits and restricted annual benefit limits on the dollar value of essential benefits;
- No rescissions, except in cases of fraud or intentional misrepresentation;
- Dependent coverage to age 26;
- Coverage of preventive services and immunizations as recommended by the U.S. Preventive Services Task Force, Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA) without cost-sharing;
- No pre-existing condition exclusions for children under age 19;
- Introduces a new Web Portal for information on available products, rates and cost sharing options;
- Health Insurance premium tax credits also went into effect in 2010;
- The Medical Loss Ratio provisions go into effect in 2011;
- Grandfathered Plans – Plans that were in effect on March 23, 2010 when PPACA was

enacted can be grandfathered. Grandfathered plans are exempt from most changes required by PPACA, but they can lose their grandfathered status if they make certain changes to their plan such as changing insurers, significantly cutting or reducing a benefit, significantly raising co-insurance, co-payment or deductibles, significantly lowering employer contribution, etc.;

- Administrative Simplification process including eligibility verification and claims status to be adopted by July 1, 2011 and effective by January 1, 2013;

Other important changes scheduled for 2014 include:

- the Consumer Operated and Oriented Plan (CO-OP) Program;
- the insurance changes effective January 1, 2014, including the small group definition set at 1 to 100; (Note: States may elect to delay the increase in the definition to 100 employees until 2016.)
- the Health Insurance Exchanges,
- guaranteed issue for all;
- the minimum benefit set and the state obligation to pay for additional coverage;
- the individual mandate; and employer penalties and obligations.

At the national level, HHS and other federal agencies such as the IRS and the US Department of Labor continue to issue new rules and guidance. In addition, the NAIC is working on recommendations and model laws to assist states in implementation of ACA.

Definitions of Small Group under the ACA:

Definition of Small Employer for an Exchange: As has been noted earlier in this report, for purposes of an Exchange, small group will be defined as employers with 1-100 employees under federal law effective in 2014 unless the state requests a waiver to delay the change in small employer definition until 2016. The NAIC's Regulatory Task Force is anticipating an analysis of the impact of this change and recommendations for model laws.

Definition of Small Employer for Medical Loss Ratio Calculations: The NAIC sent recommendations to the U.S. Department of Health and Human Services (HHS) in October related to Medical Loss Ratio requirements of federal health reform. These requirements presume state definitions of small employer continue at 2-50 employees until 2014.

VI. APPENDIX A: Legislative Charge

CHAPTER 370--S.F.No. 1905

An act relating to insurance; establishing a small group market working group; requiring a report.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **SMALL GROUP HEALTH INSURANCE MARKET WORKING GROUP.**

Subdivision 1. **Establishment.** (a) The commissioner of commerce shall convene a working group to study and report on the options available to increase rate predictability and stability for groups of 100 or fewer employees. Members of the working group shall include:

(1) two representatives from the Minnesota Council of Health Plans;
(2) two representatives from the Minnesota Association of Health Underwriters;
(3) one representative from the Insurance Federation of Minnesota;
(4) one representative from the Minnesota Chamber of Commerce;
(5) one representative from the National Federation of Independent Businesses - Minnesota;
(6) two representatives from employers whose businesses employ 50 employees or fewer;
(7) two representatives from employers whose businesses employ between 51 and 75 full-time employees;
(8) two representatives from employers whose businesses employ between 76 and 100 full-time employees;
(9) one representative from employees of businesses that employ 50 employees or fewer;
(10) one representative from employees of businesses that employ between 51 and 100 full-time employees;
(11) two senators, including one member from the majority party and one member from the minority party, appointed by the Subcommittee on Committees of the Committee on Rules and Administration of the senate;
(12) two members of the house of representatives, including one member appointed by the speaker of the house and one member appointed by the minority leader; and
(13) the commissioner of commerce or the commissioner's designee.

(b) The organizations listed in paragraph (a), clauses (1) through (5), must name their representatives to the commissioner of commerce no later than July 1, 2010. The commissioner of commerce must appoint individuals as listed in paragraph (a), clauses (6) through (10), no later than July 15, 2010. The legislative appointing authorities must appoint individuals as listed in paragraph (a), clauses (11) and (12), no later than July 15, 2010.

Subd. 2. **Duties; report.** (a) The working group shall conduct a study analyzing the implications of expanding the small employer market to 100 employees. Topics to be addressed in the study include, but are not limited to:

(1) analyzing implementation options in expanding the small group definition to 100 employees;
(2) underwriting concerns and rating requirements and the implications of change in small group market size on the entire health insurance market, and limitations on renewal, enrollment methodologies, and processes;
(3) costs for employers, employees, brokers, and health plans;
(4) how to assist employers in understanding the implications of employers migrating from fully insured to self-insured and associated risks;
(5) a uniform application form;
(6) education and compliance issues related to the offering of Section 125 plans under Minnesota Statutes, section 62U.07; and
(7) assuring compliance with federal law, including expeditious implementation of federal health care reform requirements.

(b) By November 15, 2010, the working group shall submit a report on its findings, including proposed legislation, if any, to the Health Care Access Commission.

Subd. 3. **Administration.** (a) The commissioner of commerce or the commissioner's designee shall convene the first meeting of the working group no later than August 1, 2010.

(b) The commissioner shall provide assistance with research or background information and administrative support for the working group within the existing agency budget.

(c) The working group expires June 30, 2011.

Presented to the governor May 15, 2010
Signed by the governor May 19, 2010, 9:55 a.m.

VII. APPENDIX B: Small Employer Definition (62L.02 Subd. 26)

Subd. 26. **Small employer.**

(a) "Small employer" means, with respect to a calendar year and a plan year, a person, firm, corporation, partnership, association, or other entity actively engaged in business in Minnesota, including a political subdivision of the state, that employed an average of no fewer than two nor more than 50 current employees on business days during the preceding calendar year and that employs at least two current employees on the first day of the plan year. If an employer has only one eligible employee who has not waived coverage, the sale of a health plan to or for that eligible employee is not a sale to a small employer and is not subject to this chapter and may be treated as the sale of an individual health plan. A small employer plan may be offered through a domiciled association to self-employed individuals and small employers who are members of the association, even if the self-employed individual or small employer has fewer than two current employees. Entities that are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the federal Internal Revenue Code are considered a single employer for purposes of determining the number of current employees. Small employer status must be determined on an annual basis as of the renewal date of the health benefit plan. The provisions of this chapter continue to apply to an employer who no longer meets the requirements of this definition until the annual renewal date of the employer's health benefit plan. If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based upon the average number of current employees that it is reasonably expected that the employer will employ on business days in the current calendar year. For purposes of this definition, the term employer includes any predecessor of the employer. An employer that has more than 50 current employees but has 50 or fewer employees, as "employee" is defined under United States Code, title 29, section 1002(6), is a small employer under this subdivision.

(b) Where an association, as defined in section 62L.045, comprised of employers contracts with a health carrier to provide coverage to its members who are small employers, the association and health benefit plans it provides to small employers, are subject to section 62L.045, with respect to small employers in the association, even though the association also provides coverage to its members that do not qualify as small employers.

(c) If an employer has employees covered under a trust specified in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq., as amended, or employees whose health coverage is determined by a collective bargaining agreement and, as a result of

the collective bargaining agreement, is purchased separately from the health plan provided to other employees, those employees are excluded in determining whether the employer qualifies as a small employer. Those employees are considered to be a separate small employer if they constitute a group that would qualify as a small employer in the absence of the employees who are not subject to the collective bargaining agreement.

VII. APPENDIX C: Flexible Benefit Plans

62Q.188 FLEXIBLE BENEFITS PLANS.

Subdivision 1. **Definitions.** For the purposes of this section, the terms used in this section have the meanings defined in section 62Q.01, except that "health plan" includes individual coverage and group coverage for employer plans with up to 100 employees.

Subd. 2. **Flexible benefits plan.** Notwithstanding any provision of this chapter, chapter 363A, or any other law to the contrary, a health plan company may offer, sell, issue, and renew a health plan that is a flexible benefits plan under this section if the following requirements are satisfied:

(1) the health plan must be offered in compliance with the laws of this state, except as otherwise permitted in this section;

(2) the health plan must be designed to enable covered persons to better manage costs and coverage options through the use of co-pays, deductibles, and other cost-sharing arrangements;

(3) the health plan may modify or exclude any or all coverages of benefits that would otherwise be required by law, except for maternity benefits and other benefits required under federal law;

(4) each health plan and plan's premiums must be approved by the commissioner of health or commerce, whichever is appropriate under section 62Q.01, subdivision 2, but neither commissioner may disapprove a plan on the grounds of a modification or exclusion permitted under clause (3); and

(5) prior to the sale of the health plan, the purchaser must be given a written list of the coverages otherwise required by law that are modified or excluded in the health plan. The list must include a description of each coverage in the list and indicate whether the coverage is modified or excluded. If coverage is modified, the list must describe the modification. The list may, but is not required to, also list any or all coverages otherwise required by law that are included in the health plan and indicate that they are included. The health plan company must require that a copy of this written list be provided, prior to the effective date of the health plan, to each enrollee or employee who is eligible for health coverage under the plan.

Subd. 3. **Employer health plan.** An employer may provide a health plan permitted under this section to its employees, the employees' dependents, and other persons eligible for coverage under the employer's plan, notwithstanding chapter 363A or any other law to the contrary.

History: 2010 c 384 s 24

NOTE: This section, as added by Laws 2010, chapter 384, section 24, is effective January 1, 2012. Laws 2010, chapter 384, section 24, the effective date.

ENDNOTES

[1] Laws 2010, Chapter 370 is included as Appendix A of this report.

[2] See Appendix A for full charge and list of topics to be included in report.

[3] See Appendix B for full text of the Small Employer definition under Minn. Stat. 62L.02 Subd. 26

[4] For additional discussion of Self-funding, see section G on self-funding on (page 12).

[5] Data is based on the Minnesota Department of Health, Memo dated October 18, 2010 of Stefan Gildemeister, Assistant Director, Health Economics Program, Minnesota Department of Health, based on preliminary information from the federal Agency for Health Care Research and Quality (AHRQ).

[6] "Minnesota's Small Group Market Select Statistics", Stefan Gildemeister, Assistant Director, Health Economics Program, Minnesota Department of Health (MDH), September 23, 2010 (updated, October 18, 2010)

[7] Reference to GAMC may be obsolete.

[8] Source: MDH analysis of data for private employers from the Medical Expenditure Panel Survey/Insurance Component (years are pooled to improve the statistical validity of the estimates). Note: This is preliminary data; difference between estimates have not been tested for statistical significance.

[9] Source: MDH analysis of data for private employers from the Medical Expenditure Panel Survey/Insurance Component (years are pooled to improve the statistical validity of the estimates. Note: This is preliminary data; difference between estimates have not been tested for statistical significance.

[10] Source: MDH analysis of data for private employers from the Medical Expenditure Panel Survey/Insurance Component (years are pooled to improve the statistical validity of the estimates. Note: This is preliminary data; difference between estimates have not been tested for statistical significance

[11] "Report of 2009 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies, Nonprofit Health Services Plan Corporations and Health Maintenance Organizations", Melane A. Milbert, Research Analyst Specialist Senior, Actuarial, Minnesota Department of Commerce, June, 2010

[12] Source: Agency for Healthcare Research and Quality, Center for Financing, Access and cost Trends. 2009 Medical Expenditure Panel Survey – Insurance Component.