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Administrative Efficiency in the Regulation of Minnesota Health Plan Companies

Minnesota Department of Health
Report to the Minnesota Legislature

February 15, 2013

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Protecting, maintaining and improving the health of all Minnesotans

February 15, 2013

Dear Legislators:

The 2012 Legislature charged the Commissioner of Health, in consultation with the Commissioner of Commerce, to report to the Legislature by February 15, 2013 on recommendations to maximize administrative efficiency in the regulation of Minnesota health plan companies (Chapter 247, Article 2, Section 13). The report reviews the regulatory roles and responsibilities of both agencies with respect to health maintenance organizations, county-based purchasers, insurance carriers, and related entities within the frame of maintaining quality health outcomes, regulatory stability, and price stability.

The Department of Health and Department of Commerce jointly conclude Minnesota would be best served if future regulation of health plan companies promotes quality health outcomes for all Minnesotans, ensures health plan company accountability through the range of regulatory tools available, has one unified entry point for stakeholders, and provides consumers with a unified source of information.

A joint regulatory structure aligned along these traits will help clarify roles and responsibilities, achieve administrative efficiencies, capitalize on expertise in the two agencies built over time and ensure that the health of all Minnesotans is the best in the country.

Sincerely,

A handwritten signature in black ink that reads "Edward P. Ehlinger".

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

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Introduction

In Minnesota, the state-based regulation and oversight of health insurance and other health claims payers is split between two agencies. The Minnesota Department of Health (MDH) regulates health maintenance organizations (HMOs) and County-Based Purchasers (CBPs), while the Minnesota Department of Commerce (Commerce) has jurisdiction over Nonprofit Health Service Plan Corporations (e.g. Blue Cross) and insurers.¹

Chapter 247 of the 2012 Health and Human Services Omnibus Bill raised the question of whether this is the most effective approach for regulating health plan companies into the future. Specifically, Chapter 247 charged:

EVALUATION OF HEALTH AND COMMERCE REGULATORY RESPONSIBILITIES. *The commissioner of health, in consultation with the commissioner of commerce, shall report to the legislature by February 15, 2013, on recommendations to maximize administrative efficiency in the regulation of health maintenance organizations, county-based purchasers, insurance carriers, and related entities while maintaining quality health outcomes, regulatory stability, and price stability. (Emphasis supplied)*

In responding to this question, this MDH report addresses the following topics:

1. The history behind the dual regulatory structure.
2. The current environment and implications for regulatory oversight, including which entities are under the jurisdiction of which agency, and the current level of coordination between the two agencies.
3. The options considered for future state regulatory structures, as well as the costs and benefits of each option.
4. Our final recommendation and the supporting rationale.

¹ Defined in Mn. Chapter 60A.

After conducting this review, we conclude that Minnesota will be best served if the future regulation of health plan companies promotes quality health outcomes for all Minnesotans, ensures health plan company accountability through the range of regulatory tools available, fully leverages the expertise of both agencies, has one unified entry point for stakeholders, and provides consumers with a unified source of information.

To accomplish these objectives, we recommend assigning primary responsibility for particular regulatory topics to particular agencies. This division of labor should be aligned with the agencies' core competencies and mission; i.e. in assigning the regulatory tasks that relate to "health insurance," MDH should be assigned those tasks relating to "health" and Commerce should be assigned those tasks pertaining to "insurance."

History

The states have had primary responsibility for regulating insurance since insurance regulation began in the mid-nineteenth century.² This regulatory structure typically served several purposes:

- Ensuring rates are not excessive or unfairly discriminatory, but adequate to cover the projected risk;
- Protecting individuals and businesses from the consequences of insurer insolvencies;
- Ensuring that insurance companies and agents treat policyholders fairly; and
- Ensuring that consumers have access to essential insurance coverage.

² [Insurance Regulation, January 1986 \(86-01\)](#), Office of the Legislative Auditor

Insurance, as a model for paying for medical expenses, did not exist in any meaningful way until the introduction of hospital and medical expense policies in the early 20th century. Typically, those plans operated on an indemnity approach; i.e. the plan reimbursed enrollees for medical expenses.

An alternative to the indemnity model emerged with the creation of prepaid health plans. The most well known approach to prepayment for health care is the Health Maintenance Organization (HMO). HMOs offered consumers the option of paying a fixed fee for all medical care, including services not typically provided by indemnity plans such as preventative services. As a condition of this approach, members were to receive medical treatment from physicians and facilities within the HMO network.

Prior to the late 1960s to early 1970s, Minnesotans typically received coverage via indemnity policies. The movement to HMOs accelerated in the late 1960s and early 1970s due to a number of factors. First, consumers and businesses viewed HMOs as a viable model to control costs. Second, the federal government passed the HMO Act of 1973. This act had three main provisions:

- Grants and loans were provided to plan, start, or expand an HMO;
- Certain state-imposed restrictions on HMOs were removed if the HMOs were federally certified; and
- Employers with 25 or more employees were required to offer federally certified HMO options alongside indemnity plans upon request.

This last provision, called the dual-choice provision, arguably had the greatest impact on HMO membership, as it gave HMOs access to the employer-based market. Recognizing the expanded interest in HMOs, the Minnesota Legislature considered two HMO regulation bills in 1973. The primary difference between the bills was whether HMOs could be for profit or needed to be nonprofit. The Health Maintenance Act of 1973

selected the nonprofit (or governmental) entities option. The Act assigned MDH regulatory responsibility over HMOs. In the authorizing legislation, the Minnesota Legislature stated that its purpose was to:

- Eliminate barriers to the organization, promotion and expansion of HMOs;
- Provide for HMO regulation by the Commissioner of Health; and
- Exempt HMOs from the operation of the insurance and nonprofit health service plan corporation laws of the state.

HMOs were to be nonprofit or governmental entities. There would be no lifetime limitations, no deductibles and no limitation on the frequency or extent of services provided to any specific enrollee. HMOs were granted authority to provide care within a “closed” or limited network of providers. In return, HMOs were required to have a robust quality improvement program. They were also required to offer opportunities for enrollees to appeal decisions, and to provide documentation of those opportunities in policies shared with enrollees.

The requirement that an HMO have a robust internal quality assurance and improvement system remains in place today. An applicant for an HMO certificate of authority must include a description of the procedures and programs to be implemented to:

- Conduct ongoing evaluation of the quality of health care;
- Develop, compile, evaluate and report statistics relating to the quality, availability and accessibility of its services; and
- Monitor the quality of health care provided to its members.

Current Environment

Growth in HMO enrollment inspired both imitation and partnership. Traditional indemnity insurers began introducing managed-care products that typically provided financial incentives to policyholders to use specified providers.

One such product was the Preferred Provider Organization (PPO). PPOs typically cost more than HMOs but tended to have wider networks and made it easier to get out-of-network care. Another managed care alternative to HMOs was the Point-of-Service (POS) plans, which were a blend of HMO and PPO concepts. Like HMOs, enrollees chose a primary-care doctor from the plan's network, had low co-payments and no deductibles or co-insurance costs for in-network providers, and needed a referral to see in-network specialists. As with PPOs, POS enrollees could see out-of-network providers, though a referral was needed first and enrollees had to pay a deductible and a percentage of the cost. Many HMOs currently offer a POS option.

HMOs and indemnity insurance companies started becoming more operationally similar as HMOs became managed by or affiliated with for-profit entities. In addition, HMOs started setting up for-profit subsidiaries. Finally, Blue Cross/Blue Shield plans were allowed to reorganize as for-profit insurers or have for-profit subsidiaries. As a result, Minnesota health plans have become more operationally similar, but regulatory jurisdiction continued to be determined by license type.³

In addition to this convergence of marketplace models, other factors suggest a weakening justification for differing regulatory standards between indemnity carriers and HMOs. One important factor is the increasing degree of uniformity required by the Affordable Care Act (ACA).

The ACA sets forth a number of consumer protections that apply to all "health insurance issuers." Section 2791(b) (2) defines "health insurance issuer" to mean:

...an insurance company, insurance service, or insurance organization (including a health maintenance organization) . . . which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974).

³ For example, BCBS of Minnesota owns a number of for-profit subsidiaries (see <http://bit.ly/Yonef8>) as does Medica (see, <http://bit.ly/WYH4PS>).

With these new federal standards, the difference between health coverage regulated by MDH and Commerce is narrowing. The ACA requires that all issuers of individual and small-group coverage:

- Cover minimum essential benefits as defined by the U.S. Department of Health and Human Services;
- Ban lifetime and annual benefit limits;
- Issue standardized benefit and coverage disclosures; and
- Respond to data and quality reporting mandates.⁴

The creation of the Minnesota Insurance Marketplace (Health Insurance Exchange) further accelerates the need to review regulatory standards to ensure uniformity. To participate in an exchange, issuers (no matter what their license type) must meet requirements that apply to the entire marketplace (e.g. Essential Health Benefits and Actuarial Value) and some additional requirements specific to Exchange products (e.g. Network Adequacy, Enrollment Periods, and Quality Programs). Many of the Exchange-specific requirements are requirements that under Minnesota law already apply to the entire marketplace (e.g. Marketing Standards) or to a segment of the current marketplace (e.g. Network). The consensus among most observers and stakeholders is that the Marketplace should not be another regulator. Therefore, the task of certifying plans for sale in the Marketplace has been assigned to the existing regulators - MDH and Commerce. In addition, the National Association of Insurance Commissioners (NAIC) has warned that exchanges like the Marketplace are at risk from adverse selection.⁵ Consistent regulation inside and outside the Marketplace is necessary to minimize potential risk selection issues.

The last catalyst for reviewing and rethinking Minnesota's current regulatory structure is the current structure's impact on consumers and health plan companies. Application of

⁴ For more information on the consumer protections contained in the ACA, please go to <http://www.healthcare.gov/law/>.

⁵ <http://www.naic.org/store/free/ASE-OP.pdf>

the same regulatory standard in two agencies may result in inconsistent application, potentially resulting in different products offered to consumers. Health plan companies may incur costs associated with duplicative administrative costs if the same submission is required by two agencies. Competition may also be uneven. If one agency has fewer or more lenient standards, the result could be an unfair advantage for companies subject to the less rigorous approach.

The ACA changes potentially impact a number of legal structures under Minnesota law. These include:

1. **Health Maintenance Organizations:** MDH licenses and regulates health maintenance organizations pursuant to Minn. Stat. chapter 62D and Minn. Rules chapter 4685. An HMO is a nonprofit corporation organized under chapter 317A, or a local governmental unit, which provides comprehensive health maintenance services to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee. Minnesota has nine HMOs.
2. **County-Based Purchasers:** A CBP is a county board or group of county boards that purchase or provide health care services on behalf of persons eligible for medical assistance and whom would otherwise be required to or may elect to participate in the prepaid medical assistance program under 256B.69. While CBPs are not “licensed” by MDH, they are held to the same statutory and rule standards governing HMOs or CISNs under 256B.692. Three CBPs operate in Minnesota.
3. **Nonprofit health service plan corporations:** Commerce licenses and regulates nonprofit health service plan corporations (NHSPCs) licensed under Chapter 62C to offer, sell or issue medical and dental insurance. A service plan corporation is a foreign or domestic nonprofit corporation that contracts for health service or payment for subscribers pursuant to a service plan, in exchange for periodic prepayments by or on behalf of subscribers. There are

two service plan corporations operating in Minnesota: BlueCross and Blue Shield, and Delta Dental.

4. **Insurance Companies:** Commerce also licenses and regulates insurance companies licensed under Chapter 60A to offer, sell or issue all types of insurance, such as auto, homeowners, liability, commercial, life, annuity, disability, long-term care, medical, and dental. The insurance entities that may provide medical and dental insurance include life insurance companies, fraternal benefit associations, and property and casualty insurance companies. There are 46 insurance companies and NHSPCs with in-force medical coverage in Minnesota.
5. **Health Care Network Cooperatives.** MDH and Commerce have authority to license and regulate health care network cooperatives established under chapter 62R, and MDH can license accountable provider networks under chapter 62T. A health care network cooperative can be licensed as an HMO under 62D, a nonprofit health service plan corporation under 62C, or a community integrated service network licensed under chapter 62N. No cooperatives have been licensed by either agency.
6. **Accountable Provider Networks.** An accountable provider network (ACN) is a group of health care providers organized to market health care services on a risk-sharing or non-risk-sharing basis with a health care purchasing alliance. An ACN shall operate as a not-for-profit entity or as a health care cooperative as allowed under 62R.

The purpose of government regulation is to protect the public by enforcing minimum standards for a regulated field. The standards for each regulated field are specific to the services provided, and are defined in state laws and administrative rules. Government regulation includes several basic components such as:

- Setting minimum standards;
- Enforcing laws;
- Conducting audits;
- Investigating complaints;

- Taking enforcement actions and monitoring conduct for compliance;
- Communicating to regulated parties and consumers; and
- Providing due-process rights concerning action taken by the regulatory agency.

Even before the ACA, Minnesota law had a degree of common regulatory standards. For example:

- All entity types had to meet financial solvency requirements;
- Licensed entities had to meet claims payment standards (typically around promptness of payment);
- Prior to doing business in Minnesota, entities had to meet licensing standards (usually involving review of finances, management and business practices);
- Entities were usually subject to market conduct requirements (claims and underwriting practices, advertising, marketing and rescissions of coverage);
- Consumers typically had the ability to appeal decisions of the entities;
- The products offered by these entities typically had to meet state-mandated benefit requirements; and
- The prices for the products offered by these entities were typically subject to rate review by their regulator.

Similarly, both MDH and Commerce have regulatory tools they use in carrying out their regulatory responsibilities. The list of tools includes:

- License review, issuance and revocation;
- Investigation and enforcement (consumer complaints, examinations, fines and penalties, etc.);
- Financial oversight;
- Policy form review;
- Rate review;
- Data collection and dissemination to the public, legislature and stakeholders; and
- Review of the efficacy of the medical care provided.

With the various factors supporting uniformity (e.g. convergence in business models, the ACA, the common existing standards), it appears to be an opportune time to ask whether the existing regulatory structure is appropriate for this new market and if not, what alternatives may better serve all stakeholders. Framing the question more specifically, we might ask what structure best serves the goals of ensuring the health of Minnesotans, protecting their rights as consumers, minimizing adverse selection to the Marketplace and reducing the administrative burden on health plan companies.

Interagency Collaboration

Even before this report, the agencies recognized the importance of working collaboratively and jointly. Section 62D.14 directs the Commissioner of Health to conduct examinations of HMOs as often as deemed necessary for the protection of the interests of Minnesotans, and at minimum every three years. MDH is required to conduct periodic financial and quality examinations of HMOs and CBPs. Prior to 2000, MDH carried out both financial and quality examinations for all of these entities.

Recognizing that Commerce had expertise in financial and solvency matters, MDH entered into an interagency agreement with Commerce in 2000 to perform financial exams for HMOs and CBPs and rate review of HMOs. Recognizing that MDH had expertise in health matters, that agreement also directs MDH to provide consultative services to Commerce in a number of areas such as utilization review.

MDH continues to conduct the quality examinations of HMOs and CBPs. In addition, MDH (pursuant to an interagency agreement with the Minnesota Department of Human Services) conducts quality assurance reviews for the public health care programs administered by HMOs and CBPs. In performing this work for DHS, MDH consults with DHS staff on the selection of annual HMO and CBP performance measures. MDH also reviews and approves HMO and CBP legal documents, and evaluates CBP applicants for compliance with state and federal law and rules.

In summary, the agencies have a history of working together in some areas. The question for this report is whether that collective activity should be expanded or modified to reflect current and future needs.

Discussion

The Minnesota Legislature charged MDH with offering recommendations on how best to achieve administrative efficiency while ensuring quality health outcomes, and regulatory and price stability. In consultation with Commerce, MDH identified three possible regulatory structures:

Option 1: The Status Quo

The first option is to maintain the current system, in which MDH regulates HMOs/CISNs/APNs/CBPs/cooperatives and Commerce regulates insurers and NHSPCs. From the perspective of the agencies, the current structure has resulted in a high level of compliance with applicable law in most instances. Violations and deficiencies have been identified, reported and addressed, with the agencies continuing to monitor the corrective actions. Where administrative efficiencies have been identified (such as leveraging the financial expertise of Commerce or the health expertise of MDH), duties have been transferred via interagency agreement.

Notwithstanding that observation, critics have argued that such a bifurcated regulatory structure could lead to inconsistent interpretation of differing standards, duplication of regulatory resources, and possible confusion from stakeholders about which agency was the responsible regulator for a particular area. In addition, the status quo approach ignores the larger environment of market convergence, changes in the legal environment, impact on the Marketplace and potential value for consumers and health plan companies. For those reasons, we do not recommend maintenance of the status quo.

Option 2: One Agency

A second option would be to move all health plan issuer regulation to a single agency - MDH, Commerce, or some new entity.⁶ Such an option arguably maximizes efficiency and uniformity. Stakeholders would clearly know which entity was responsible for creating, interpreting and enforcing the rules and regulations applicable to health plan issuers. In addition, there may be some theoretical cost savings as consolidation of staff in a single agency may allow for eliminating duplicate staff. Further cost savings may accrue as transferred staff may be able to specialize in particular issues and handle variations in workflow.

Considerations in favor of moving all regulatory duties to MDH would include:

- MDH experience with “health” matters such as clinical efficacy, access to care, quality monitoring, oversight of integrated systems, access to market-wide data, provider contracts, managed care and integrated delivery systems;
- MDH membership in the Association of State and Territorial Health Officials and the resulting access and input on matters pertaining to health;⁷
- Aligning regulation of the health insurance industry with the many health system reforms taking place at the federal and state level; and
- Being embedded in the agency whose core mission is “protecting, maintaining and improving the health of all Minnesotans.”

Considerations in favor of moving all regulatory duties to Commerce would include:

- Commerce experience on matters such as solvency and rate review;
- ACA-specific expertise on matters such as premium rate review, medical loss ratio, and actuarial value;

⁶ See, e.g. the Rhode Island Health Insurance Commissioner; Rhode Island Chapter 42.14.5

⁷ From the ASHTO Mission Statement: ASHTO is the national non-profit organization representing the public health agencies of the United States, the U.S. Territories, and the District of Columbia, as well as the 120,000 public health professionals these agencies employ. ASHTO members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and to assuring excellence in state-based public health practice. Mission: To transform public health within state and territories to help members dramatically improve health and wellness.

- Commerce membership in the National Association of Insurance Commissioners and the resulting access and input on matters pertaining to insurance;⁸ and
- The ability to integrate health carrier regulation within a broader framework (e.g. if that carrier is a subsidiary in a multi-line carrier, Commerce would have authority over the parent organization).

The disadvantages of consolidating all regulatory duties into one agency include:

- Centralization of these particular duties creates new challenges for integration into larger policy initiatives. For example, if Commerce took over all oversight, there is a potential loss of connectivity between private-market oversight and the larger health market landscape, including the connection of private health plan oversight to broader health reform initiatives. Similarly, if MDH took over all oversight of these health plan issuers, there is a chance that financial oversight may be fragmented - especially if an issuer is part of a larger multi-line insurance organization.
- Consolidation may present additional costs. For example, if all duties were consolidated at MDH, it would need to develop resources around financial management and actuarial functions that Commerce would still need to have since it still would be doing that work for other types of insurance carriers. Conversely, moving all duties to Commerce would require Commerce to develop expertise around medical necessity, clinical efficacy, and quality-of-care assessment - all of which would still need to be maintained at MDH for duties not pertaining to health plan issuer regulation.

⁸ The mission of the NAIC is to assist state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost effective manner, consistent with the wishes of its member: Protect the public interest; Promote competitive markets; Facilitate the fair and equitable treatment of insurance consumers; Promote the reliability, solvency and financial solidity of insurance institutions; and Support and improve state regulation of insurance.

We briefly considered delegation of these duties to a new entity, but concluded that option has the disadvantage of additional cost, potential duplication of state resources and loss of connectivity to the broader missions at the current agencies. For the above, reasons, we concluded that consolidation in one agency was not the best alternative.

Option 3: Clear Accountability by Topic

The last approach we considered was to assign regulatory responsibility for all health plan companies by core expertise and alignment with the agency's mission. For example, if a topic related to health matters, MDH would be the responsible and accountable agency with Commerce as a consultative partner. Conversely, if the topic pertained to insurance, Commerce would be lead with MDH as the consultative partner. Where a topic or regulatory function did not clearly fall into the health or insurance categories, responsibilities would continue to be joint (for example, we concluded both agencies need enforcement power, as a regulator without enforcement power is not a regulator).

In implementing this shared responsibility model, we would create a common entry point for consumers, health plans and other stakeholders. From the consumer's perspective the interaction would be seamless and clear. Behind the scenes, inquiries or issues would be routed to the appropriate agency. In our view, this approach best addresses the legislative direction to ensure movement toward a more efficient regulatory structure that maintains quality health outcomes. By including a common entry point that moves questions to the agency with the relevant skills and mission, we create a regulatory structure that:

- Is unified from the user's standpoint;
- Benefits from the financial and insurance expertise of Commerce; and
- Benefits from expertise in health quality, assessment and improvement found at MDH.

We also believe this approach results in regulatory efficiency, since the agencies can focus on enhancing core skills and talents rather than directing resources to tasks that fall outside the scope of their day-to-day activities and mission.

To ensure that this new regulatory structure is implemented in a way that ensures regulatory stability and price stability, we recommend legislative language be drafted to realign duties and responsibilities consistent with the guiding principles: matters pertaining to health go to MDH and matters pertaining to insurance go to Commerce.

An alternative approach would be a bill directing Commerce and MDH to enter into interagency agreements to accomplish regulatory alignment (with a target date of completion by December 1, 2013). MDH and Commerce could also be directed to work on a technical “cleanup” bill to ensure that all statutory provisions in a particular topic are assigned to the correct agency, and that any redundant or unnecessary statutory provisions are eliminated. That cleanup bill would be presented to the Legislature by January 15, 2014.

To ensure price stability, we recommend the new regulatory structure be designed to be cost-neutral to the industry (thereby eliminating impact from this regulatory redesign on consumers). MDH and Commerce should be directed to review all current sources of funding (e.g. carrier license fees and filing charges) to see what modifications, changes or revisions are needed to ensure cost-neutrality to insurers. We would also include recommendations on new funding mechanism in the 2014 “cleanup” bill.

Lastly, both agencies should be directed to continue to review the statutes and regulations under their purview. Such work should be conducted with the objectives of ensuring the highest level of consumer protection, improving and maintaining the health of all Minnesotans, and achieving further regulatory efficiencies.

The following exhibit outlines where MDH and Commerce agreed accountability and responsibility should lie.

Draft Roles and Responsibilities for State Agencies Regulating Risk Bearing Entities in the Health Insurance Market RACI Chart¹

Activity	Responsible	Accountable	Consulted	Informed
ADMINISTRATIVE				
Issue licenses to risk bearing entities/certification by license type	Commerce	Commerce	Health	Stakeholders
Revoke licenses (prior to revocation, Commerce will consult with Health)	Commerce	Commerce	Health	Stakeholders
Levy fines (by topic/violation)	Commerce/Health	Commerce/Health	Commerce/Health	Stakeholders
REVIEW QUALIFICATIONS OF RISK BEARING ENTITIES				
Rate setting	Commerce	Commerce	Health/HIX	Stakeholders
Financial solvency	Commerce	Commerce	Health/HIX	Stakeholders
Form review (benefit set, EHB certification/approvals)	Commerce	Commerce	Health/HIX	Stakeholders
Mandated additional coverage (Health for medical efficacy, Commerce for cost)*	Health/Commerce	Health/Commerce	MMB/HIX	Stakeholders
Network adequacy	Health	Health	Commerce/HIX	Stakeholders
Quality assurance requirements	Health	Health	Commerce/HIX	Stakeholders
Actuarial value	Commerce	Commerce	Health/HIX	Stakeholders
Enrollment periods	Commerce	Commerce	Health/HIX	Stakeholders
Claims payment practices and appeals	Commerce	Commerce	Health/HIX	Stakeholders
Accreditation	Health	Health	Commerce/HIX	Stakeholders
Utilization management and utilization management appeals	Health/Commerce	Health/Commerce	MMB/HIX	Stakeholders
COMPLAINT INVESTIGATION AND RECOMMENDATION FOR ACTION **				
Complaints – producer actions (i.e. – agent/brokers)	Commerce	Commerce	Health/HIX	Stakeholders
Complaints – provider actions (i.e. – practitioners/hospitals, quality)	Health	Health	Commerce/HIX	Stakeholders
Complaints - medical necessity	Health	Health	Commerce/HIX	Stakeholders
Complaints - claims payment practices (i.e. – timeliness, accuracy)	Commerce	Commerce	Health/HIX	Stakeholders

*Structure to ensure information sharing between agencies will be developed over the next year.

** Shared intake for all complaints with routing to subject matter experts will be seamless to caller. Regular review by both agencies of trends and summary of conclusions will occur.

¹ A RACI Chart is used to clarify roles and responsibilities in an organization. It is a table that provides a list of activities and information about roles different people have in relation to those activities. For each activity, different people are designated a letter in the acronym "RACI". This acronym stands for (i) **R**esponsible, or the person doing the work; (ii) **A**ccountable, or the person responsible for making sure the work is done adequately; (iii) **C**onsulted, or the person(s) who is asked for their input; and (iv) **I**nformed, or the person(s) who must be told about the work.

Conclusion

Minnesota's dual health insurance regulatory structure emerged as the product of a number of policy and marketplace dynamics over the past few decades. Oversight of health coverage is divided between the Minnesota Department of Health (MDH) and the Minnesota Department of Commerce (Commerce). Both agencies have their own statutory provisions, administrative structures and culture, and legal frameworks. While both agencies are focused on serving the needs of Minnesotans, they have different missions and approaches to achieving that common goal.

This dual regulatory structure potentially results in consumer confusion, insurance carrier administrative burdens, and difficulty in monitoring what is being bought and sold in the insurance marketplace. In addition, there is no longer validity to one of the underlying assumptions supporting the need for different regulatory regimens - that is, that HMOs and insurers are distinct enough that they should be regulated differently. HMOs and insurers sell similar products and in many cases are parts of the same corporate family. Furthermore, the federal Affordable Care Act (ACA) enacts sweeping changes to the way health care services are purchased, delivered, and regulated. With all of those dynamics in play, it is prudent to take a fresh look at the way Minnesota regulates health coverage. Based on that analysis, MDH recommends a regulatory structure with four key traits.

These include:

- A common “front-end” for users;
- The designation of a particular agency as the lead regulator for particular topics;
- Shared regulatory duties in areas of joint capability; and
- A formal methodology to guide the collaboration of the agencies.

A joint regulatory structure with these traits will help clarify roles and responsibilities, achieve administrative efficiencies, capitalize on expertise in the two agencies built over time, and ensure that the health of all Minnesotans is the best in the country.