

Community Benefit Provided by Nonprofit Health Plans

Minnesota Department of Health

January, 2009



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January 15, 2009

The Honorable Linda Berglin
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Minnesota Senate
Room 309, State Capitol
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The Honorable John Marty
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To the Honorable Chairs:

The 2008 Legislature required the Minnesota Department of Health (MDH) to study and report on issues related to community benefit provided by nonprofit health plans in Minnesota (2008 Minnesota Laws, Chapter 358, Article 5, Sec. 4, Subd. 3). Specifically, MDH is required to make recommendations on community benefit standards for nonprofit health plans, including recommendations for a public reporting process and an enforcement and remediation mechanism.

The enclosed report provides an overview of the role of nonprofit health plans in Minnesota, identifies issues related to defining and reporting community benefit for nonprofit health plans, and discusses a range of options related to health plan community benefit requirements. Questions and comments on the report may be directed to the Health Economics Program at (651) 201-3560.

Sincerely,

A handwritten signature in black ink that reads "Sanne Magnan". The signature is written in a cursive, flowing style.

Sanne Magnan, M.D., Ph.D.
Commissioner
P.O. Box 64975
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Enclosure

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Introduction

The Minnesota Department of Health (MDH) was directed by the 2008 Legislature to study and report on issues related to community benefit provided by nonprofit health plans¹ in Minnesota. Specifically, MDH is required to “make recommendations to the Legislature on community benefit standards to be required of nonprofit health plan companies doing business in the state,” including recommendations for a public reporting process and an “enforcement and remediation mechanism.”²

As specified by the legislation, this report focuses primarily on community benefit activities that:

- Support public health;
- Improve the art and science of medical care; or
- Address the need for financial assistance to access ongoing coverage.

In preparing this report, MDH analyzed publicly available information from Minnesota nonprofit health plans, collected and analyzed data on community benefit from the nonprofit health plans, researched health plan community benefit requirements in other states, and reviewed other publicly available information on health plan community benefit standards. MDH also solicited public input on the range of options and the accountability measures, as required by the law.

Background on Nonprofit Health Plan Companies in Minnesota

Nonprofit health plan companies play a significant role in Minnesota’s health insurance marketplace, and Minnesota is unique in requiring all health maintenance organizations (HMOs) to be nonprofit as a condition of licensure. The nonprofit health plan companies included in this report are Blue Cross and Blue Shield of Minnesota (BCBSM) and the state’s nine licensed HMOs. The term “health plan company” as defined in Minnesota Statutes also includes several other types of organizations (such as fraternal benefit societies, joint self-insurance employee health plans, and community integrated services networks).³

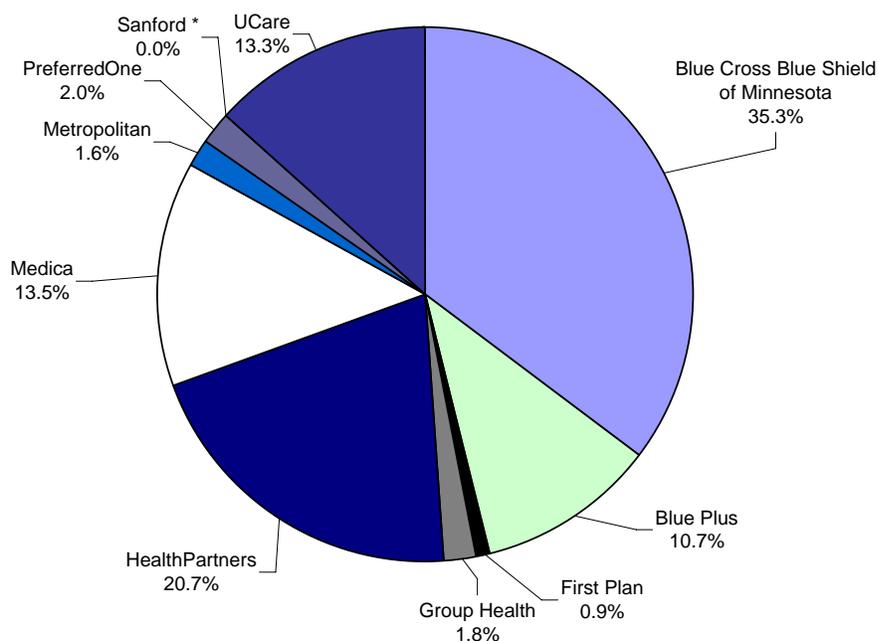
Figure 1 shows the relative market shares of Minnesota’s nonprofit health plans. As a group, nonprofit health plans account for a large share of Minnesota’s health insurance market, but their share of the total market has declined in recent years. In 2007, nonprofit health plans accounted for about 65 percent of the fully insured market, compared to 80 percent in 2002 (see Figure 2). One reason for this change is that premium revenues of for-profit affiliates of some of the nonprofit health plans have increased rapidly.

¹ For purposes of this report, the terms “nonprofit health plan company” and “nonprofit health plan” are used interchangeably.

² 2008 Minnesota Laws, Chapter 358, Art. 5, Sec. 4, Subd. 3. See Appendix 3 for the complete legislative language.

³ Only one of these additional types of organizations, Thrivent Financial for Lutherans, was identified by MDH as having any significant health insurance premium revenue in Minnesota. Thrivent did not respond to MDH requests for information for this study.

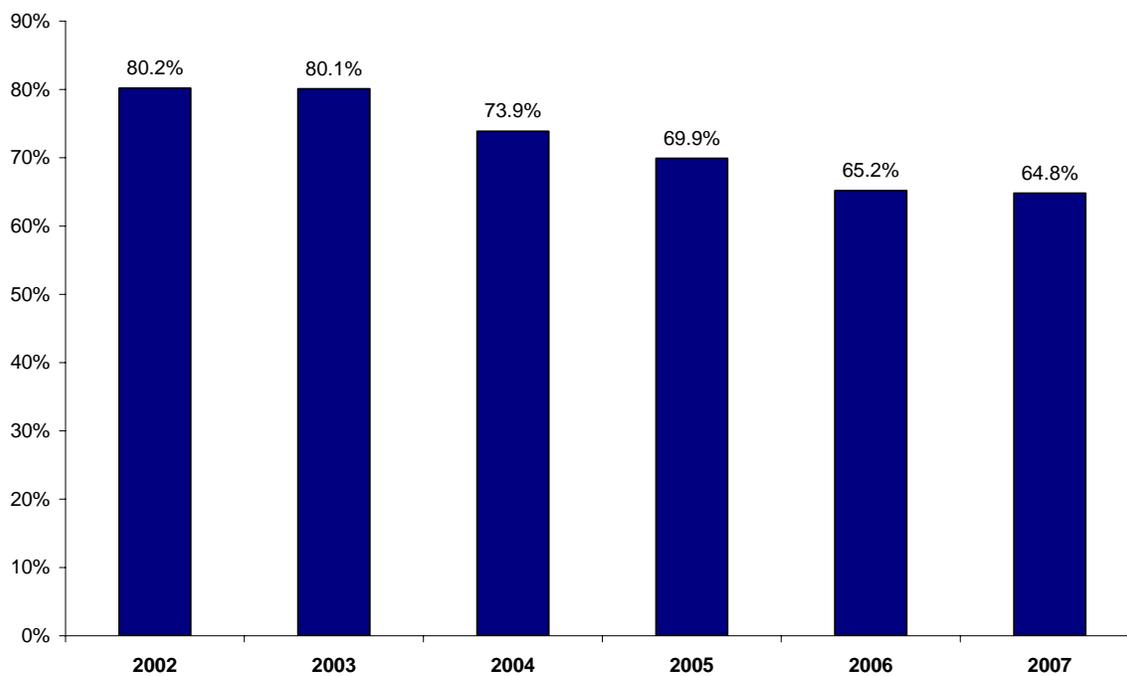
Figure 1
Carriers' Share of the Nonprofit Health Plan Market, 2007



* Less than 0.05%

Source: MDH analysis of health plan financial reports

Figure 2
Market Share of Minnesota Nonprofit Health Plans



Market share calculated as share of premiums in the fully insured health insurance market.

Source: MDH analysis of the premium assessment base for the Minnesota Comprehensive Health Association

Table 1
Enrollment in Nonprofit Health Plans, by Product Type

	2003	2004	2005	2006	2007
Commercial	1,216,161	1,132,539	1,052,421	1,018,175	980,313
State	418,153	412,341	415,558	403,869	401,074
MSHO & MnDHO	5,458	6,151	8,974	33,058	32,149
GAMC	24,474	23,314	25,197	20,727	14,819
PMAP	247,757	250,410	258,482	238,253	245,079
MinnesotaCare	140,464	132,466	122,905	111,830	109,027
Medicare	267,522	250,073	255,750	287,677	292,353
All Products	1,901,836	1,794,953	1,723,729	1,709,721	1,673,740

MSHO is Minnesota Senior Health Options; MnDHO is Minnesota Disabled Health Options; GAMC is General Assistance Medicare Care; PMAP is Prepaid Medical Assistance Program.

Medicare enrollment includes Medicare Cost, Medicare Advantage, Prescription Drug Plans, and Medicare Supplement plans.

Source: MDH analysis of health plan financial reports

Combined, Minnesota's nonprofit health plans enrolled nearly 1.7 million Minnesota residents in 2007. As shown in Table 1, however, between 2003 and 2007 enrollment in nonprofit health plan companies declined from about 1.9 million to less than 1.7 million. Nearly all of this enrollment decline was in commercial products. As a result, publicly funded insurance programs account for an increasing share of nonprofit health plans' enrollment (41 percent in 2007, compared to 36 percent in 2003).

As an industry, nonprofit health plan companies in Minnesota have been profitable over time (see Table 2). In 2007, nonprofit health plans in Minnesota earned net income of about \$117 million, or 1.5 percent of premium revenue. Between 2003 and 2007, nonprofit health plans as a group had positive net income each year, ranging from 0.5 percent to 3.7 percent of premium revenue.

Table 2
Net Income and Premium Revenue for Nonprofit Health Plans
(Millions of dollars)

	2003	2004	2005	2006	2007
Net Income	\$225.3	\$142.7	\$123.2	\$34.1	\$117.3
Premium Revenue	\$6,040.6	\$6,139.4	\$6,476.6	\$7,103.7	\$7,608.1
Net Income as % of Premium Revenue	3.7%	2.3%	1.9%	0.5%	1.5%

Source: MDH analysis of health plan financial reports

Table 3
HMO Net Income by Product Type
(Millions of dollars)

	2003	2004	2005	2006	2007
Commercial	\$17.2	\$21.4	\$1.2	-\$11.1	\$23.0
State	\$58.9	\$78.9	\$30.2	\$7.2	\$57.1
MSHO & MnDHO	\$8.3	\$9.0	\$8.0	\$77.2	\$78.4
GAMC	-\$16.3	-\$19.1	-\$18.0	-\$21.4	-\$30.2
PMAP	\$40.3	\$37.9	\$10.4	-\$63.4	\$18.7
MinnesotaCare	\$26.7	\$51.0	\$29.7	\$14.8	-\$9.8
Medicare	\$44.3	\$23.0	\$24.3	\$27.6	\$37.8
Other	\$8.5	\$10.0	\$7.9	\$9.5	\$3.4
Total	\$128.8	\$133.3	\$63.5	\$33.2	\$121.2

MSHO is Minnesota Senior Health Options; MnDHO is Minnesota Disabled Health Options; GAMC is General Assistance Medicare Care; PMAP is Prepaid Medical Assistance Program.

Medicare includes Medicare Cost, Medicare Advantage and Medicare Supplement plans.

"Other" includes administrative fees and other sources of income.

Note: Financial reporting requirements are different for HMOs and other health plans. Income by product line is not available for Blue Cross Blue Shield of Minnesota.

Source: MDH analysis of health plan financial reports

Table 3 shows the trend in net income by product line for HMOs.⁴ In 2007, state public programs accounted for nearly half (47 percent) of net income, and Medicare products accounted for an additional one-third (31 percent) of net income. Although income from state public programs represents a large share of net income, some programs are consistently more profitable than others. For example, HMOs lost money on their General Assistance Medical Care (GAMC) business each year from 2003 through 2007.

What is Required of Nonprofit Health Plans?

There is currently no explicit state or federal requirement that nonprofit health plans engage in community benefit activities or community benefit reporting. Minnesota HMOs are required to file "collaboration plans" with MDH every four years, with progress updates every two years. These plans describe HMOs' planned activities to support high priority public health goals and to collaborate with local public health and other community organizations.⁵

⁴ Financial reporting requirements are different for HMOs than other types of health plans. Income by product line is not available for Blue Cross and Blue Shield of Minnesota.

⁵ Minnesota Statutes, Section 62Q.075.

In contrast to what is required of nonprofit health plans, federal policy explicitly requires nonprofit hospitals to engage in community benefit activities in order to maintain their tax exempt status.⁶ In addition, a 2007 state law requires that Minnesota hospitals publicly report their community benefit activities in a standardized way.⁷

How are Nonprofit Health Plans Different from For-Profit Health Plans?

Minnesota law treats nonprofit and for-profit health plans similarly in some ways. For example, the annual assessment to offset the losses of the Minnesota Comprehensive Health Association (MCHA), Minnesota's high-risk insurance pool, is levied on premiums of nonprofit and for-profit health plans. In 2007, this assessment was about 2 percent of premium revenue. Another similarity between nonprofit and for-profit health plans is that both are exempt from the state corporate income tax (except that Blue Cross and Blue Shield of Minnesota, licensed under Minnesota Statutes Chapter 62C, is subject to the tax).⁸

There are two main differences in the way that Minnesota tax law treats nonprofit and for-profit health plans. First, both nonprofit and for-profit health plans pay premium taxes, but at different rates (1 percent and 2 percent, respectively).⁹ The value of this lower tax rate for nonprofit health plans is estimated to be \$79.4 million in fiscal year 2009.¹⁰ Second, Minnesota HMOs pay a 0.6 percent Medicaid surcharge that is not paid by other types of health plans; the total amount of this surcharge is estimated to be about \$22.3 million in 2009.¹¹ Table 4 summarizes the differences in taxes and assessments paid by nonprofit and for-profit health plans in Minnesota.

Table 4
Health Plan Taxes and Assessments in Minnesota

	Nonprofit Plans	For-Profit Plans
MCHA assessment*	2.1%	2.1%
Premium tax	1.0%	2.0%
Medicaid surcharge	0.6%**	--
Corporate income tax	Exempt	Exempt

*Varies by year, depending on MCHA losses and size of assessment base. For premiums collected in 2007, the assessment rate was about 2.1%.

** HMOs only.

*** except Blue Cross and Blue Shield of Minnesota.

⁶ Internal Revenue Service, Revenue Ruling 69-545, 1969.

⁷ Minnesota Statutes, Section 144.699.

⁸ Minnesota Statutes, Section 290.05, subdivisions 1 and 2.

⁹ The 1 percent premium tax on nonprofit plans is deposited into the Health Care Access Fund, and the 2 percent premium tax on for-profits is deposited into the General Fund.

¹⁰ Minnesota Department of Revenue, 2008 Minnesota Tax Expenditure Budget.

¹¹ The surcharge applies to total premium revenue, excluding premiums from the Federal Employees Health Benefit Program and Medicare premiums.

Defining and Reporting Community Benefit for Nonprofit Health Plans

Because there are no explicit federal requirements related to nonprofit health plan community benefit and only a few states that have addressed this issue,¹² there are no widely accepted definitions of community benefit and reporting categories designed specifically for health plans. However, a set of guidelines developed by the Catholic Health Association and VHA, Inc. (CHA/VHA) for nonprofit health care organizations – primarily hospitals - serves as a useful frame of reference.¹³

Based on the CHA/VHA guidelines, MDH established a working definition of “community benefit” as a planned approach to identifying and addressing the needs of a community. Specific to health plans, general principles related to defining activities that qualify as community benefit include the following:

- The activities should benefit a general population, and not be targeted to individual health plan members; and
- Expenses incurred in the normal course of doing business as a health plan should not be included in a definition of community benefit.

To understand the range of activities that Minnesota’s nonprofit health plans consider to be community benefit, MDH collected information from Minnesota’s nonprofit health plans (including affiliated foundations) on their 2007 community benefit activities. Due to the lack of consensus standards for what constitutes community benefit, there is variation across health plans in the types of activities that are considered community benefit. Because of this variation, MDH framed its request to the health plans in a way that would allow for the greatest flexibility in reporting. In the description that follows, MDH analyzed the data provided by the health plans in order to organize it based on the specific categories of interest to the Legislature and to enable “apples to apples” comparison to the extent possible.

Nonprofit health plans in Minnesota reported many different types of activities that they consider to be community benefit; as expected, there were differences across health plans in the types of activities that were reported. Major categories of activities that at least one health plan reported as community benefit include the following:

- **Support for public health:** Examples of activities in this category include community health education, health fairs, information campaigns focusing on healthy lifestyles and tobacco cessation, and support for efforts to reduce health disparities. This category also includes support for health care resources available to the community in general, such as a health plan sponsored 24-hour nurse line that is available to anyone regardless of their insurance status or health care provider.

¹² In the course of preparing this report, MDH identified only a few other states where nonprofit health plans report community benefit. Some simply require reporting of community benefit plans, similar to current Minnesota requirements for HMOs. Massachusetts has voluntary standardized reporting of HMO community benefit activities, and Maryland requires nonprofit health plans to demonstrate community benefit in an amount at least equal to the value of premium tax exemptions.

¹³ “A Guide for Planning and Reporting Community Benefit,” Catholic Health Association, with VHA, Inc, May 2006.

-
- **Improving the art and science of medical care:** This category includes support for collaborative efforts such as the Institute for Clinical Systems Improvement (ICSI) and MN Community Measurement (MNCM). It also includes health services research, support for medical education, and support for provider infrastructure to improve quality of care (e.g., patient disease registries).
 - **Addressing the need for financial assistance to access ongoing coverage:** Examples of expenditures in this category include health plans' support for outreach to identify and enroll qualifying Minnesota residents in state programs. This category also includes financial support for initiatives that serve uninsured or underinsured Minnesotans (e.g., community clinics, Portico Healthnet, and mental health prescription drug assistance).
 - **Philanthropy:** Many health plans provide matching funds for employee charitable donations, or provide direct financial support for community-based nonprofits such as the United Way, and included these expenses as community benefit.
 - **Financial losses incurred on state public insurance programs:** Some health plans counted financial losses on state public insurance programs as community benefit. Issues related to whether the definition of health plan community benefit should include these losses are discussed in greater detail below.
 - **Tax payments:** Several health plans noted that they pay a variety of taxes, some of which directly support access to health insurance coverage. The types of taxes itemized by health plans include the MCHA assessment, Medicaid surcharge, 1% premium tax, and property taxes. The issue of whether tax payments should be included in calculations of nonprofit health plan community benefit is discussed in greater detail below.
 - **Activities of affiliated health care providers:** Health plans that are part of integrated delivery systems provide other types of community benefit related to directly delivering health care services, such as charity care or financial losses incurred to provide health care services for public program patients. For purposes of this report, MDH included only activities that were directly associated with the health plan business.
 - **Provider pay for performance initiatives:** This category includes financial incentives for health care providers that meet quality goals. Although this type of initiative has significant potential for improving health outcomes and containing cost, for purposes of this report MDH considered pay for performance initiatives to be a normal cost of doing business as a health plan and not community benefit, because this type of activity is widely undertaken by both for-profit and nonprofit health plans.
 - **Activities targeted to individual health plan members:** Examples of reported activities that benefit individual health plan members include interpreter services and programs that reward individual health plan members for activities such as getting recommended preventive services or leading a healthy lifestyle. MDH did not consider these activities to be community benefit for purposes of this report. These activities are more appropriately considered to be part of the normal business of operating a health plan – for example, individual member incentives are most often part of a strategy to reduce future claims costs.
 - **Training, licensing, and continuing education:** One health plan reported costs associated with employee training, continuing education for health plan staff, and insurance agent licensing and continuing education as community benefit activities. For purposes of this report, MDH considered these activities normal costs of doing business as a health plan, and not community benefit.
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- **Unquantified or unquantifiable community benefit activities:** Nonprofit health plans described a wide range of other activities that clearly meet a definition of community benefit, but that they were not able to quantify. For example, many health plans provide in-kind support and participation in local, state, regional, and national collaborative efforts to improve health care system performance, reduce health disparities, and promote health.

Public program losses

Two of the ten nonprofit health plans that provided information to MDH on community benefit included losses on state public insurance programs in their calculations. One plan counted net losses across all state public programs, and one plan counted only losses incurred on General Assistance Medical Care (GAMC). As shown in Table 3, in each year from 2003 to 2007 Minnesota HMOs earned profits on all state public insurance programs combined, although they lost money on GAMC each year.

Treating net health plan losses across all state public programs as community benefit would be consistent with the way that underpayments from state public programs are treated for the purpose of calculating community benefit provided by nonprofit hospitals in Minnesota.¹⁴ Counting the net losses across all state public programs combined would provide a measure of the effective subsidy (if any) that health plans provide to fund access to state-funded health insurance programs. Health plans that earned positive net income on their state business would not count any community benefit in this category, while health plans that experienced a net loss across all state programs would count it as community benefit. Defined in this way, community benefit attributable to net losses on state public programs was \$8.3 million in 2007, as shown in Appendix 1.

On the other hand, an argument against counting state public program losses as community benefit is the fact that payment rates paid to health plans for state public program enrollees are required to be actuarially sound (for programs in which the state receives federal matching payments) – in other words, the payment rates must be sufficient to cover the cost of providing services to the enrolled population. If a health plan is paid an actuarially fair rate and still incurs losses, it could be a reflection of health plan inefficiency rather than an effective subsidy from the health plan to the broader community.

¹⁴ Minnesota Statutes, Section 144.699.

Taxes

Nonprofit health plans in Minnesota pay a variety of taxes and assessments. These include:

- A one percent tax on premiums, which is deposited into the Health Care Access Fund. Because the revenue from this tax directly supports health care access for low-income Minnesotans, it could be considered a form of community benefit. On the other hand, it is important to note that nonprofit health plans in Minnesota pay *lower* premium taxes than their for-profit counterparts. It can be argued that this tax differential is actually the primary reason for an *expectation* of community benefit. By this logic, the one percent premium tax would be excluded by definition from calculations of community benefit.
- A 0.6 percent surcharge on premiums paid by HMOs. This tax is not paid by Blue Cross and Blue Shield of Minnesota or by for-profit health plan companies. To the degree that revenue from this tax directly increases public program payment rates to health plans (by leveraging additional federal funds), it would be consistent with CHA/VHA community benefit guidelines to count this surcharge as community benefit. However, there are two arguments against including the surcharge in community benefit calculations. First, revenues from the HMO surcharge are deposited in the general fund and are not dedicated to health care. In addition, excluding the surcharge from health plan community benefit would be consistent with the way that Minnesota law treats hospitals for community benefit public reporting – for hospitals, taxes that directly support higher provider payment rates are excluded from community benefit calculations.¹⁵
- Assessments to offset losses of the Minnesota Comprehensive Health Association (MCHA), Minnesota's high-risk insurance pool. The amount of this assessment is determined by a health plan's share of the fully insured market, and the assessment is calculated in the same way for nonprofit and for-profit health plans. For 2007, the total MCHA assessment was about 2 percent of fully insured premiums, or about \$115 million; nonprofit health plans paid about two thirds (65 percent) of this total. Because the assessment applies in the same manner to for-profit and nonprofit health plans, it can be considered a normal cost of doing business that should be excluded from community benefit calculations. In addition, the MCHA assessment functions to a significant degree like a reinsurance mechanism for the private insurance market – health plans may reject applicants for coverage in the individual insurance market, but they must all contribute to the cost of covering high-risk populations. This reinsurance function is also more appropriately characterized as a normal cost of doing business than as community benefit.
- Property taxes, which MDH excluded from community benefit totals because they are a normal cost of doing business for nonprofit and for-profit health plans alike.

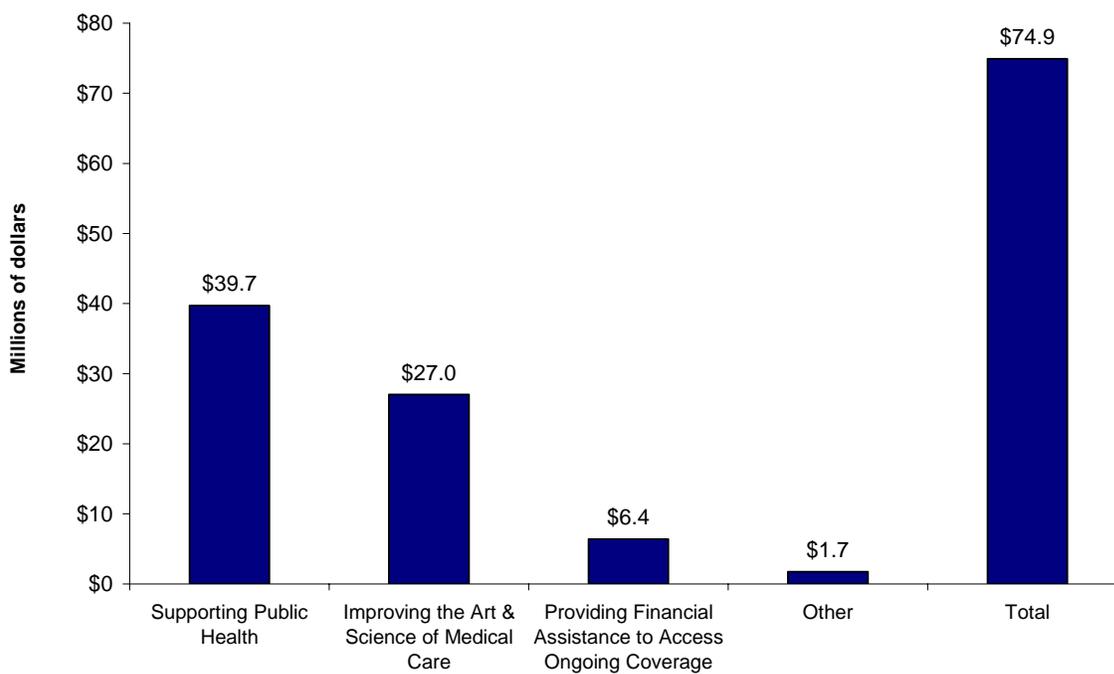
¹⁵ For hospitals, CHA/VHA guidelines allow provider taxes that are used as matching funds for federal Medicaid resources to be included as part of the calculation of payment shortfalls from state public programs, because without these taxes the shortfalls would be even larger than they actually are. However, Minnesota Statutes, Section 144.699 defines hospital shortfalls from state public programs as the difference between hospitals' cost of providing services to public program beneficiaries and payments from public programs, and does not include provider taxes in the calculation.

Analysis of Reported Community Benefit

In the analysis that follows, the definition of community benefit includes: support for public health; activities that improve the art and science of medical care; activities that address the need for financial assistance for ongoing coverage or that directly subsidize health care services for people without coverage; and other activities (primarily philanthropy). Using this definition, MDH estimates that nonprofit health plans provided \$74.9 million in community benefit in 2007, or about 1 percent of total premiums. As shown in Figure 3, about half of this amount (\$39.7 million) supported public health activities. An additional one third of the total (\$27.0 million) was expended on activities to improve the art and science of medical care, \$6.4 million was spent to provide financial assistance to access ongoing coverage or support for services to people who do not have insurance coverage, and \$1.7 million was expended for other community benefit, including general philanthropy.

This initial attempt to quantify and categorize community benefit resulted in significant variation across health plans. As a percentage of each plan's premium revenue, the definition used above results in community benefit that varies between 0.1 percent and 2.6 percent of premium revenue, with all plans except one falling below 1 percent of premium revenue. Because this initial effort to measure health plan community benefit was made in the absence of previously existing consensus definitions, it is possible that the establishment of these standards would produce considerably different results in the amount of community benefit reported by health plans. For this reason, MDH decided not to present community benefit estimates for individual health plans in this report. In addition, it is likely that health plan community benefit varies significantly from year to year, because of changes in health plan financial results.

Figure 3
2007 Minnesota Nonprofit Health Plan Community Benefit



Source: MDH analysis of data collected from Minnesota nonprofit health plan companies

Options for Community Benefit Standards

There is a wide range of options that could be considered for developing community benefit standards for Minnesota nonprofit health plans. These include:

- Retain the status quo and do not establish standards for community benefit or public reporting;
- Develop uniform definitions of community benefit and require transparency through periodic public reporting, either directly to the public or to a state agency;
- Establish specific priorities for community benefit activities and expectations that health plans focus on these priority activities;
- Require that nonprofit health plans provide a specific level of community benefit (for example, as a percentage of premium revenue, net income, or some other measure).

In choosing among these options, one important issue to take into account is the need to balance considerations about the appropriate level of community benefit with concerns about the rising cost of health insurance. In general, there are two sources from which health plans can finance community benefit – current premiums or accumulated reserves. Requiring health plans to provide a specific level of community benefit could have at least two unintended results: higher health insurance premiums, and increased movement from nonprofit to for-profit health plans as a result of increased costs in nonprofit plans. One exception to this would be a one-time spend-down of “excess” reserves (combined with a cap on future reserves). The text box on page 12 provides some background and context related to the level of reserves held by Minnesota nonprofit health plans.

Similar to the decision about what, if any, requirements there should be for health plan community benefit activities and reporting, there is also a range of options with regard to the development of accountability measures. These include:

- No accountability measures;
- Transparency and accountability through public reporting;
- Administrative fines for failure to report;
- Loss of tax preferences or loss of license.

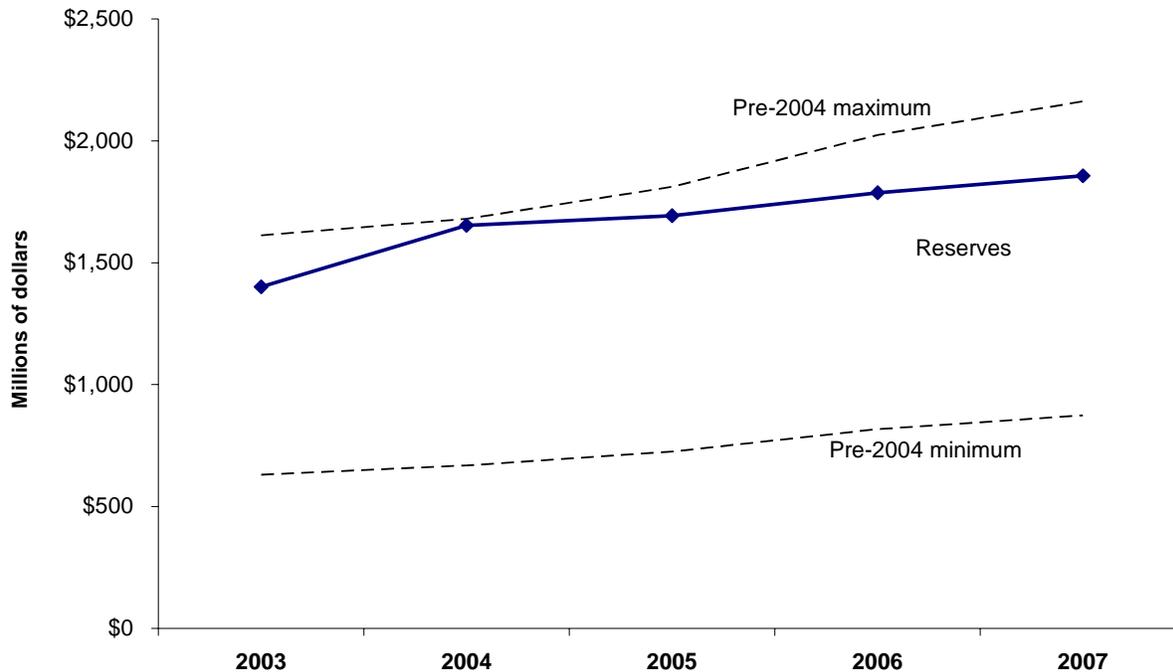
Clearly, the level of accountability that makes sense will vary with the level of expectations about health plan community benefit activities and reporting. For example, loss of tax preferences or loss of license is an option that would likely only be seriously considered if health plans were required to provide a minimum level of community benefit and failed to do so.

Health Plan Reserves

Health plans are required by law to maintain sufficient financial reserves to ensure that they are financially able to meet their commitments to policyholders. Prior to 2004, Minnesota law set both minimum and maximum requirements for health plan reserves. HMOs were required to maintain between one and three months' worth of expenses in reserve, and Blue Cross was required to hold reserves between two and four months of expenses. In 2004, Minnesota adopted a "risk-based capital" approach to regulating health plan reserves, in accordance with standards recommended by the National Association of Insurance Commissioners (NAIC). Under the new system, there is no cap on health plan reserves.

Figure 4 shows the level of Minnesota nonprofit health plans' reserves from 2003 to 2007, in comparison to the minimum and maximum levels of reserves that would be required under the regulatory system in place prior to 2004. As shown in the figure, as a group Minnesota's nonprofit health plans continue to maintain reserve levels that fall within the minimum and maximum requirements prior to 2004. In general, reserve levels for individual health plans have also continued to be in this range.

Figure 4
Nonprofit Health Plan Reserves



Source: MDH analysis of health plan financial reports

Public Input

MDH solicited public input on the range of options for developing community benefit standards and establishing accountability measures in two ways. First, MDH sent a letter to stakeholder groups representing consumers, employers, health care providers, and health plans inviting them to comment on the range of options for community benefit standards and accountability mechanisms. In addition, a general announcement of the opportunity to provide public input was made on the MDH health reform website and sent by e-mail to people who have subscribed to a distribution list for announcements related to implementation of the 2008 health reform bill.¹⁶

The request for public input provided information on the range of options described above and solicited input on the following questions:

- What types of health plan activities should be considered community benefit?
- What, if any, standards should be put in place for uniform reporting of community benefit?
- What, if any, mechanisms should be in place to establish accountability for community benefit?

MDH received input from two organizations, the Minnesota Council of Health Plans (MCHP) and the Minnesota Business Partnership. Copies of their comments are included as Appendix 2 of this report.

MCHP argued that nonprofit health plans should be expected to provide community benefit through their operations and unique programs addressing the specific needs of their members or geographic area, and that the benefits should be identifiable and part of each organization's plan. MCHP proposed to issue an annual report on community benefit on behalf of the industry. MCHP's proposed report would include all of the activities that MDH included in the calculation of community benefit for this report, plus payment of taxes and assessments.

The Minnesota Business Partnership's comments pointed out the importance of balancing nonprofit health plans' unique role in advancing public health and the art and science of medical and health care with the need to provide affordable health coverage for members. The Minnesota Business Partnership stated that creating a standard set of definitions for community benefit would allow for better comparison across health plans, but that the state should not set a minimum level of required community benefit or specify the activities that health plans should undertake to benefit the community.

¹⁶ This list currently has over 700 members.

Table 5
Recommendations on Community Benefit Definitions

	Activity/Expense	Examples
Include	<ul style="list-style-type: none"> - Support for public health - Improving the art and science of medical care - Supporting financial access to care - Other activities that benefit the general community 	<ul style="list-style-type: none"> - Health promotion, community health education, reducing health disparities - Improving quality of care, supporting medical education, health services research - Outreach for public program enrollment, funding for safety net clinics - Philanthropy, community supports not directly related to health or health care
Possibly include	<ul style="list-style-type: none"> - Losses on state public programs, only if net loss across all programs 	
Exclude	<ul style="list-style-type: none"> - Taxes and assessments - Activities of affiliated health care providers - Normal costs of business - Activities targeted to individual health plan members 	<ul style="list-style-type: none"> - Provider pay for performance, staff training and education

Recommendations

Community Benefit Standards

Based on the information provided to MDH for this report, there is clear variation across health plans in which types of activities are currently considered community benefit. If a requirement for ongoing public reporting of health plan community benefit is established, it will be necessary to establish a set of standards and definitions for what types of activities should be included in calculations of health plan community benefit. Without such standards, it will be impossible to make comparisons across health plans. Table 5 provides MDH recommendations about specific types of activities that should be included and excluded from health plan community benefit calculations. MDH recommends, for the reasons discussed earlier in this report, that taxes and assessments not be counted as health plan community benefit. There are reasonable arguments for and against the inclusion of net losses on state public programs, but if they are included MDH recommends that the calculation be across all state public programs combined (i.e., offsetting losses on some state programs against profits from others).

While it would be beneficial to establish definitions about what constitutes community benefit, there is no clear rationale for establishing a requirement that nonprofit health plan companies provide minimum levels of community benefit. Establishing a minimum level of community benefit for health plans would be inconsistent with Minnesota's current expectations of nonprofit hospitals (which, in contrast to nonprofit health plans, *are* required to provide at least some level of community benefit to retain their nonprofit status), and would likely have the unintended effect of increasing health insurance costs.

Public reporting and enforcement

Although MDH received only two written comments on the options for health plan community benefit reporting, both were supportive of periodic and uniform public reporting of health plan community benefit.

Public reporting could be accomplished through several alternative mechanisms. One would be to add community benefit reporting to existing public reports filed by health plans with regulators. Another would be for health plans to individually issue reports, and a third option would be for the Minnesota Council of Health Plans to issue an annual consolidated report for all of the nonprofit health plans.

One advantage of reporting through a state agency is that state agencies would have the enforcement authority to require reporting and to ensure that reporting is done consistently across health plans. However, because reporting requirements for nonprofit health plans currently vary depending on the type of organization,¹⁷ establishing these reporting requirements and definitions would likely be a fairly complex process requiring multiple state agencies to jointly develop forms and definitions for reporting by different types of nonprofit health plans.

Summary of recommendations:

- Minnesota should not require nonprofit health plans to provide a specified level of community benefit. Doing so would be inconsistent with the state's expectations of nonprofit hospitals (which, in contrast to nonprofit health plans, *are* required to provide at least some level of community benefit to retain their nonprofit status), and would likely have the unintended effect of increasing health insurance costs.
- It would be beneficial to establish standard definitions of what should be included in calculations of health plan community benefit. MDH recommends excluding taxes and assessments from the calculation.
- Public reporting of health plan community benefit using a set of standard definitions could be done either through the Minnesota Council of Health Plans or incorporated into existing annual public financial statements submitted to the Minnesota Department of Health and Minnesota Department of Commerce. There are advantages and disadvantages to either approach: the decision will need to weigh the advantages of the enforcement authority of state agencies against the administrative complexity of new requirements that will need to be coordinated across multiple agencies and types of nonprofit health plans.

¹⁷ In general, public financial statements for the health plans follow a format defined by the National Association of Insurance Commissioners (NAIC) that is uniform across all states. In Minnesota, HMOs file supplemental reports that are not required of other types of health plans.

Appendix 1

HMO Net Income by Product Type (Millions of dollars)

	State Public Programs										All Products	
	Commercial	MSHO & MnDHO	GAMC	PMAP	MNCare	Total State Programs	Medicare	Other				
2007												
Blue Plus	\$0.6	\$45.6	-\$8.1	-\$9.2	-\$6.5	\$21.7	\$0.8	\$4.6		\$27.8		
First Plan	\$0.8	-\$0.2	-\$1.8	\$0.1	-\$1.2	-\$3.0	n/a	n/a		-\$2.2		
Group Health	\$11.3	n/a	n/a	n/a	n/a	n/a	-\$5.7	-\$0.1		\$5.5		
HealthPartners	\$23.8	\$4.8	-\$4.7	\$0.6	-\$1.3	-\$0.6	\$12.9	-\$1.5		\$34.6		
Medica Health Plans	-\$11.6	\$15.6	-\$10.3	\$22.5	-\$5.5	\$22.3	\$21.0	\$0.4		\$32.0		
Metropolitan	n/a	-\$2.1	-\$0.3	-\$1.3	-\$1.0	-\$4.7	-\$1.8	n/a		-\$6.5		
PreferredOne	-\$2.1	n/a	n/a	n/a	n/a	n/a	n/a	n/a		-\$2.1		
Sanford Health Plan	\$0.2	n/a	n/a	n/a	n/a	n/a	\$0.0	n/a		\$0.2		
UCare Minnesota	n/a	\$14.6	-\$5.0	\$5.9	\$5.7	\$21.3	\$10.6	\$0.0		\$31.9		
Total	\$23.0	\$78.4	-\$30.2	\$18.7	-\$9.8	\$57.1	\$37.8	\$3.4		\$121.2		

MSHO is Minnesota Senior Health Options; MnDHO is Minnesota Disabled Health Options; GAMC is General Assistance Medicare Care; PMAP is Prepaid Medical Assistance Program; MNCare is MinnesotaCare.
 Medicare includes Medicare Cost, Medicare Advantage and Medicare Supplement plans.
 "Other" includes administrative fees and other sources of income.
 Source: MDH analysis of HMO financial reports.

Appendix 2:

Public Comments



COURT INTERNATIONAL BUILDING

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SUITE 255 SOUTH

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December 8, 2008

Nitika Moibi
Health Economics Program
MN Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

RE: Recommendations on Minnesota community benefit standards

Dear Ms. Moibi:

Thank you for the opportunity to provide input on community benefits standards.

Minnesota's unique nonprofit environment¹

Commitment to community is inherent in the business model of Minnesota's nonprofit health plans. Unlike for-profit health plans, the Boards of Directors for Minnesota's nonprofit plans are not charged with maximizing dividends for shareholders, but rather are focused on investing in the community. These boards are comprised of members who live in our neighborhoods – which ensure these individuals have a personal and vested interest in improving the health of our communities. And despite their nonprofit status, Minnesota plans contribute significantly to the state's tax base. In fact, last year Minnesota's nonprofit plans paid more than \$218 million in premium taxes alone, a 26 percent increase over the past four years.

Additionally Minnesota's health plans are known around the country for their leadership in bringing stakeholders together to leverage local knowledge. The Institute for Clinical Systems Improvement and MN Community Measurement are two high profile examples of this collaboration. This attention to shared community benefit is rare in other states.

The nonprofit environment in Minnesota is also visible in the smaller earnings margins (.70 percent over the last four years) compared to for-profit health plans. In nonprofit health plans, these margins are reinvested to benefit the long-term needs of the communities. In trying times such as these, the reserves ensure the plans maintain financial stability.

In addition, while national health plans spend less than 86 cents of the premium dollar on care², Minnesota's nonprofit plans lead the nation in keeping administrative costs low, spending nearly 91 cents of every dollar on health care.³

¹ See Minn. Chap. 62D.02, Subd. 4.

² Price Waterhouse Coopers report, Factors Fueling Rising Healthcare Costs, 2008.

³ Minnesota Department of Health.

Nonprofit health plan taxes continue to increase

Minnesota's health plans, although nonprofit, are not tax exempt. Health plans provide great community benefit through the hundreds of millions of dollars in taxes paid each year; yet our commitment to the community reaches far beyond taxes. Community benefits such as working to improve the health status of Minnesotans and partnering with the state to provide coverage to low income Minnesotans are woven into daily operations. This work is evident in the health plans' community benefit policies and we recommend that standards developed by the state reflect these robust policies.

In response to questions raised in Mr. Golden's letter:

What types of health plan activities should be considered community benefit?

Community benefits are defined broadly as program investments, activities or donations that support health improvement in the community. These activities align with the nonprofit plan's business model and strategic plan. Many of these efforts center on projects which improve access and affordability for at-risk or underserved populations or improve the health status or quality of life for the broader community through:

- Education
- Public health campaigns
- Community outreach
- Health screenings
- Public health policy advocacy
- Medical education
- Research and funding
- Employee volunteerism

What, if any, standards should be put in place for uniform reporting of community benefit?

Each plan should be expected to provide community benefit through its operations and unique programs that address specific needs of their members or geographic area. The community benefits should be identifiable, and part of the organization's plan. Minnesota's nonprofit health plans also often work in concert with community members and organizations on population health improvement, affordability initiatives and improving access.

What, if any, mechanisms should be in place to establish accountability for community benefit?

We propose that the Minnesota Council of Health Plans issue a report each year on behalf of the industry. To ensure access to timely and complete information, we recommend that the report to the community is issued after the required financial audits and reports are filed each April.

In closing, we offer the following recommendations that amplify the categories outlined in the legislation. The table below is a summary of health plan recommendations to meet these guidelines:

Legislative Guidance	MCHP Recommendations
Support public health	<ul style="list-style-type: none">• Provide or support community health promotion and related services.• Support community development/community building.
Improve the art and science of medical care	<ul style="list-style-type: none">• Participate in medical and health professions education such as student/intern/resident/nursing/clinical training opportunities, student scholarships• Contribute to research and community collaboration including Institute for Clinical Systems Improvement, MN Community Measurement, MN Credentialing Collaborative, Minnesota Health Information Exchange, E3: Streamlining Healthcare Transactions in Minnesota and more.
Provide financial assistance to access ongoing coverage	<ul style="list-style-type: none">• Support community based coverage initiatives such as financial support to safety net initiatives, community health centers, public program enrollment assistance or mental health centers.
Other community benefit activities and supports	<ul style="list-style-type: none">• Payment of taxes and assessments, promotion of employee volunteerism, community leadership and more.

Health plans are integral to Minnesota's strong future. Community needs across the state vary greatly and therefore the community is best served when health plans conduct needs assessments, consult with community partners, review public health goals and priorities and respond to emerging needs. This work can build on our established record of public/private partnerships and we look forward to working with you to draft the legislative recommendations.

Sincerely,



Julie Brunner
Executive Director

cc: Commissioner Sanne Magnan
Scott Leitz
Jim Golden
Stefan Gildemeister
MCHP Board of Directors



December 8, 2008

Nitika Moibi
Health Economics Program
Minnesota Department of Health
PO Box 64882
St. Paul, MN 55164-0882

RE: Comments on Community Benefit Standards for Nonprofit Health Plan Companies

Dear Ms. Moibi:

The primary obligation of any health plan company is to provide health services to its members as they have contracted to do. However, as nonprofits in Minnesota, health plan companies also play an important role in advancing public health and the art and science of medical and health care within the state. Therefore, providing community benefits is another function of health plan operation in Minnesota.

However, community benefits should not come at the detriment of providing affordable coverage for plan members. The market will determine the appropriate level of community benefit spending outside of coverage through competition to provide the best value. The state should not arbitrarily set a dollar threshold for community benefits provided by plans.

Creating a standard set of definitions for community benefits would allow for better comparison of the various entities. However, the state should not determine what activities a plan supports to advance public health and health care.

As you study community benefits standards for Minnesota nonprofits, please consider plans' primary obligations to provide affordable health coverage for their members.

Sincerely,

A handwritten signature in black ink, appearing to read 'Beth McMullen', with a long horizontal line extending to the right.

Beth McMullen
Health Policy Director
Minnesota Business Partnership

Appendix 3:

Study Charge from the Legislature

Language excerpted from 2008 Minnesota Laws, Chapter 358, Article 5, Section 4, Subdivision 3:

...Community Benefit Standards. Of this appropriation, \$84,000 is for the commissioner to make recommendations to the legislature on community benefit standards to be required of nonprofit health plan companies doing business in the state. The expectations of the community benefits provided and reported should be related to the statutory expectations in Minnesota Statutes, sections 62C.01 and 62D.01, and focus on supporting public health, improving the art and science of medical care, and addressing the need for financial assistance to access ongoing coverage, and not related to general philanthropic endeavors. The commissioner shall seek public input regarding the range of options to be explored and the accountability measures. The recommendations must include a procedure by which each nonprofit health plan company would periodically and uniformly report to the state and to the public regarding the company's compliance with the requirements. The commissioner shall recommend a fair and effective enforcement and remediation mechanism....