SMALL GROUP HEALTH INSURANCE MARKET WORKING GROUP

REPORT TO THE MINNESOTA HEALTH CARE ACCESS COMMISSION

In accordance with the Laws of 2010, Chapter 370

NOVEMBER 15, 2010

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I. INTRODUCTION:

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

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

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

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

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

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

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

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

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

Employer Representatives:

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

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

Employee Representatives:

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

Minnesota Department of Commerce:

- John Gross, Director, Health Care Policy

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

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

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

II. EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MAJOR FINDINGS

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

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

RECOMMENDATIONS

The Working Group was split on the following issue:

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

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

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

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

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

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

III. LEGISLATIVE BACKGROUND

A. Small Employer Definition

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

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

B. History of Minnesota Small Employer Health Insurance Laws

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

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

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

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

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

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

C. Flexible Benefit Plans

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

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

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

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

IV. STAKEHOLDER CONCERNS

A. Employers and Employees

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

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

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

B. Insurance Companies

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

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

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

C. Agents

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

V. ITEMS CONSIDERED

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Costs for Employers, Brokers and Health Plans

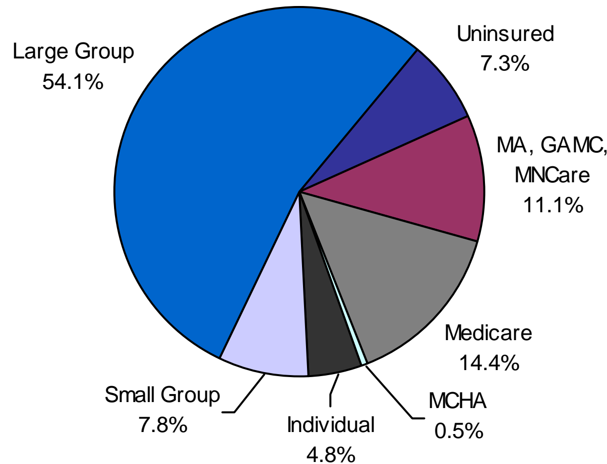
Trends in the Number of Private Establishments in Minnesota, by Firm Size[5]

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

Minnesota Small Group Health Insurance Market Statistics[6]

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

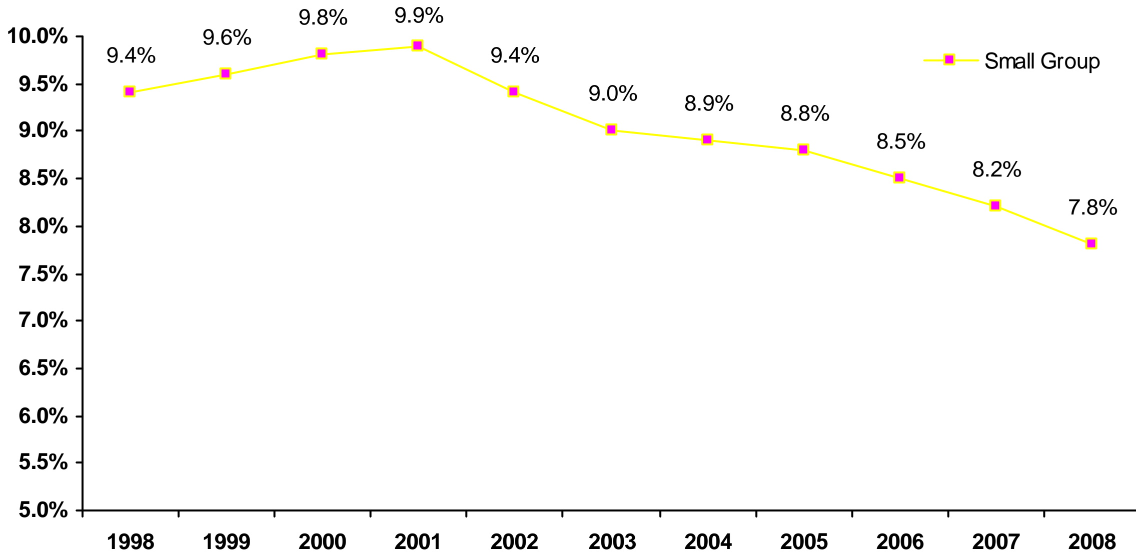
Distribution of Minnesota Population by Primary Source of Insurance Coverage, 2008



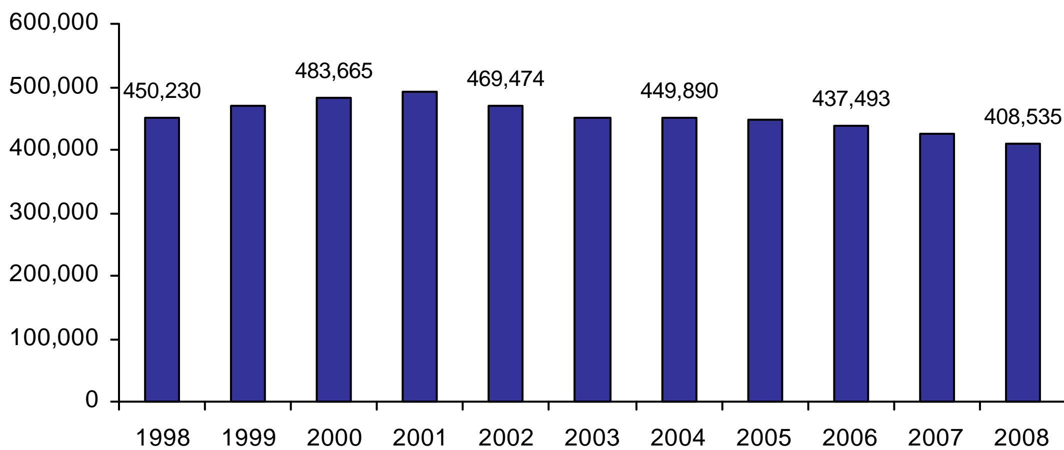
Source: MDH Health Economics Program; population estimates are from the U.S. Bureau of Census, July 2009
MA is Medical Assistance, MNCare is MinnesotaCare, GAMC is General Assistance Medical Care

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

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

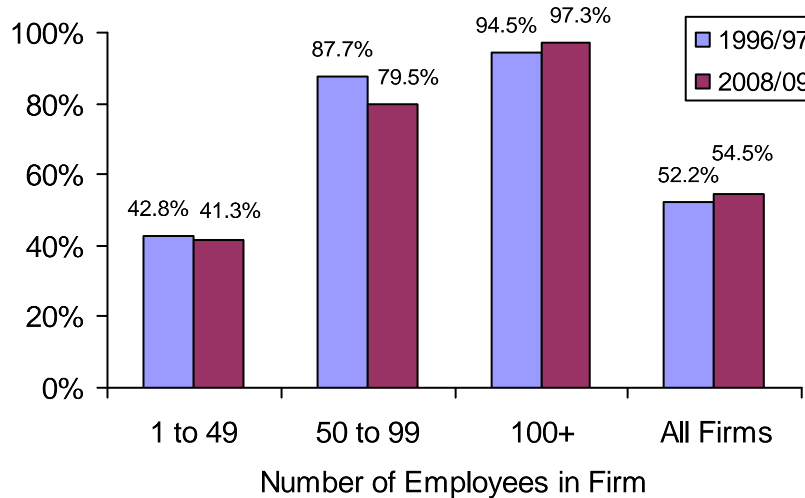


Trends in Minnesota Small Group Health Enrollment, 1998 to 2008: In 1998 there were 450,230 enrollees in the fully insured Small Group market compared to 408,535 in 2008. During this period of time, the number of small employers remained virtually the same at approximately 80,000 establishments in firms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



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

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



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

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

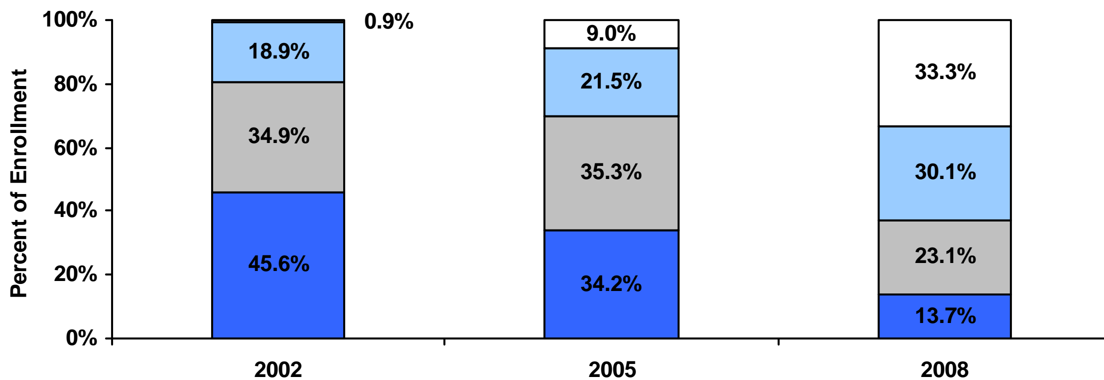
Average Health Insurance Premium/Single Coverage: During the time period from 1996/97 to 2008/09, the average annual health insurance premium in Minnesota for Single Coverage increased from $1,757 to $4,563 in firms of 1 to 49 employees; from $1,835 to $4,704 for firms with 50 to 99 employees and from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

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

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

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

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



Less than $1,000 | $1,000 to $1,999 | $2,000 to $3,999 | $4,000 or higher

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

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

Loss Ratio Experience[11]

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

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

Additional Change Brings Additional Cost

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Uniform Application Form

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

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

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

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

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

Exchanges.

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

Minnesota's Current Market – Universal Application

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

The Benefits of electronic universal application include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

G. Impacts of Federal Law

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

Recently initiated programs include:

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

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

The overview focused on:

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

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

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

enacted can be grandfathered. Grandfathered plans are exempt from most changes required by PPACA, but they can lose their grandfathered status if they make certain changes to their plan such as changing insurers, significantly cutting or reducing a benefit, significantly raising co-insurance, co-payment or deductibles, significantly lowering employer contribution, etc.;
- Administrative Simplification process including eligibility verification and claims status to be adopted by July 1, 2011 and effective by January 1, 2013;

Other important changes scheduled for 2014 include:

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

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

Definitions of Small Group under the ACA:

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

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

VI. APPENDIX A: Legislative Charge

CHAPTER 370--S.F.No. 1905

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 26. **Small employer.**

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

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

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

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

VII. APPENDIX C: Flexible Benefit Plans

62Q.188 FLEXIBLE BENEFITS PLANS.

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

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

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

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

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

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

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

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

History: 2010 c 384 s 24

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

ENDNOTES

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

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

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

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

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

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

[7] Reference to GAMC may be obsolete.

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

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

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

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

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