TASK FORCE ON SMALL BUSINESS HEALTH INSURANCE

A REPORT TO THE LEGISLATURE

STAFF ASSISTANCE BY:

MINNESOTA DEPARTMENTS OF COMMERCE AND HEALTH

FEBRUARY 4, 2002

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TASK FORCE ON SMALL BUSINESS HEALTH INSURANCE

The 2001 Legislative session enacted House File 1155, Chapter 170 which created a Task Force on Small Business Health Insurance. This Task Force on Small Business Health Insurance was directed to study Minnesota's health coverage market that was available to small businesses and make legislative recommendations for solutions that would make group health coverage more accessible and affordable for small business. The Commissioners of Commerce and Health assisted the Task Force. The Task Force will expire on June 30, 2002.

TASK FORCE MEMBERS LEGISLATION

The Task Force consisted of the following members:

- Three members of the Senate, including at least one member of the minority, appointed by the subcommittee on committees of the Senate committee on rules and administration.
- Three member of the House, including at least one member of the minority, appointed by the Speaker of the House.
- Four members representing small business owners, three appointed by the Minnesota Chamber of Commerce and one appointed by the National Federation of Independent Business.
- Two persons appointed by the Minnesota Council of Health Plans.
- One person appointed by the Insurance Federation of Minnesota.
- One insurance agent, appointed by the Minnesota Association of Health Underwriters.
- The Commissioner of Commerce or the Commissioner's designatee.
- Four consumers appointed by the Commissioner, two had to reside outside the metropolitan area.

Report Summary

The Task Force adopted the recommendations contained in this report. Because of the divergence of the group, recommendations were by consensus but some ideas did not receive total support of each member. However, by having state legislatures, small employers, consumers, health carriers, and various organizations in these meetings, progress was made in understanding the concerns of each individual and organization.

The Task Force is supposed to expire on June 30, 2002. However, the Task Force would like to continue meeting to develop further recommendations to improve Minnesota's small employer market.

Meeting Dates

The Task Force met on September 19, October 16, October 29, October 31, November 13, November 29, December 5, December 13, December 18, 2001 and January 7, 2002.

Recommendation Summary

The following changes were recommended by the Task Force to make health care more accessible and affordable for small business:

- Cap renewal rate increases for each small employer group to 15 percent plus the index change or trend. This will eliminate a small employer's rates increasing 67 percent in one year when they move from the lower rate band to the top rate band. This will reduce the number of employers dropping health coverage when they experience sudden high losses and rate increases.

- Allow existing groups that go to one employee to continue coverage for 12 months unless they become a small employer (2 to 50 employees) again. This legislative change is required by recent federal interpretation of the HIPAA's definition of a "small employer."

- Conform state legislation to comply with HIPAA's definition and requirements of "guarantee renewability" when a small employer's size shifts between small and large group markets.

- Increase HMOs flexibility on their deductibles and co-payments by removing current restrictions. This would increase competition, offer more products to employers and individuals and reduce costs.

- Eliminate current minimum loss ratio standards. This change could encourage new health carriers to enter Minnesota's market but could also increase premiums.

- Amend Minnesota Statutes sections 62A.02 and 62D.08, subd. 1 so forms are "file and use." Health carriers would be able to file their forms and rates and use them prior to the Commissioner's approval. This would speed up the introduction of new products and rate increases but could cause problems for both the policyholder and company if the rate or form is incorrect.

The following recommendations involve partial implementation during the current session and need further review of other portions:

- Expand potential rate variations due to geographic differences. Amend Minnesota Statutes sections 62L.08, subd. 4 which limits geographic variation to 20 percent and requires the Minneapolis/St. Paul metropolitan area to be the highest. The Task Force agreed that it needed to obtain further information about cost in specific areas to determine whether the Minneapolis/St. Paul metro area is subsidizing some other areas.

- Remove the 90 percent cap on premiums offered for individual conversion contracts. Premiums should be permitted to increase to 100 percent of the MCHA premium. The policy should be guarantee renewable for a specific period of time, with the individual converting to MHCA thereafter. However, the Task Force thought a permanent funding source for MCHA needed to be found.

The following recommendations need additional information, further review or could be delayed:

- The Task Force discussed requiring groups with more than 50 employees to be treated as a small employer if their legitimate waivers (employees who are covered by their spouse should not be counted as an employee) reduce the number of employees to fewer than 50 was discussed. Further information and actuarial review is needed to determine if this is feasible.

- Eliminate when fiscally possible, all premium related taxes, the MA surcharge and the MCHA assessment. Currently all large and small employers and individual and families purchasing health coverage in Minnesota from a licensed health carrier have to pay these additional costs, while self-insured employers are exempt. This increases costs for private insurance from 3.8 to 4.2 percent. This recommendation cannot be implemented at this time due to the budget shortfall.

- Modify the current Multiple Employer Welfare Arrangement (MEWA) Regulations (Chapter 62H). This would include:

  * Give employers a vested interest in the reserves.

  * Employers remaining in the MEWA for at least three years.

  * Employers providing an additional premium deposit when joining MEWA, with deposit being forfeited if they leave prematurely (before three years).

  * Charging trustees of the MEWA with the responsibility of reviewing the financial strength of MEWA applicants to ensure that they meet membership requirements and solvency requirements.

  * Ensuring that employers participating in the MEWA are a bona fide employers.

  * Prohibiting MEWAs from must not discriminating against the sick or targeting the healthy.

  * Requiring health care benefits to equal or exceed federal mandates for an employer with 50 or more employees. (See mandates listed at end of report.)

  * Requiring health care mandates to cover all employers and employees unless they receive a waiver or have a union exemption.

  * Directing MEWA to develop a criteria for open enrollment period.

  * Requiring MEWAs to pay a 2 percent tax to the Department of Revenue and the Minnesota Comprehensive Health Association (MCHA) assessments.

Task Force on Small Business Health Insurance
Final Recommendations

RECOMMENDATIONS	LAW OR RULE	DESCRIPTION	IMPACT ON ACCESSIBILITY & AFFORDABILITY FOR SMALL BUSINESS
1. Cap renewal rate increase for each employer group to 15% plus index change	New Provision in 62L.08	**The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following: (a) the percentage change in the new business premium; (b) an adjustment, not to exceed 15% annually due to claim experience, health status or duration of coverage; and (c) any adjustment due to change in coverage or change in the case characteristics of the small employer. Add an exception for purposefully falsifying information. RECOMMENDATION ADOPTED 12/18/01.**	The employers which would benefit from this provision are those which would receive a large rate increase due to a dramatic change in claims experience. Employer groups not benefiting from the cap would have no significant increase or a modest increase generally less than 1%, depending upon the past practices of the carrier in voluntarily limiting large premium increases.

Task Force on Small Business Health Insurance
Final Recommendations

RECOMMENDATIONS	LAW OR RULE	DESCRIPTION	IMPACT ON ACCESSIBILITY & AFFORDABILITY FOR SMALL BUSINESS
2. Expand potential variation due to geographic differences in costs.	62L.08, Subd. 4	**Increase in the rating band due to geographic variation from 20% to 40% and increase in number of geographic regions from 3 to 6. RECOMMENDATION ADOPTED 12/18/01.** Obtain more data on impact of dropping the provision that rural regions may not exceed metro Twin Cities area even if certain non-metro regions have higher health care costs. Based upon data obtained, over the next 5 year period, eliminate the provision that the metro area is always highest.	The rating band of 20% for geographic variation in costs does not allow for employers in certain low costs rural areas to obtain the justifiable rate reduction due to low health care costs. Expanding the band to 40% would permit employers in lowest cost rural areas to receive lower premiums. Non-metro regions of the state with higher health care costs than the metro Twin Cities region currently are capped at the same level as Twin Cities employers. Premiums for employers in the Twin Cities metro area would reduce by 5.5% if their variation compared to certain other non-metro regions could be recognized. More data is needed about the amount of any rate increase for employers in non-metro areas with highest health care costs. Recognizing the true difference in geographic costs may create an incentive for providers to charge less so that employers in that region would benefit.
3. Eliminate minimum loss ratio standards	62A.021,Subd. 1 (a) and (f)	**Eliminate the current requirements for 71% loss ratio for employers with fewer than 10 employees and 75% for all her small employers using carriers with 3% or less of the market and 82% loss ratio for larger carriers. RECOMMENDATION ADOPTED 1/07/02.**	This would permit a greater return on the investment by health insurance carriers. By eliminating a barrier to entrance or expansion in the Minnesota health insurance market, eventually there may be more options and competition in the market. More competition may provide the incentive for carriers to be more efficient in administrative operations. Employers may have increases in premium rates if significant competition is not stimulated.

Task Force on Small Business Health Insurance
Final Recommendations

RECOMMENDATIONS	LAW OR RULE	DESCRIPTION	IMPACT ON ACCESSIBILITY & AFFORDABILITY FOR SMALL BUSINESS
4. Eliminate all premium related taxes including the premium taxes, MA surcharge and the MCHA assessment.		**At a time when it is feasible within the State budget, repeal premium related taxes and replace the MCHA assessment with a broader source of funding. RECOMMENDATION ADOPTED 1/7/02.**	These taxes result in employers in the regulated health plan market paying 4.2% more for indemnity premiums and 3.8% more for HMO and BCBSM premiums.
5. Conforming state legislation to be consistent with HIPAA by allowing existing groups that go to one employee to continue coverage for at least 12 months.	62L.08	**Require existing groups that go to one employee to continue coverage under as a small employer for at least 12 months RECOMMENDATION ADOPTED 1/07/02.**	This conforming legislation will permit employers which drop to one employee to have additional time to return to 2 or more employees instead of termination of the group at the next contract renewal date.
6. Require groups with more than 50 employees to be treated as small employers if their legitimate waivers reduce the number of covered employees to fewer than 50.		Require groups with more than 50 employees to be treated as small employers if their legitimate employees reduce the number of covered employees to fewer than 50. All criteria for small employer contribution and other requirements shall be applied to these employers. Methods shall be developed to prevent excessive adverse selection by this voluntary selection by employers. **RECOMMENDATION ADOPTED 1/7/02.**	While more small businesses could take advantage of the benefits of the small employer group law through this expansion, there would be primarily poor risk employer groups which would use this option. Good risk employer groups would have an economic advantage in remaining in the large group category. If it were mandatory for all employers in this category to be covered as small employers, then there would be a rate increase for a portion of these employers.

Task Force on Small Business Health Insurance
Final Recommendations

RECOMMENDATIONS	LAW OR RULE	DESCRIPTION	IMPACT ON ACCESSIBILITY & AFFORDABILITY FOR SMALL BUSINESS
7. Remove 90% cap on premiums offered for individual conversion contracts.	62A.65, Subd. 5	**The premium should be capped at 100% of the MCHA rate at this time. When MCHA funding is broadened, the right to conversion coverage should be replaced by the option to purchase individual coverage or go to MCHA coverage at the end of continuation.** **RECOMMENDATION ADOPTED 1/7/02.**	Employers of all sizes are currently subsidizing the premium for these individual conversion contracts at a level of as much as 1% of premium If there were no premium incentive to take conversion coverage, more people may choose MCHA. If the source of funding MCHA were to change from the current assessment on regulated health plans, employers would no longer subsidize conversion coverage.
8. Conforming state legislation to comply with HIPAA on size shifts between small group and large group markets		**An employer that grows beyond 50 employees has the option to keep the small group product within the rate bands. Similarly, for a large employer that shrinks below 50, the employer has the right to continue to renew the coverage purchased in the large group market. Recommendation Adopted 1/7/02.**	Employers affected by this provision would have the choice of continuing coverage at a more affordable rate. Other employers may receive a small rate increase due to this permitted selection.
9. File and use by health carriers	62A.02 and 62D.08, Subd. 1	**Health carriers would be permitted to market and issue policy forms and rates immediately after being filed with the State agency. If the policy form or rates are denied, the form or rates which had been implemented would be retroactively corrected. Currently, policy forms and rates must be approved prior to being implemented. RECOMMENDATION ADOPTED 1/7/02.**	New policy forms and rates would be marketed more quickly. Health carriers would be required to incur the additional administrative costs for retroactive correction of denied policy forms and rates.

Task Force on Small Business Health Insurance
Final Recommendations

RECOMMENDATIONS	LAW OR RULE	DESCRIPTION	IMPACT ON ACCESSIBILITY & AFFORDABILITY FOR SMALL BUSINESS
10. Reduce the current restrictions for HMO deductibles and copayments.	62D.02, Subd. 8, 62E.06 and 4685.0801	**HMO deductibles may not exceed, for group plans, $5,000 per individual per year and $10,000 per family per year and for individual plans, $10,000 per person per year and $20,000 per family per year. Copayments must not exceed 50% of the cost of covered services. Copayments and deductibles may not be applied to preventive health services. Out of pocket maximum on enrollee cost-sharing must not exceed $8,000 per person per year on group plans and $15,000 per person per year on individual plans. RECOMMENDATION ADOPTED 1/7/02.**	HMOs are not permitted to use deductibles over $1,000/person /year and $5,000 per family. HMO may not use copayments over 25% of the cost of the services. Out of pocket limits are currently $3,000 per person. This proposal maintains the current law in which nonprofit health service plans and indemnity plans have no limits on enrollee cost-sharing.
11. Modify Multiple Employer Welfare Arrangement (MEWA) statutes (Chapter 62H) and rules (Chapter 2765).	Chapter 62H MN Rules 2765	**MEWAs are self-insured employers who pool their risks jointly. They have to comply with state health care mandates, have reserves and stop-loss coverage to pay for their health claims, contract for administrative and financial services, be regulated by Commerce, have a board of directors and trust fund managers and file annual audits and reports.** **They pay an annual 2% fee to Revenue but no assessments to MCHA.**	If current regulations are reduced, this group of self-insured employers would be similar to a fully insured group but would not have to provide state health care mandates. Would have to assume their own health care losses, thus need to be adequately reserved and be protected by stop-loss coverage. Would provide an alternative method for employers to be their own insurance carrier. Unless properly funded and managed, could financially fail and be a burden to the private health care market (and MCHA) and be disruptive to the enrollee's health care needs.

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Sec. 9. [TASK FORCE ON SMALL BUSINESS HEALTH INSURANCE]

(a) The Task Force on small business health insurance shall study Minnesota's health coverage market available to small businesses and make recommendations for solutions that could made group health coverage more accessible and affordable for small businesses. The Task Force shall recommend any legislative changes needed to permit those solutions.

(b) The Task Force shall report its recommendations in writing to the legislature, in compliance with Minnesota Statutes, section 3.195, no later than December 15, 2001.

(c) The commissioners of commerce and health shall provide any necessary assistance to the Task Force.

(d) The Task Force consists of the following members:

(1) three members of the senate, including at least one member of the minority, appointed by the subcommittee on committees of the senate committee on rules and administration;

(2) three members of the house, including at least one member of the minority, appointed by the speaker of the house;

(3) four persons representing small business owners, three appointed by the Minnesota chamber of commerce and one appointed by the national federation of independent business;

(4) two person appointed by the Minnesota council of health plans;

(5) one person appointed by the insurance federation of Minnesota;

(6) one insurance agent, appointed by the Minnesota association of health underwriters;

(7) the commissioner of commerce or the commissioner's designee; and

(8) four consumers appointed by the commissioner, two of whom must reside outside the metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2.

(e) The Task Force shall not provide compensation or expense reimbursement to its members.

(f) The Task Force expires on June 30, 2002.

FEDERAL MANDATES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Employee Retirement Income Security Act of 1974 (ERISA)

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Parity in the Application of Certain Limits to Mental Health Benefits

Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status

Title VII of the Civil Rights Act of 1964 Section 2000e (Section 701), K (maternity benefits)