Minnesota Employees Insurance Program (MEIP):

IMPACT AND CONTINUED VIABILITY REPORT

A study for the Minnesota Legislature,
as required by the Laws of Minnesota (1997), Chapter 225, Article 2, Section 58

Prepared by the Minnesota Department of Employee Relations (DOER)
April, 1998

Minnesota Employees Insurance Program (MEIP): IMPACT & CONTINUED VIABILITY REPORT
Section I: Executive Summary

A. Charge of this Study

Chapter 225 of the Laws of Minnesota, 1997 session, require that

"The commissioner of employee relations shall study the current Minnesota employees insurance program (MEIP) and report to the legislature by January 15, 1998, on:

1. *recommendations on whether this program provides greater accessibility to small employers for purchasing health insurance; and,*

2. *on the continued viability of the program, including whether the program could be modified in terms of underwriting, marketing, and advertising to create a program that would provide a cost incentive for small employers to purchase health coverage through this program."*

B. Study Methodology

This study includes a thorough analysis of questions of MEIP's viability conducted during the spring and summer of 1997 by DOER staff, the MEIP advisory group, and consultants. Additional reviews of MEIP administrative data, relevant legislative history, the current health care environment, and other information were also compiled in the late summer and autumn of 1997 for this report.

C. Key Findings

1. MEIP has helped improve health insurance purchasing for employers and the state by:

- *Increasing access to employer-based group coverage for employers which previously did not offer group coverage*
- *Providing an additional purchasing alternative with many desirable features, most notably choice of health plan*
- *Helping maintain small group reforms which benefited all small employers*

2. MEIP's regulatory and market environment has been dramatically reshaped since its inception. The following have been significant factors in this reshaping:

- Guaranteed issuance is now available to all small employers in the market.
- There are some anecdotes suggesting that the availability of the MinnesotaCare insurance program may result in the decision of some rural employers to refrain from purchasing a group medical insurance if their employees are eligible for MinnesotaCare. However, no systematic data exists to support this notion.
- Most private employers in the state now contract on a "winner take all" sole source basis with carriers and health plans to achieve lower rates and rate guarantees. In response to these market forces, suppliers are consolidating and becoming more homogeneous in an effort to offer a "one size fits all" presence for employers seeking a single health carrier to provide their coverage. With fewer, less distinct offerings in the market, the degree to which choice of health plan companies provides true choice is increasingly being questioned.
- Competitive pressures have (until very recently) resulted in very attractive prices for firms seeking coverage independent of purchasing pools.

3. MEIP is not financially viable. It must cease operations to prevent anticipated losses from operating expense which will exceed revenues and cash reserves.

- Participating health plans have used "worst case" assumptions (assuming that the plan would not get all the employees from the entire employer group and could very well get the highest health care risks of the group) in rating MEIP's employer groups, often resulting in MEIP rates that are higher than in the market generally, and putting the program into a downward spiral. Higher rates have meant that MEIP could not achieve a critical mass of enrollees over which to economically spread its fixed costs or to assert itself more strongly as a purchaser in the market. The pool was too small to be financially viable.
- The offering of multiple choice of health plans, while perceived as a benefit by some employers, has also created additional administrative costs -- which cost-conscious smaller employers have been reluctant to pay as certain lower cost options have become available.
- Initially the program was not marketed through the insurance broker community. MEIP subsequently paid commissions to brokers, but there are some anecdotes suggesting commissions have been viewed as too low. The effect has been that independent insurance agents have had little incentive to market MEIP.
- MEIP utilized a general sales agent in addition to marketing through the insurance broker community. The commissions paid to the general sales agent were comparable to those paid to the insurance broker community. Following a determination that the commissions paid to independent agents offered little incentive, the commissions paid to independent agents were increased, while the fees paid to Sedgwick were decreased. Had MEIP done direct marketing as opposed to contracting a general sales agent, fewer commissions would have been paid, thus reducing administrative expenses and consequently, rates charged to groups would have been more competitive.

- When MEIP was established, the program utilized the serves of in-house marketing personnel to build relationships with the insurance broker community. When the employee performing MEIP's in-house marketing left state employment, that position was not filled. As an alternative, MEIP spent dollars advertising to secure new groups. Without dedicated personnel to continue to build relationships with the insurance broker community, the necessary business relationships between MEIP and the independent brokers was never fully developed.
- A downward trend in MEIP enrollment began in the third quarter of FY 1997, due to the growing disparity between MEIP's premium rates and the going market rate. In order to improve its competitive position, MEIP requested in 1997 that its participating carriers provide new issue rates comparable to the small group rates they charged directly to small employers. The carriers refused the request, and MEIP's lowest cost participating carrier actually raised its rates 25% for 1998.
- The participating plan that enjoyed the largest enrollment of MEIP members announced in 1997 that it would withdraw from the program in 1998. We believed that this development would begin a "domino effect" in which other participating carriers would follow suit and also withdraw from participation in MEIP - until the program would be left with only one participating plan; or none at all.
- MEIP's benefit consultants estimated that the impact of these developments would be a loss of 50% of MEIP's groups in 1998, another round of price increases on those remaining in the pool, and a further loss of 50% of the remaining groups in 1999.
- MEIP's situation was extensively reviewed in the spring and summer of 1997 by DOER staff, its benefits consultants and the MEIP advisory committee. As a result of these discussions, several different models were explored as possible new delivery options to address the significant problems described above. The conclusion reached following review was that alternative models considered for MEIP would not be effective or were not likely to find sufficient support to be implemented.
- DOER's review revealed that continuing to operate MEIP would only delay an inevitable termination long enough to use up cash reserves -- leaving little or no funding to repay start up loans from the state which MEIP had previously received, and eroding any reserve which might be needed if a later re-entry to the marketplace was indicated.
- The situation was judged untenable; and DOER decided to terminate new enrollment in MEIP as of July 31, 1997. Renewal of existing MEIP groups was discontinued effective October 1, 1997.

D. Recommendations

- Although MEIP itself has been discontinued, this study recommends that the program's enabling legislation should be retained in the event that circumstances change to again warrant the MEIP concept.

- If MEIP's current cash reserves are liquidated in order to partially repay its loan from the Health Care Access Fund, a new appropriation of start-up funds from the state legislature is recommended.

Minnesota Employees Insurance Program (MEIP):
IMPACT & CONTINUED VIABILITY REPORT
Section II: Overview

A. MEIP Background

The Minnesota Employees Insurance Program (MEIP) was enacted in 1992 as part of a larger package of ongoing health care reforms to improve health care accessibility, affordability, and quality in the state known as "MinnesotaCare." Originally known as the Private Employees Insurance Program, the name was changed to MEIP to avoid confusion with another state sponsored purchasing pool for public employees.

Like other reforms passed as part of MinnesotaCare, MEIP was intended to help address the need for affordable employee group insurance among Minnesota's small employers. Employers providing health coverage in the early 1990's were experiencing double-digit annual rates of premium increase. As costs rose, concerns about maintaining quality and access intensified.

Small employers were often the most seriously affected because they typically do not have the insurance purchasing power enjoyed by larger employers; and are therefore generally unable to negotiate better premium rates from insurers. Not only do small employers generally pay more, but they are apt to get less. Administrative costs account for a much higher proportion of the total insurance cost for small employers because the fixed costs of marketing, enrollment, and other expenses cannot be spread widely over a large number of people. In addition, insurance is based on the "law of large numbers" for calculating risk and exposure (the larger and more stable the group, the more accurately an insurer can calculate the risk of claims). Small firms are more uncertain risks, and more difficult to rate. At this time employers were often denied coverage, or were charged significantly higher rates, on the basis of even a single high risk or medical event in the group.

MEIP was intended to help employers obtain the potential advantages of purchasing health care coverage together as a single pool, with the following features:

- guaranteed issue (employers could not be denied coverage);
- spreading of administrative costs and risk more widely through a central administrative mechanism;
- greater negotiating strength in the market; and,
- choice of competing insurers and health plans

But despite the program's initial success in achieving its intended purpose, a number of factors eventually combined to prompt the Minnesota Legislature to order a study regarding MEIP's preliminary impact and continued viability.

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1. *recommendations on whether this program provides greater accessibility to small employers for purchasing health insurance; and,*

2. *on the continued viability of the program, including whether the program could be modified in terms of underwriting, marketing, and advertising to create a program that would provide a cost incentive for small employers to purchase health coverage through this program."*

C. Study Methodology

This study includes a thorough analysis of questions of MEIP's viability conducted during the spring and summer of 1997 by DOER staff, the MEIP advisory group, and consultants. Additional reviews of MEIP administrative data, relevant legislative history, the current health care environment, and other information were also compiled in the late summer and autumn of 1997 for this report.

D. Key Findings

1. **MEIP has helped improve health insurance purchasing for employers and the state by:**

    - *Increasing access to employer-based group coverage for employers which previously did not offer group coverage*
    - *Providing an additional purchasing alternative with many desirable features, most notably choice of health plan*
    - *Helping maintain small group reforms which benefited all small employers*

2. **MEIP's regulatory and market environment has been dramatically reshaped since its inception.**

3. **MEIP, in its current form, in the current environment, is not financially viable. It must cease operations to prevent anticipated losses from operating expense which will exceed revenues and cash reserves.**

These findings are explored in more detail below.

E. Discussion

1. MEIP has helped improve health insurance purchasing for employers and the state by:

- *Increasing access to employer-based group coverage for employers which previously did not offer group coverage*

To date, an estimated 494 employer groups have been enrolled at some time in MEIP. The average employer size was seven employees, for a total of approximately 3100 covered employees among the 494 groups. The largest enrollment at any one point in time was 356 employers, with an average of about seven employees per group, for a total of approximately 2831 employees. Including dependents, this amounted to an estimated 6500 covered lives.

Employers enrolling in MEIP were asked whether they had previously offered group coverage prior to joining MEIP. An estimated 284 of the 494 employers who have been in MEIP (57.5% of the total) offered only individual coverage or no coverage at all prior to purchasing group coverage through MEIP. Employees who were offered just individual coverage faced medical underwriting and the possibility of being rated up, limited in some aspects of coverage, or rejected completely. 204 employers (41.3% of the total) offered their employees only individual coverage prior to joining MEIP. 80 employers (16.2% of the total) had not offered any form of coverage prior to enrolling in MEIP. It is not known how many employees of these 80 employers were uninsured prior to obtaining coverage through MEIP (the employees may have been uninsured, may have maintained an individual policy at their own expense, or they may have been covered under a spouse's policy). However, other studies have shown higher rates of uninsurance among persons who are self-employed or working for small firms.[1]

- *Providing an additional purchasing alternative with many desirable features, most notably choice of health plan*

Of the 494 employer groups which have been enrolled in MEIP, 186 employers (37.7% of the total) previously offered group coverage prior to joining MEIP. MEIP offered combinations of value and added features, ranging from ease and convenience, to choices of delivery system, which were considered attractive by employers which had previously purchased group coverage through other arrangements. According to marketing surveys and focus groups, an important value added by MEIP was the employer's ability to offer employees a choice of health plans.[2] This is a feature which has become increasingly less available in the market, especially to smaller employers. While MEIP has offered a selection of up to four participating health plans from among which each covered employee could choose, the trend in the market has been toward sole source contracting between health plans and employers. The Minnesota Department of Health estimates that 83% of firms in the state, covering approximately 53% of employees, offer only one choice of health plan.[3]

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[1] *Health Care Financing Reform to Cover the Uninsured*, Richard E. Curtis et al., 1992.
[2] Marketing study prepared for MEIP by Lynch Jarvis Jones Advertising, 1996.
[3] Data from the Health Economics Program (HEP) of the Minnesota Department of Health, based on data from the 1993 Robert Wood Johnson survey of Minnesota employers.

- *Helping maintain small group reforms which benefited all small employers*

A less visible, but perhaps even more significant impact of MEIP, was to help maintain a number of reforms in the small group insurance market both in the State of Minnesota as well as nationally which have benefited all small employers and greatly increased the number of small firms purchasing coverage in the small group market. These reforms, also part of the larger package of MinnesotaCare reforms which was enacted in 1992, included requirements for guaranteed issuance to all groups of size 2-25 employees (later increased to 2-49 employees), as well as restrictions on the level of premiums which could be charged.

When the reforms were implemented, there was considerable concern by insurers and health plans regarding their potential impact. The creation of MEIP as a guaranteed issue product signaled the state's commitment to the principles of the small group reforms. It also changed market dynamics as it began enrolling small groups even as debates and opposition to the reforms continued. According to those familiar with the MEIP's legislative intent and history, it was anticipated that MEIP would function as just such a catalyst to help ensure the implementation of the small group insurance reforms.

In part due to MEIP's presence, the small group reforms have succeeded in dramatically increasing coverage in the small group market. As MEIP and other products became available in the post-reform environment, competitive pressures among insurers to obtain a larger share of the market mounted. During the period 1994-1996, enrollment in the small group insurance market grew by over one-third, from an estimated 300,000 covered lives, to over 400,000.

With increased coverage through the small group market, enrollment in individual insurance (where persons are subject to underwriting and possible rejection for coverage) has diminished over the same time period from 9.4% of the population to 5.0%. Similarly, because of MinnesotaCare reforms and an active market, Minnesota has been able to achieve relatively constant rates of persons who lack health coverage, while the rate of uninsurance has increased nationally.[4] Small group reforms and the subsequent competition generated have resulted in a viable small group insurance market.

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[4]*Minnesota Health Care Insurance and Access Survey*, University of Minnesota School of Public Health, 1995

2. MEIP's regulatory and market environment has been dramatically reshaped since its inception.

Addressing the questions posed by the charge of this study requires that MEIP be examined in the context of a rapidly changing regulatory and market environment. In particular, the MinnesotaCare reforms have dramatically reshaped the health care delivery and financing landscape in Minnesota with a variety of policy initiatives, including:

- Small group insurance reforms (described above);
- Creation of the MinnesotaCare subsidized health insurance program for low income persons;
- Additional alternative delivery and purchasing arrangements, including forms of provider and purchaser "co-ops", as well as legislation which authorizes a wide variety of health care purchasing pools.

At the same time, the state's health care market has been marked by vast restructuring in the private sector, with the widespread adoption of various forms of managed care, supply-side consolidation, growth of self-insured arrangements, and new purchaser initiatives, including the growth of private sector purchasing pools.

These changes have had a profound effect on health care delivery and financing in the state, but have also weakened many of the original arguments for MEIP. For example, in contrast to the pre-1992 conditions which provided a basis for MEIP, at present:

- Guaranteed issuance is now available to all small employers in the market.
- Anecdotal data suggests that the availability of the MinnesotaCare insurance program may result preclude some rural employers from implementation of a group insurance program if their employees are eligible for MinnesotaCare.[5]
- Most private employers in the state now contract on a "winner take all" sole source basis with carriers and health plans to achieve lower rates and rate guarantees. In response to these market forces, suppliers are consolidating and becoming more homogeneous in an effort to offer a "one size fits all" presence for employers seeking a single health carrier to provide their coverage. With fewer, less distinct offerings in the market, the degree to which choice of health plan companies provides true choice is increasingly being questioned.
- Competitive pressures have (until very recently) resulted in very attractive prices for firms seeking coverage independent of purchasing pools.

3. MEIP, in its current form, in the current environment, is not financially viable. It must cease operations to prevent anticipated losses from operating expense which will exceed revenues and cash reserves.

[5] Because it is a subsidized program, MinnesotaCare may be less expensive for the employee than any program the employer could purchase.

The environmental changes noted above have been exacerbated by a number of MEIP design characteristics and implementation decisions. For example:

- Participating health plans have used "worst case" assumptions (since the plans are not assured of securing the enrollment of the entire group, they assume the higher risk members will select their plan) in rating MEIP's employer groups, often resulting in MEIP rates that are higher than in the market generally, and putting the program into a downward spiral. Higher rates have meant that MEIP could not achieve a critical mass of enrollees over which to economically spread its fixed costs or to assert itself more strongly as a purchaser in the market. The pool was too small to be financially viable.
- The offering of multiple choice of health plans, while perceived as a benefit by some employers, has also created additional administrative costs -- which cost-conscious smaller employers have been reluctant to pay as certain lower cost options have become available.
- When MEIP was established, the program utilized the serves of in-house marketing personnel to build relationships with the insurance broker community. When the employee performing MEIP's in-house marketing left state employment, that position was not filled. As an alternative, MEIP spent dollars advertising to secure new groups. Without dedicated personnel to continue to build relationships with the insurance broker community, the necessary business relationships between MEIP and the independent brokers was never fully developed.
- Initially the program was not marketed through the insurance broker community. MEIP subsequently paid commissions to brokers, but there are some anecdotes suggesting the commissions have been viewed as too low. The effect has been that independent insurance agents have had little incentive to market MEIP.

Despite these challenges, MEIP's enrollment increased each quarter until the third quarter of fiscal year 1997. A downward enrollment trend began in the third quarter of FY 1997, due to the growing disparity between MEIP's premium rates and the going market rate. In order to improve its competitive position, MEIP requested in 1997 that its participating carriers provide new issue rates comparable to the small group rates they charged directly to small employers. The carriers refused the request because of significant loss ratios experienced, and MEIP's lowest cost participating carrier actually raised its rates 25% for 1998.

Furthermore, the participating plan that enjoyed the largest enrollment of MEIP members announced in 1997 that it would withdraw from the program in 1998. We believed that this development would begin a "domino effect" in which other participating carriers would follow suit and also withdraw from participation in MEIP - until the program would be left with only one participating plan; or none at all.

MEIP's already uncompetitive position therefore became even less viable, and the spiral effect accelerated. MEIP's benefit consultants estimated that the impact of these developments would be a loss of 50% of MEIP's groups in 1998, another round of price increases on those remaining in the pool, and a further loss of 50% of the remaining groups in 1999. This pricing scenario reflected a self-fulfilling prophecy as healthier groups left the pool to obtain less expensive coverage elsewhere, concentrating the increasingly higher risk -- and higher cost -- groups remaining in MEIP. The circumstances leading to this situation has been the fate of many small association pools. If the situation was allowed to continue, MEIP would be in the untenable position of incurring unsustainable losses exceeding revenues and reserves.

This situation was extensively reviewed in the spring and summer of 1997 by DOER staff, its benefits consultants and the MEIP advisory committee. As a result of these discussions, MEIP's situation was judged untenable -- and DOER decided to discontinue the program. Details of MEIP's discontinuance are provided in the next section.

Minnesota Employees Insurance Program (MEIP): IMPACT AND CONTINUED VIABILITY REPORT

Section III: Discontinuance of the Program

A. Introduction

In April 1997, the Minnesota Department of Employee Relations (DOER) launched a comprehensive internal study aimed at determining the future disposition of its Minnesota Employees Insurance Program (MEIP). After examining the program's history, its role in the local insurance marketplace, its present status and future prospects, the study concluded that MEIP should be discontinued. The facts considered to formulate this decision and the specifies of the study's conclusion are contained in the next sections of this document.

B. Mission of the Program

MEIP was established on July 1, 1993, as part of the 1992 MinnesotaCare health care legislation. The legislative intent (M.S. 43A. 317, subd. 1) called for the creation of a statewide program to provide employers with the advantages of a large pool for insurance purchasing that would advance the welfare of the citizens of the state. The program was to be administered by DOER (Department of Employee Relations).

The following are the initial assumptions and proposed solutions regarding small group insurance purchasing at the time MEIP legislation was enacted, followed by the current reality:

1. **Small employer groups were not always able to obtain health insurance for their employees. Solution for this was to create a guaranteed issue program.**

   - MEIP was created as a guaranteed issue program. However, small group insurance reforms were subsequently enacted that required guaranteed issue for all groups of less than 50 employees.

2. **Prior to the MEIP legislation, some small employer groups were being charged very high rates for health insurance. MEIP's solution to this problem was to create a purchasing pool that would reduce costs by spreading risk and fixed expenses. In addition, promoting managed competition by creating a multiple plan offering based upon a low cost carrier contribution formula was thought to keep rates lower than a single plan offering.**

- Results have proven that the participating health plans use "worst case" assumptions (since the plans are not assured of securing the enrollment of the entire group, they assume the higher risk members will select their plan) in rating for MEIP groups. Consequently, MEIP rates are higher and fewer groups have enrolled than anticipated. With fewer groups enrolled, fixed costs are not spread out over a larger base. In addition, the multiple plan offering creates additional administrative overhead for DOER. Also, DOER's utilization of contracting with a general sales agent as opposed to performing marketing in-house resulted in commissions paid and additional administrative expenses. Lastly, managed competition has not produced incentives for the health plans to compete to be the low cost plan as they have in the State Employees Group Insurance Program, which is also administered by DOER.

3. **Small employer groups could not offer a choice of provider networks to their employees as larger employers could. MEIP's solution was to provide multiple plan offerings to small employers.**

   - While the "choice" model has been good for the consumers, and as such has been MEIP's strongest selling point, the overlapping provider networks among carriers has diminished the value-added of plan choice. More importantly, small employers place an extremely high priority on price. According to market research conducted for MEIP in 1996 by the Lynch Jarvis Jones advertising agency, most small employers are not willing to pay anything extra for choice.

4. **It was assumed that the positive impact of pooling and plan competition would offset additional administrative costs resulting from multiple plan offerings.**

   - In reality, the health plans had little incentive to market MEIP. The health plans losing money under the fully-insured MEIP program, selling MEIP than they earn by selling similar products offered directly by the health plans. In addition, the discontinuance of the DOER in-house marketing staff resulted in the lack of relationship building with the insurance agency community.

C. Financial Information

NOTE: See Appendix I for Financial Statements and Additional Detail.

1. **MEIP was implemented and introduced to the marketplace during fiscal year 1993. Fiscal years 1993 through 1995 were considered by DOER to be the start-up years for the program. The following events occurred during this three-year period:**

   - MEIP received a start-up loan of $2.075 million, which was provided through the Health Care Access Fund (HCAF) appropriation.

- DOER formulated and implemented a MEIP marketing strategy, designed to attract as many groups as possible during the program's start-up years. Establishment of competitive rates was the key to this strategy. In order to establish competitive rates, the program did not charge its enrolling groups with a load that would cover expenses beyond the cost of purchasing insurance from the carriers.
- DOER decided to pay commissions to independent agents who would market MEIP.
- MEIP enrolled 277 groups by the end of fiscal year 1995.
- MEIP incurred an accumulated net loss (revenues less than expenses) of $1.575 million.
- MEIP's cash reserves subsidized administrative expenses (including commissions to brokers and third party administration expenses) in the amount of $1.46 million.
- MEIP spent approximately three-fourths of the start-up it had received from the HCAF appropriation to subsidize both the rates charged to groups and the program's administrative costs.

2. **During fiscal year 1996:**

- There were no draws made from the HCAF appropriation, the subsidy to premium rates was discontinued, an administrative load was charged to groups, and enrollment in MEIP increased to 354 groups by June 30.
- The load charged to groups, the increased enrollment and reduction of DOER's fixed costs were the primary reasons why MEIP generated a net profit of $250,800 during fiscal year 1996.

3. **Enrollment continued to increase during the first two quarters of fiscal year 1997. However, MEIP enrollment experienced its first downward trend during the third quarter of fiscal year 1997.**

- The downward trend in enrollment (noted above) occurred despite the fact that MEIP spent $160,000 on advertising during fiscal year 1997, which was approximately $120,000 more than had been spent in any one previous year.
- It became obvious that the differential between MEIP's base rates and the rates charged directly to small groups by the health plans for similar products created a very uncompetitive situation for MEIP.

4. **MEIP is projected to earn a net profit of only $1,100 for fiscal year 1997, compared to a net profit of $250,800 for the previous year.**

- The 1997 projection has been conservatively estimated and actual operating results could be more positive than noted in the projected financial.

5. **MEIP requested that its participating carriers provide new issue rates equal to the small group rates that the carriers charged directly to small employers.**

- The carriers declined because of substantial loss ratios experienced - and MEIP's lowest-cost participating health plan actually increased its 1998 rates by 25 percent.
- The above mentioned rate increase on the part of MEIP's lowest cost health plan, when considered with the existing rate differential of the other two carriers, has created a situation in which MEIP rates are very uncompetitive in the health insurance market.
- MEIP's benefit consultants (Deloitte & Touche and Sedgwick James) estimate that MEIP will lose 50 percent or more of its groups in fiscal year 1998. A 50 percent loss of MEIP groups has been incorporated into the budget for fiscal year 1998. As a result, MEIP is expected to incur an overall loss and a corresponding decrease in cash of $86,000 for fiscal year 1998.

6. **The loss of groups for fiscal year 1998 is expected to cause further deterioration of the MEIP pool, resulting in higher claims in relation to premium revenue.**

   - This in turn will result in another round of large rate increases for fiscal year 1999 and another year of projected 50 percent loss of groups.
   - If the program were to continue on through fiscal year 1999, a loss from operations of $236,000 is expected.

7. **The strategy to not change administrative load into the rates to groups during fiscal years 1993 to 1995 resulted in adequate enrollment for MEIP to attain financial feasibility. However, the groups enrolling into MEIP did not represent a good risk compared to groups that are enrolled in the three health plans' overall book of business.**

   - The poor claims experience of the MEIP groups, coupled with the rate differential that existed from the inception of MEIP, produced uncompetitive renewal rates for MEIP during fiscal year 1997 and beyond.
   - Based upon fiscal year 1998 and 1999 budgets, it is apparent that the program cannot continue to operate in a financially feasible manner without a major overhaul to the delivery system.

8. **Rate Differential: Since the inception of MEIP, DOER has been aware that a differential has existed between base rates charged directly to small employer groups by the participating health plans and the rates the plans charged MEIP groups.**

   - Deloitte & Touche prepared a comparison of this differential during December of 1996. This comparison was updated for consideration of the 1998 MEIP renewals, as well as the health plans' 1998 small group filings.
   - The differential for fiscal year 1998 is estimated to be in the range of 20 to 45 percent.
   - The rate differential exists for a variety of reasons, but the gap is continuing to expand because of the poorer claims experience in the MEIP pool compared to the health plans' overall small group book of business.

- The carriers charge a rate differential (excluding consideration of claims experience) due to additional administrative costs of operating a multi-carrier program, the cost of offering a point-of-service option and the feature of "employee choice" (because carriers could be adversely selected against and carriers cannot purchase reinsurance for business related to MEIP).
- During the renewal process for fiscal year 1998, DOER formally requested that participating carriers provide MEIP with rates on a go forward basis equal to those being charged to their small employer group book of business. None of the carriers would voluntarily comply with DOER's request because of high loss ratios previously experienced.

9. **Start-up Loan Status: MEIP was designed to operate self-sufficiently, with funds generated from group premiums charged to cover all costs, and supplemented by start-up appropriations from the Health Care Access Fund (HCAF).**

- Transfers from the HCAF of $2.075 million have been made to MEIP to date for start-up purposes.
- Under current law, all transfers from the HCAF to MEIP are to be repaid by June 30, 1998.
- A projection was prepared during fiscal year 1995 noting repayment of the loan in full by fiscal year 1999. However, that projection was based on the assumption of net growth of 150 groups per year. Another projection was prepared during December of 1996 that assumed a net growth of 60 groups per year. This more recent projection assumed a final payment on the loan during fiscal year 2003.
- Based upon the most recent budget for fiscal years 1998 and 1999, no payment could be made on the loan without jeopardizing MEIP's cash flow requirements. Even if MEIP was terminated immediately, there would be costs associated with winding down the program's business. The date of termination and the manner in which groups would exit the program will be determining factors regarding the amount of the HCAF loan MEIP may be able to be repay.

D. Enrollment

NOTE: See Graphs In Appendix II

1. **MEIP's growth was steady from the time its first group enrolled during the second quarter of fiscal year 1994 through the second quarter of fiscal year 1997. The third quarter of fiscal year 1997 reflects the first downward trend in the number of groups and covered lives.**

2. **According to the Cash Flow Projection prepared during fiscal year 1995, MEIP met its growth expectations through fiscal year 1997. However, due to the widening of the rate differential, MEIP is projected to fall below the original growth expectations beginning in fiscal year 1998 and for all years beyond.**

- Due to the increasing uncompetitiveness of MEIP's rates including the impact from the most recent rate renewal, DOER's benefit consultants project that MEIP will lose 50 percent of its enrolled groups during fiscal year 1998.
- With such a loss, MEIP's pool is projected to continue deterioration (claims experience will get worse) and the rate differential gap will continue to widen. This would cause further loss of groups until eventually only a few (if any) would remain with the program.

E. Marketing

NOTE: See Graphs In Appendix III

1. During the first three years (fiscal years 1993 to 1995) of operation, MEIP enjoyed a significant amount of marketing activity (inquiries about the program, issuing preliminary and final proposals and enrolling new groups).

- The significant marketing activity during the first three years can be attributed to the relationship building with the insurance agent community, as well as successful advertising campaigns.
- However, starting with the first quarter of fiscal year 1996 through the current period, all aspects of marketing activity have been on a continued downward trend.
- The peak of MEIP's marketing activity just happens to coincide with the years when the strategy not to charge an administrative load to the group rates was practiced.
- During the last two fiscal years, MEIP's marketing activity has been reduced to about one tenth to one quarter of the level enjoyed during the first three years of the program's operation. This is despite the fact that $160,000 was spent on marketing efforts during fiscal year 1997.
- The amount spent on marketing efforts during fiscal year 1997 was approximately $120,000 more than spent in any one previous fiscal year.
- Until rates become more competitive, there will be little benefit from the expenditure of marketing dollars.
- In a study conducted during fiscal years 1996 and 1997, MEIP's contracted advertising consultant noted the lack of competitive pricing as the primary barrier affecting MEIP's growth. The second leading reason cited to explain the program's lackluster marketing gains was the lack of effort independent agents are expending towards selling MEIP. MEIP's pricing, lean commissions, involvement with Sedgwick James, and connection with state government were all given as reasons why independent agents have not made much effort to sell MEIP.

F. Customer Service

1. MEIP's customer service function provides services to life/health agents, enrolled groups, the marketing and third party administrator and other vendors.

- Most of the program's administrative function is focused on agents. Approximately 65 percent of MEIP's groups enrolled in the program through agents.
- An estimated 2,000 agents have attended MEIP agent training seminars since 1993. However, a lack of follow-up with the trained agents did not develop the relationship which would have led to enhanced growth in the program.
- Significant energy has been expended to improve the relationship between the independent agents, MEIP's general sales agent and the state; but not with the success hoped for.

G. Exploration of Alternative Models for MEIP

NOTE: See Appendix IV for Additional Detail

1. **Through discussions with MEIP's participating carriers, benefit consultants, Advisory Board members, the management personnel of DOER's Employee Insurance Division and others, several different models (each with two variations) were explored as possible new delivery options for MEIP. When applicable, a fully-insured and a self-insured version of each of these options was also examined. Following are conclusions about each model considered for delivery of MEIP:**

    - The single carrier models (both fully-insured option and self-insured option) were not considered viable for two reasons. First, the employer groups could go directly to the carriers and purchase the same products at a lower cost. In addition, the single carrier models provide no choice to the employees, which is believed to be part of the intent of MEIP's statute as it applies to the advantages of a large pool for insurance purchasing.
    - Of the care system models, the option of enrolling MEIP groups in the HealthPartners Ultimate Choice Product fits well with MEIP's mission of offering choice. However, Ultimate Choice is available only in the metro area - there is no care system model currently available statewide. In addition, HealthPartners denied our request to consider being the sole carrier to provide coverage to MEIP eligible groups. HealthPartners' reason for declining to be considered as the sole carrier was that they would be competing against their own product.
    - The other option under the care system model is not considered viable because MEIP as a pool of employers cannot join BHCAG (the only self-insured care system model available) under current regulations.
    - Under the multi-carrier model, the fully-insured option (MEIP's current delivery model) would not succeed unless the legislature were to pass a mandate directing carriers to provide MEIP with rates equal to those charged to their small group book of business. Passing of such legislation is likely to face strong opposition and therefore is not considered a viable delivery model.
    - The multi-carrier model's self-insured option is not considered viable because it would require substantial appropriation for reserves prior to start-up.

- If the state legislature chooses to continue MEIP, one or more of the models explored as possible alternative for the program may be viable in the long-term perspective. However, MEIP's need for financial feasibility is immediate and short term.

H. Conclusion

Under the delivery model upon which MEIP was structured, the program's future operation was not financially feasible. Continuing to operate MEIP on a status quo basis would only have delayed its inevitable termination long enough to use up the program's cash reserves - leaving little or nothing to repay its HCAF loan or maintain a reserve for future re-entrance in the marketplace.

MEIP has been a success for its initially intended purpose, but is not currently needed in the Minnesota health insurance marketplace and there is no advantage for employer groups to be enrolled in MEIP. Through small group insurance reform (motivated to an extent by MEIP's presence in the market), small businesses can obtain insurance at better rates by purchasing directly from the carriers than they can obtain through MEIP and there is no reason for the State to compete against private industry.

No feasible change in MEIP's delivery system or financing arrangement will overcome the program's structurally created competitive disadvantage. Business process redesign of MEIP administrative functions will improve operations to a limited extent, but will not be enough to make the program competitive.

For these reasons, DOER decided to discontinue enrollment of new MEIP subscriber groups effective July 31, 1997; and to discontinue renewal of existing MEIP groups effective October 1, 1997.

Minnesota Employees Insurance Program (MEIP): IMPACT AND CONTINUED VIABILITY REPORT

Section IV: Recommendations

MEIP has served as source of coverage for a sizable number of employers, and has provided a vital laboratory for testing a number of purchasing pool concepts in practice. Considerable lessons have been learned from the experience which could be valuable in continuing to help meet the needs of Minnesotans for quality, affordable, accessible health care in the future.

- If MEIP's current cash reserves are liquidated in order to partially repay its loan from the Health Care Access Fund - and if the Minnesota Legislature decides to continue the program - a new appropriation of state money for start-up funds is recommended.

- Although MEIP has been discontinued and will officially cease all operations within the next few months, it is recommended that the program's enabling legislation be retained in the event that circumstances change and implementation of a program similar to MEIP is warranted. At such time, the program will be ready to offer a financially feasible insurance purchasing vehicle capable of placing affordable, high quality health coverage within the reach of Minnesota's citizens.

Minnesota Employees Insurance Program (MEIP):
IMPACT AND CONTINUED VIABILITY REPORT
Section V. Notes On Preparation of This Report

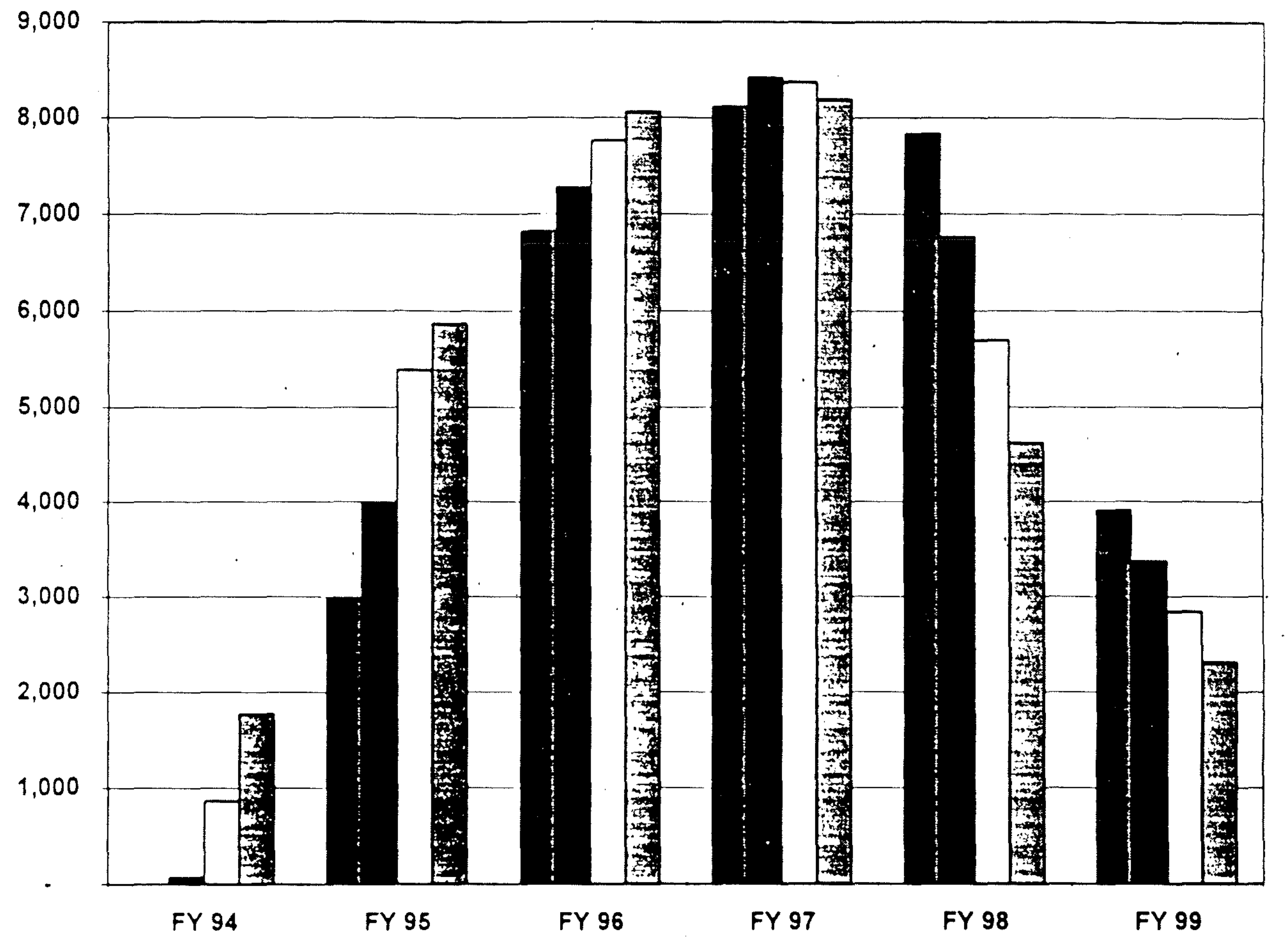
- The estimated cost of preparing this report (including staff time, printing and distribution) is $12,323.95
- This report was printed with a minimum of 10% post-consumer materials.
- Upon request, this report may be made available in alternative formats such as large print, Braille or audio tape.

Minnesota Employees Insurance Program (MEIP):
PRELIMINARY IMPACT AND CONTINUED VIABILITY
Appendix II: Enrollment Data

Contents:

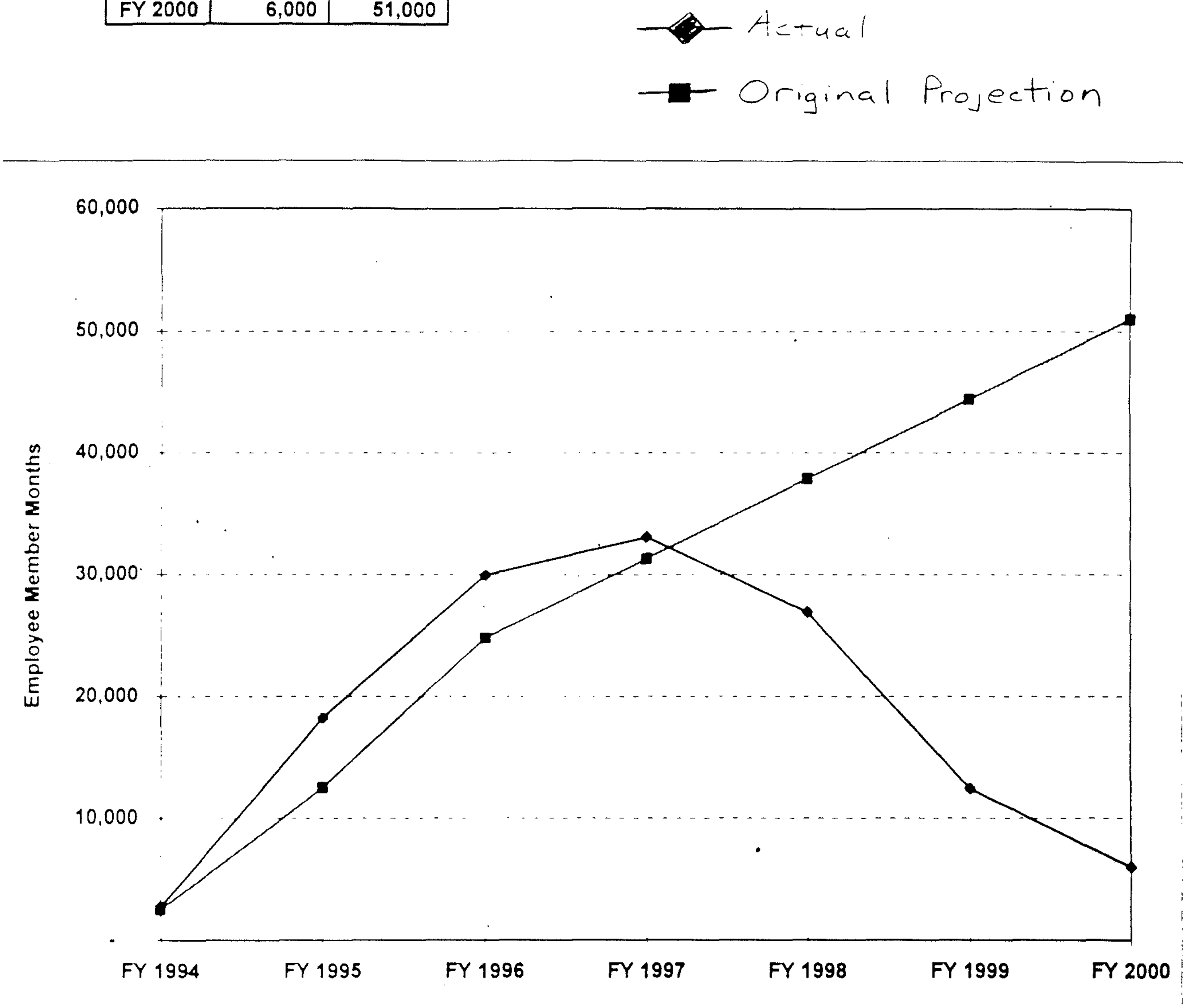
MEIP
EMPLOYEE MEMBER MONTHS
BY QUARTER

	FY 94	FY 95	FY 96	FY 97	Budget FY 98	Budget FY 99
1st Quarter	-	2,983	6,823	8,119	7,836	3,911
2nd Quarter	69	3,997	7,281	8,421	6,765	3,378
3rd Quarter	864	5,387	7,766	8,375	5,694	2,844
4th Quarter	1,771	5,868	8,065	8,200	4,623	2,311



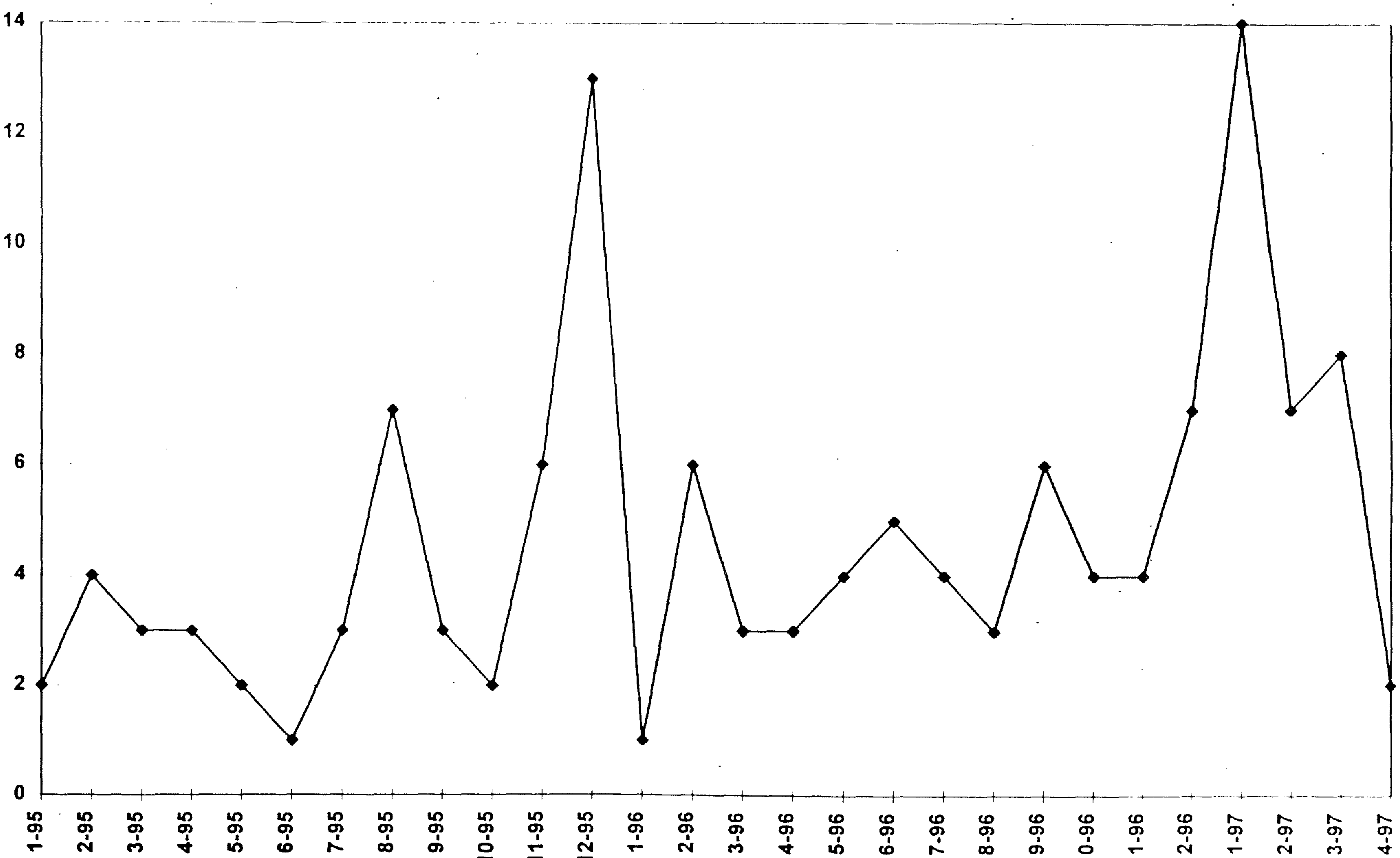
EMPLOYEE INSURANCE DIVISION
MINNESOTA EMPLOYEE INSURANCE PROGRAM (MEIP)
COMPARISON OF EMPLOYEE MONTHS - ACTUAL TO ORIGINAL PROJECTION

	Actual Or Revised Projection	Original Projection
FY 1994	2,704	2,500
FY 1995	18,235	12,500
FY 1996	29,935	24,800
FY 1997	33,100	31,300
FY 1998	26,900	37,900
FY 1999	12,400	44,400
FY 2000	6,000	51,000

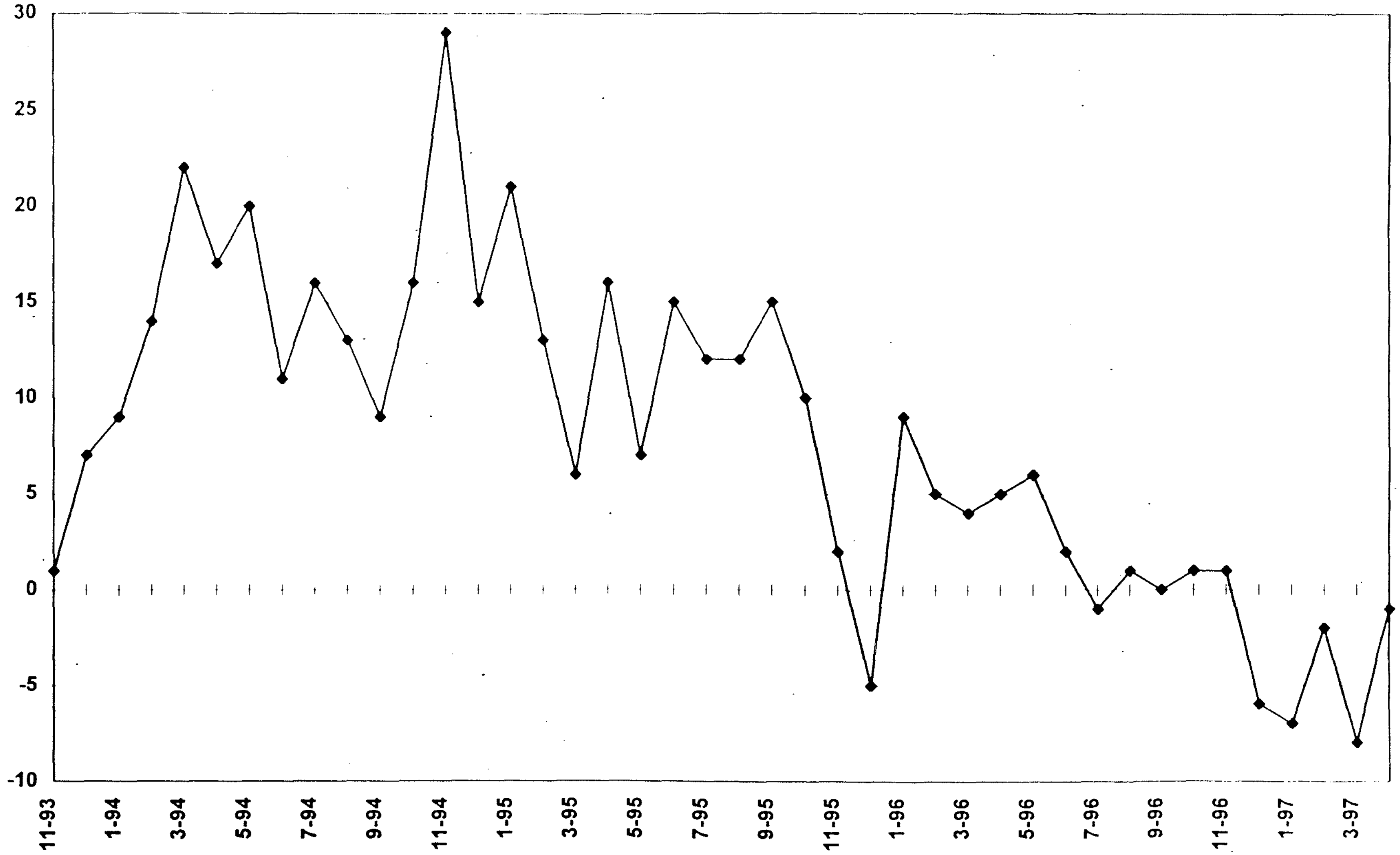


MEIP

NUMBER OF GROUPS TERMINATED BY MONTH



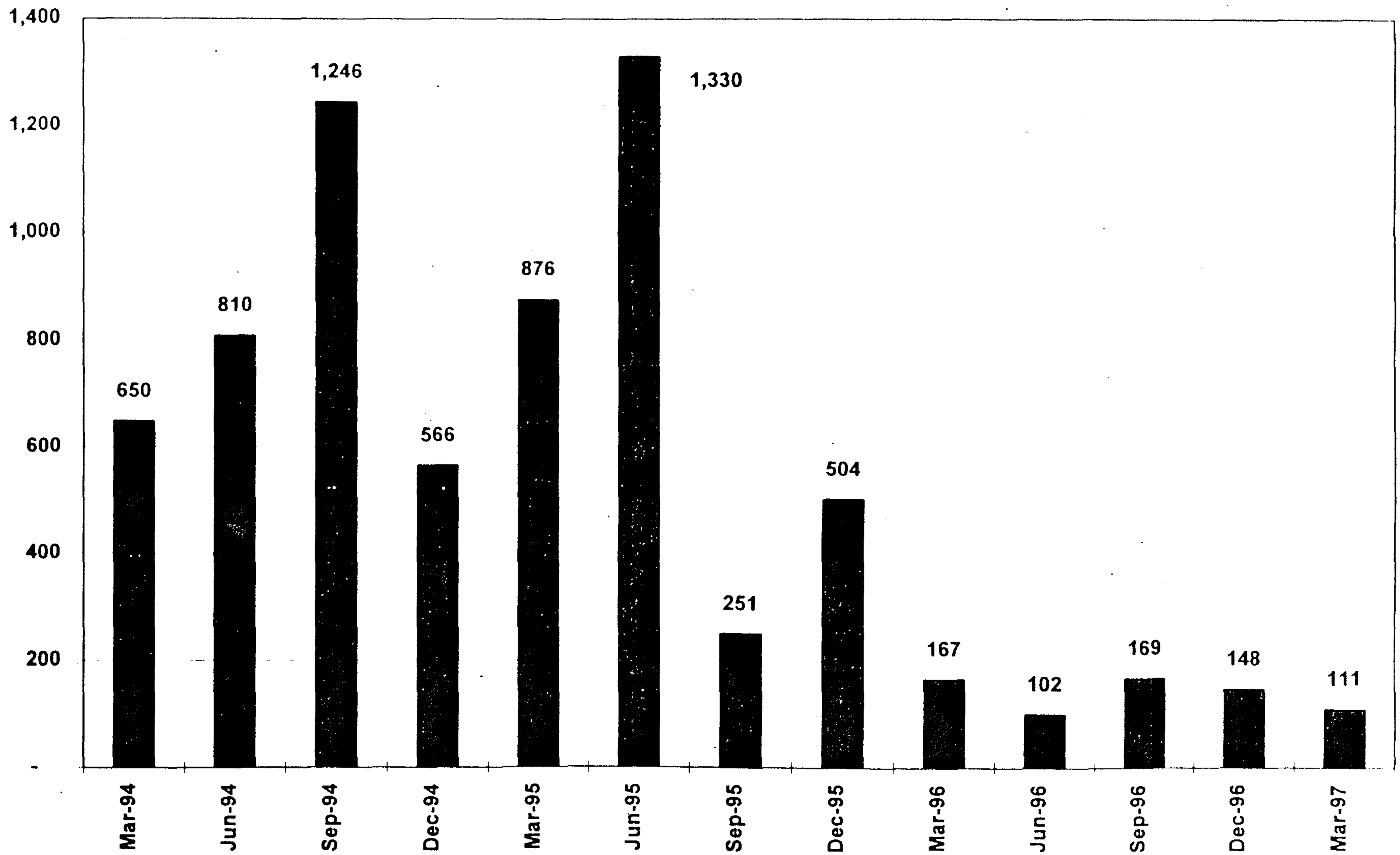
MEIP
NUMBER OF NET GROUPS ADDED\TERMINATED BY MONTH



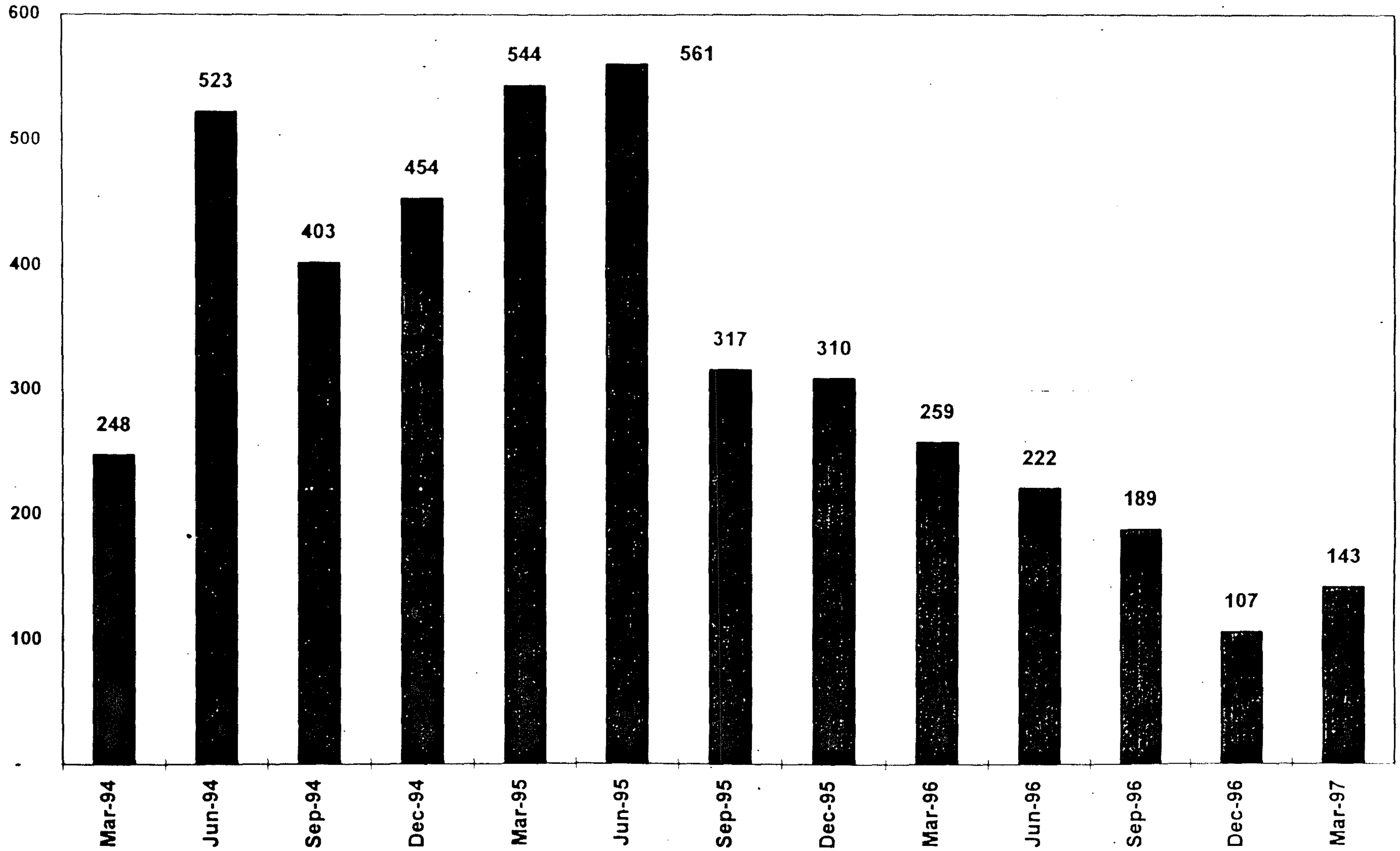
Minnesota Employees Insurance Program (MEIP):
PRELIMINARY IMPACT
AND CONTINUED VIABILITY
Appendix III: Marketing Statistics

Contents:

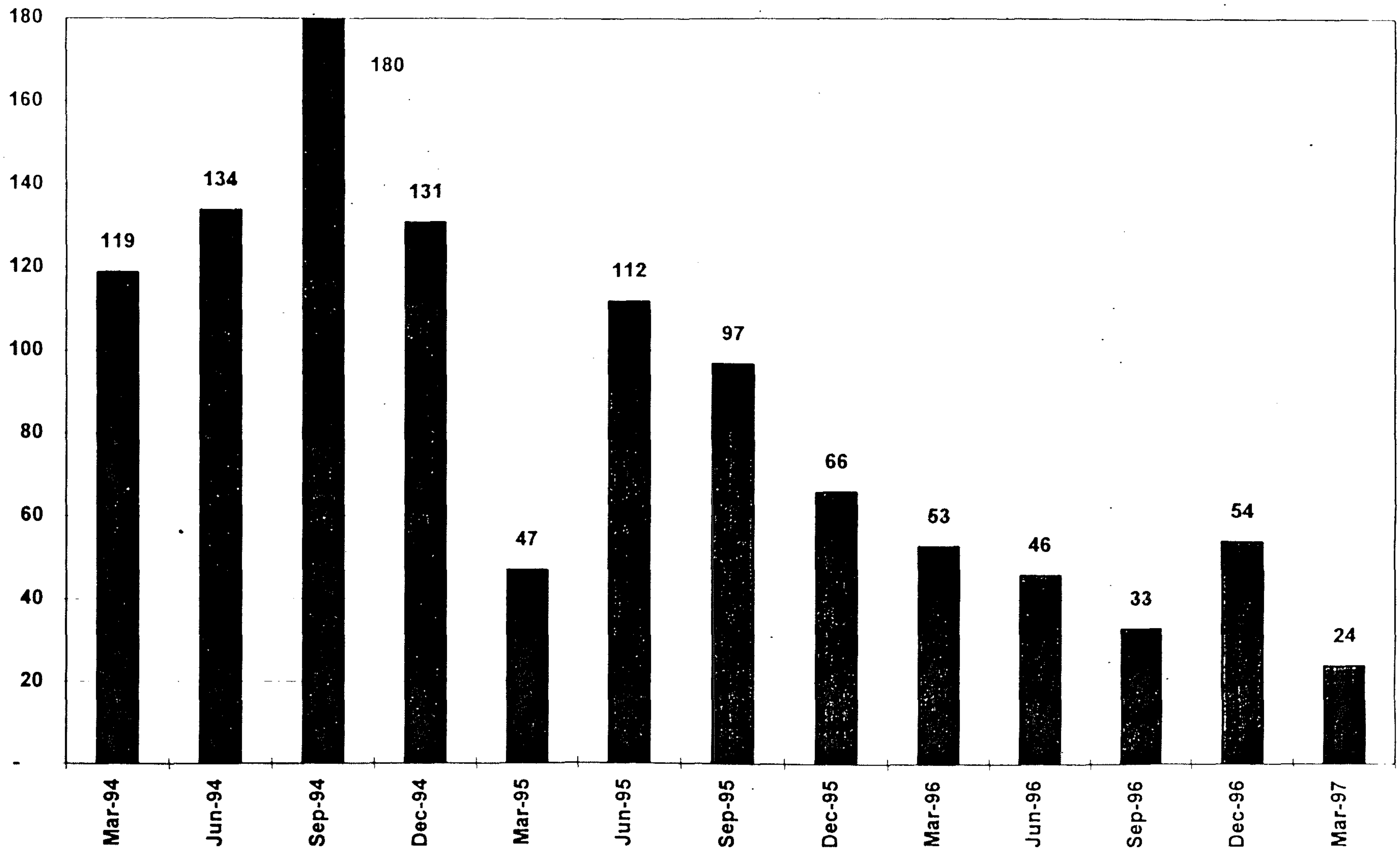
MEIP
NUMBER OF FIRST INQUIRIES BY QUARTER



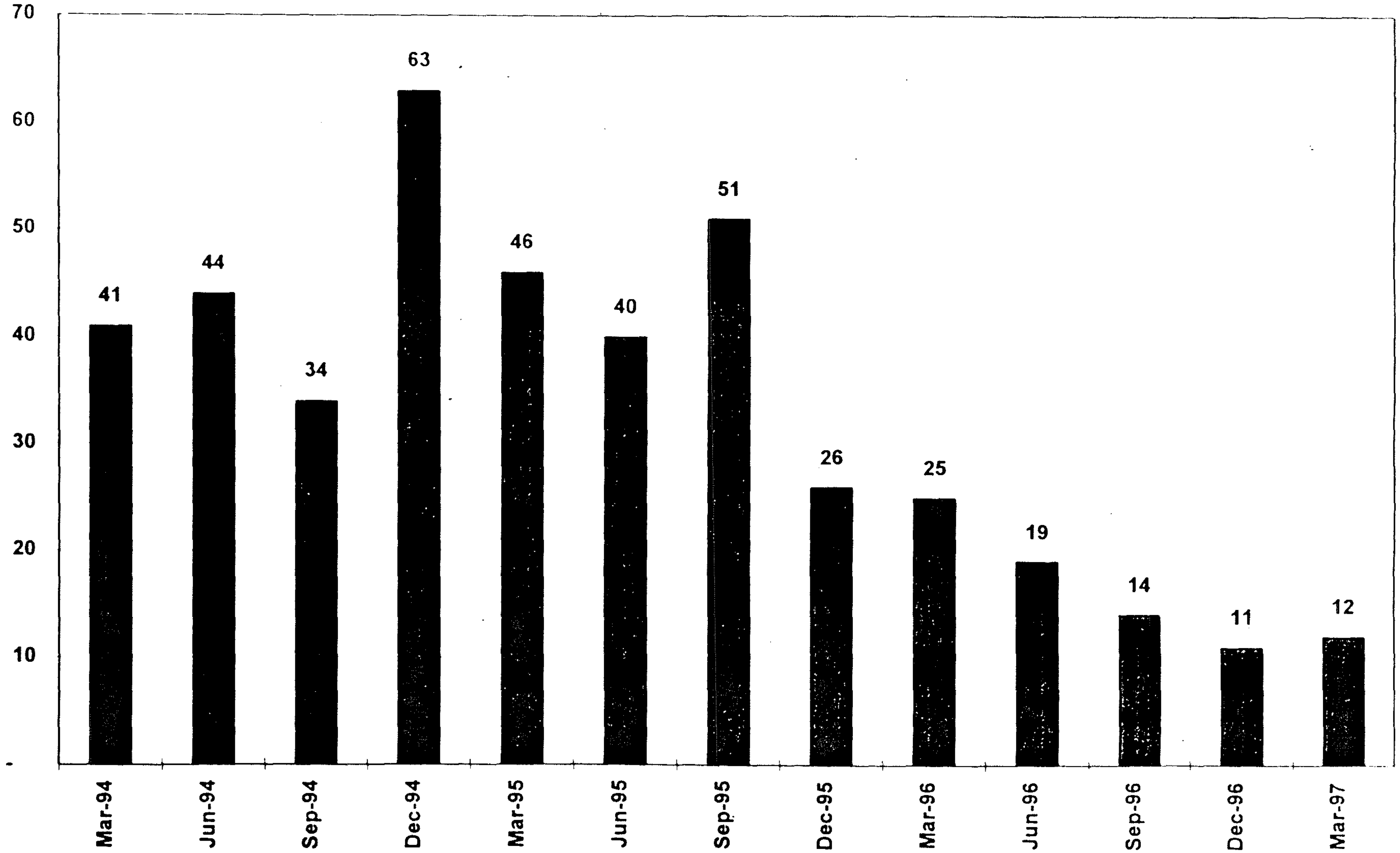
MEIP
NUMBER OF PRELIMINARY PROPOSALS BY QUARTER



MEIP
NUMBER OF FINAL PROPOSALS BY QUARTER



MEIP
NUMBER OF NEW GROUPS ENROLLED



MEIP
MARKETING STATISTICS

	First Inquiries	Preliminary Proposals	Final Proposals	Enrolled
1994				
Jan	68	80	61	7
Feb	120	50	27	14
Mar	462	118	31	20
Apr	230	159	44	14
May	393	196	64	18
Jun	187	168	26	12
Jul	66	71	32	15
Aug	865	153	79	9
Sep	315	179	69	10
Oct	126	165	47	17
Nov	94	156	44	28
Dec	346	133	40	18
TOTAL 1994	3272	1628	564	182
1995				
Jan	125	136	14	18
Feb	61	218	9	10
Mar	690	190	24	18
Apr	372	204	29	8
May	802	171	41	17
Jun	156	186	42	15
Jul	86	85	34	19
Aug	101	135	44	17
Sep	64	97	19	15
Oct	69	121	25	8
Nov	148	99	17	8
Dec	287	90	24	10
TOTAL 1995	2961	1732	322	163
1996				
Jan	86	81	24	9
Feb	44	72	12	8
Mar	37	106	17	8
Apr	41	87	23	9
May	34	66	16	7
Jun	27	69	7	3
Jul	20	61	7	4
Aug	76	57	9	5
Sep	73	71	17	5
Oct	64	77	22	5
Nov	46	73	16	5
Dec	38	36	16	1
TOTAL 1996	586	856	186	69
1997				
Jan	32	41	5	7
Feb	39	66	6	5
Mar	40	38	13	0
Apr	28	55	12	6

Minnesota Employees Insurance Program (MEIP):
PRELIMINARY IMPACT
AND CONTINUED VIABILITY
Appendix IV: Alternative Delivery Models Explored

I. Introduction

In April 1997, an internal panel representing DOER's Employee Insurance Division was assigned to considered possible models upon which the Minnesota Employees Insurance Program (MEIP) could be redesigned. The panel examined the following models and options to determine the potential success of each as an alternative structure for the program.

	Option #	
	Fully Insured	**Self Insured**
Single Carrier	1	2
Care System	3	4
Multi Carrier	5	6
Multi Carrier - With Subsidy From State	7	8

II. Analysis of Models and Options considered for MEIP

The following notes summarize the panel's analysis of each of the models and options listed in Section I.

1) Single Carrier - Fully-Insured

If this option were chosen as the new structure for MEIP, it would offer no advantage for employer groups to purchase the product. Employer groups can go directly to carriers at a lower cost even under rate equalization, because of the additional costs MEIP charges for DOER internal administrative costs. There would be administrative efficiencies from implementing this model, because third party administration and many other functions performed by the program's contracted benefit consultant could be eliminated. This is the model used by the Employers Association.

2) Single Carrier - Self-Insured

This option would offer MEIP the same minimal advantages - and the same disadvantages as the Single Carrier - Fully-Insured option. In addition, this option also carries with it the risks associated with self-insuring - which greatly outweigh any potential benefits. However, the program would not be subject to the carriers setting rates based upon past experience, as is the current practice.

3) Care System - Fully-Insured

If MEIP were to adopt a Care System structure, DOER would be able to eliminate its role in the program's administration process. There would be no value added by DOER duplicating administration procedures. However, in order to adopt this option as its new structure, MEIP would have to offer HealthPartners Ultimate Choice as its only participant health plan. Otherwise, MEIP would have to establish its own care system, which would be cost prohibitive. The likelihood of persuading HealthPartners to offer their Ultimate Choice product through MEIP is low. This is because HealthPartners would have to provide a duplicate product to compete against themselves.

Another disadvantage of this option is that the Ultimate Choice product is available only in the metro area. Approximately 75 percent of the current MEIP groups are based outside of the metro area. To serve MEIP's outstate customers, the program would be required to contract with HealthPartners or an additional carrier to provide coverage in greater Minnesota. Barring this solution, MEIP could simply exclude groups based in greater Minnesota from enrollment - but such an approach would be contradictory to the program's mission and the mandate of its enabling legislation.

The Buyers' Health Care Action Group (BCHAG) does feature a statewide network of care systems, but BCHAG works exclusively with self-insured employers. MEIP could not be brought into BCHAG on a fully-insured basis unless BHCAG were to add a reinsurance component. BCHAG has little incentive to expending the money and effort adding a reinsurance component would require just for the sake of admitting MEIP and its 7,000 lives.

4) Care System - Self-Insured

The advantages or disadvantages under this option are the same as the Care System - Fully-Insured model. Nevertheless, the care system self-insured option could be adopted if MEIP could piggy back on the BCHAG model under a self-insured structure. It might also work if MEIP were to self- insure the Ultimate Choice (or the PreferredOne) product. This option may even be possible in the unlikely event that MEIP could use the State Health Plan Select Network as its own statewide care system.

However, MEIP groups would be required to join BCHAG as individual employers and could not enter that organization as a single group. All MEIP groups would also have to join BCHAG on a self-insured basis. Because of their smaller size and exposure to risk from self insuring, many MEIP groups would not join BCHAG. In addition, the BCHAG model has a standardized set of benefits that is different from MEIP's.

Another disadvantage of this option is a lack of coverage in greater Minnesota. Again, this problem would require MEIP to either drop its coverage in greater Minnesota or contract separately with another carrier to provide statewide coverage. The implementation of a combined BCHAG care system model with a carrier network to provide coverage to greater Minnesota could be costly.

Finally, MEIP's current cash reserves would not provide the reserve necessary under a self-insured program.

5) Multi Carrier - Fully-Insured

This is the current model and option utilized by the MEIP Program. Based upon the current renewal rate increases, the projected net loss in the number of MEIP groups is estimated by Deloitte and Touche to range from 30% to 50%. Sedgwick James projects a 75% net loss of MEIP groups under this structure.

Based upon the projected loss of MEIP groups, it did not appear feasible to continue MEIP's operations under the multi carrier - fully-insured option. Knowing this, EID management asked to provide base rates to MEIP equal to the carriers own small group market rates for new issue groups only. None of the carriers were willing to comply with our request.

If a legislative mandate were passed, the carriers would be required to subsidize MEIP (at a higher subsidy than is the case now) in the hope that the number of groups in the pool will grow and attract a better risk. Once that point is reached - and the carriers would occur losses until that point - the carriers would experience loss ratios equal to their small group pool. This would probably satisfy the carriers; and MEIP could go on carrying out its mission with the ultimate benefit of choice to employees.

In short, continued operation of MEIP under the multi carrier - fully-insured structure would not be financially feasible without rate equalization mandated by legislation. However, passing this type of legislation under current market conditions is unlikely.

6) Multi Carrier - Self-Insured

Under this option, MEIP would be structured much as it is now - except that because the program would be self-insured, it would be unnecessary to obtain a legislative mandate for rate equalization.

One of the advantages of this model is that premiums could be charged based upon the assumed value of the carrier networks. In addition, certain administrative costs could be eliminated - such as the retrospective risk adjustment calculation.

However, self funding raises a previously mentioned concern: MEIP's current cash reserves would not provide the reserve necessary under a self-insured program.

The three methods to increase the MEIP's cash reserves to a level that would support a self-funded program are as follows:

a) Increase the premium charged to groups. This approach probably wouldn't work because it would raise MEIP's group rates making them even more uncompetitive than they are at present.

b) Solicit additional funding from the State of Minnesota.

c) Build reserves from the time the program begins to self fund until claims are processed for payment. However, the reserve must be maintained at required levels to pay the IBNR at plan termination.

7) Multi Carrier - Fully-Insured With State Subsidy

This model assumes the same characteristics as the Multi Carrier - Fully-Insured model with the following exceptions:

a) Legislative mandate to require rate equalization would not be necessary.

b) Instead, a legislative mandate would be sought to subsidize the rates charged to groups.

Under this option, a State subsidy would be utilized to buy down MEIP rates to make them more competitive with the carriers.

The probability passing a legislative mandate to subsidize MEIP is low - the State is unlikely to compete against private industry with a publicly-funded program designed to benefit private sector employees.

Another disadvantage presented by the multi-carrier/state subsidized option is that under such a structure, MEIP would tend to attract higher-risk groups and would still be obligated to cover such risks after its subsidy is discontinued or reduced.

8) Multi Carrier - Self-Funded With Subsidy From The State

This option's general characteristics are:

a) Funding provided by the State to subsidize rates to groups.

b) Self funding.

The disadvantages of this model include:

a) The State would have to assume the risk on a self insured program that is in direct competition with private industry.

b) A subsidized program would attract higher health risk groups once its subsidy is discontinued or reduced.