

Who was minding the store?



A report on Minnesota's problem with contracting out the state public health care programs to HMOs:

***Lack of accountability and transparency;
misuse and waste of state and federal taxpayer
funding, from the 1990s until 2011***

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August, 2012

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Executive Summary

The state of Minnesota is learning about, and struggling to come to terms with, a large issue involving its low income public health care programs: Medical Assistance, MinnesotaCare and others. The problem is the nature of the contracting that the state has conducted, over the past two decades, in which it gave prepayments to Health Maintenance Organizations (HMOs). Under these contracts, the HMOs were prepaid a set amount, and allowed to keep whatever they didn't spend on the enrollees' health care needs. In all, the state has overpaid these HMOs several hundred million dollars and perhaps much more. A large portion of that originated as federal Medicaid dollars. The federal government is conducting multiple investigations at present. Obviously, this issue needs to and will be resolved.

The Dayton administration has begun addressing and correcting the overpayment problem that it inherited from the prior administration, and this is a promising development. However, the past history is still very important to scrutinize for two reasons:

- First, the potential for **recouping the overpayments could bring at least a few hundred million badly-needed dollars back into the state treasury**, with a similar share to the federal government; and
- Second, to the degree that the past overpayments hinged on inaccurate and deceptive financial reporting by the HMOs, and possibly fraudulent practices, **it is imperative to correct those practices and eliminate any inaccurate or deceptive reporting, as well as excessive profit, as we move forward, especially in light of the large expansion of Medicaid scheduled for 2014.**

Greater Minnesota Health Care Coalition (GMHCC), a grass roots consumer advocacy non-profit organization, has conducted extensive original research and analysis -- which should have been done all along by state agencies, but wasn't. GMHCC identified and calculated excess profits and reserves wasted in these programs, and questionable practices by the HMOs in regard to their financial management and reporting.

GMHCC shared its findings with officials in the administration, the legislature, the state Attorney General, and federal authorities. Our actions have played a significant role in bringing this issue to light, with increasing momentum, over the past five years.

In this position paper we also describe GMHCC's conclusions regarding policy implications which we draw from the story of how the contracted-out public programs has played out.

At the end of this paper there is background information about GMHCC, including contact information. We invite anyone to ask about details of our source material and computations, which are not included here for brevity's sake.

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By: Greater Minnesota Health Care Coalition, 47 Park St. N., Mora, MN 55051

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1. Overview of the HMO accountability and transparency issue

Over the past year and a half, increasingly intense public attention has been brought to bear on Minnesota's practice of contracting out its low income public health care programs to private HMOs (Health Maintenance Organizations), also known as health plans. There are currently four that the state contracts with: Medica, Blue Plus (a division of Blue Cross/Blue Shield of MN), HealthPartners, and UCare. The programs, which are Medical Assistance, MinnesotaCare, MN Senior Health Options, and a few others, each vary in some mixture of federal and state funds. The total payments for these programs amount to over 4 billion dollars a year. It is one of the largest expenditure items in the state budget.

The original rationale for contracting out these programs to private HMOs, instead of having the state Dept. of Human Services (DHS) continue to pay medical providers directly as it had been doing, was the theory that foremost, the new method would save the state money, and also improve access to care. This key theory behind the privatizing "demonstration project," however, was never evaluated to see if it was true. No determination was ever made if this system saves the state money. Two decades later, it is still officially described in state statutes as an experimental "demonstration project."

Actions of the Dayton Administration have shown that the HMOs were, overall, getting paid in the past much more than they needed to by the state. Legislators from both parties have repeatedly cited the need for full information on exactly how the HMOs spend the money that the state gives to them, and the need for better audits. Several issues and questions have come to light:

1. *How much have the HMOs been overpaid over the years by the state, and why did that happen?*
2. *Was the federal government misled or defrauded in any way about the payments to the HMOs?*
3. *Have the financial numbers that have been reported, particularly regarding expenses and profits, accurate and truthful? Have all reports, and rate certifications, been done according to the rules?*
4. *Are the current levels of the HMOs' reserves excessive or not? How would that be determined?*
5. *Are the HMOs' expenditures free of conflicts of interest, and are they fulfilling the public purpose non-profit mission proscribed for them in state statute?*
6. *Should and can the state and federal governments recover past overpayments?*

2. What GMHCC found

A. Excessive profits from Minnesota's low income public programs

GMHCC's original research, examining the financial reports submitted by the private HMOs to the MN Dept. of Health (MDH) from 1995 forward, has revealed two facts regarding profits (technically known as "contribution to reserves" or "contribution to surplus") from the state's public programs:

(1) **A very high amount of profit was accumulated from 1995 through 2011, exceeding \$824 million.** This includes investment income from the reserves from the programs, and it includes the most profitable program of all, MN Senior Health Options (MSHO), which is a mixture of Medicare Advantage and Medical Assistance funding. [See chart on page 5]

(2) In addition, these profits greatly exceeded the target levels of contributions to reserves, on the order of hundreds of millions of dollars. As part of its payments to the HMOs, DHS set "targets" of



contributions to reserves for Medical Assistance and MinnesotaCare, ranging from 0% to 1.0% (not including investment income). However, the actual contributions, including investment income from the reserves for the programs, actually averaged over 3% per year – over three times what DHS had deemed to be an appropriate level. **DHS’ contracts with the HMOs, prior to 2011, never included any provision for return of excesses earned above the targets.** Of the \$838 million in total public program profits, it is likely that over \$500 million represents an amount above the profit percentage that DHS itself had cited as a reasonable and appropriate rate. Potentially, the federal government might deem the profits which are above and beyond the target profits as exceeding the actuarially sound certified Medicaid rates, and subject to be refunded.

The MN Council of Health Plans has told the Legislature that the HMOs’ profits from the state programs is much lower – 1.6% from 2005 to 2011-- and that they actually lost money overall in 2006. However, this is not true. The Council deliberately misrepresented the facts, by excluding from its calculation the very profitable MSHO program, and also excluding the investment income from the program reserves. DHS under the previous Administration painted the same misleading picture, on the exact same basis, in its Feb., 2009 report to the Legislature.

B. Excessive financial reserves

As of the end of 2011, the accumulated financial reserves of the four private HMOs with the public program contracts (Blue Plus, HealthPartners, Medica, and UCare) amounted to a combined total of \$1.7 billion. (This does not include the reserves of each HMOs’ affiliated companies, including Blue Cross/Blue Shield of Minnesota.) There is a required minimum level of reserves to protect from insolvency, known as the Risk Based Capital (RBC) standard. Twice this amount, or 200% of RBC, is viewed as the basic level of safety. Amounts below this level trigger regulatory action. The actual RBC levels of the four private HMOs at the end of 2011 were: Blue Plus – 924%; HealthPartners – 560%; Medica – 740%; and UCare – 524%. [See chart on page 6]

There is no established consensus on what is a reasonable upper limit (expressed as a percentage of RBC) of insurance reserves, above which should be considered an excessive or unnecessary amount. In the case of for-profit insurance companies, the question is hardly ever posed. In the case of non-profit insurance companies, however, the question of an upper limit is very justified. In Minnesota, non-profit HMOs have a public purpose mission, to provide care in a more economical way than if they were for-profit, and with better access. Expenses and reserves are supposed to be “reasonable.” Excess net revenues, which accumulate as excess reserves, violate this principle. Minnesota used to have a very crude upper limit on reserves, but it was quietly removed in 2004 at the same time that the RBC standard was instituted to construct a carefully computed minimum necessary level of reserves.

The Greater MN Health Care Coalition (GMHCC) asserts that a reasonable and safe upper limit for the HMOs’ reserves should be 400% of RBC. This is four times the bare minimum needed for solvency, and twice the amount that triggers regulatory engagement. Using that standard, the dollars amounts above 400% of RBC at the end of 2011, which GMHCC considers to be excessive and unnecessary, are for each of the HMOs: Blue Plus - \$206.6 million; HealthPartners - \$176.6 million; Medica - \$191.3 million; and UCare - \$76.3 million. **The total of these excess amounts is \$650.9 million.**

It must be noted that the bulk of these reserves resulted from the HMOs’ profits on the state’s public programs. Coincidentally, the excess reserves also very roughly approximate the “excess profit” which the HMOs took above the profit rate determined by DHS to be reasonable.

In addition, the way that DHS historically has set its payment rates to the HMOs shows that it was the state, not the HMOs, that was actually shouldering the financial risk. Because of that, GMHCC believes that there was little or no need for the state to help the HMOs build up reserves at all.

The HMOs have testified to the legislature of their perceived need to hold huge reserves to cover

Greater Minnesota Health Care Coalition (GMHCC) Revisions to the MN Council of Health Plans' graph of net revenue (profits) from Minnesota's public health care programs. All GMHCC information is in boxes.

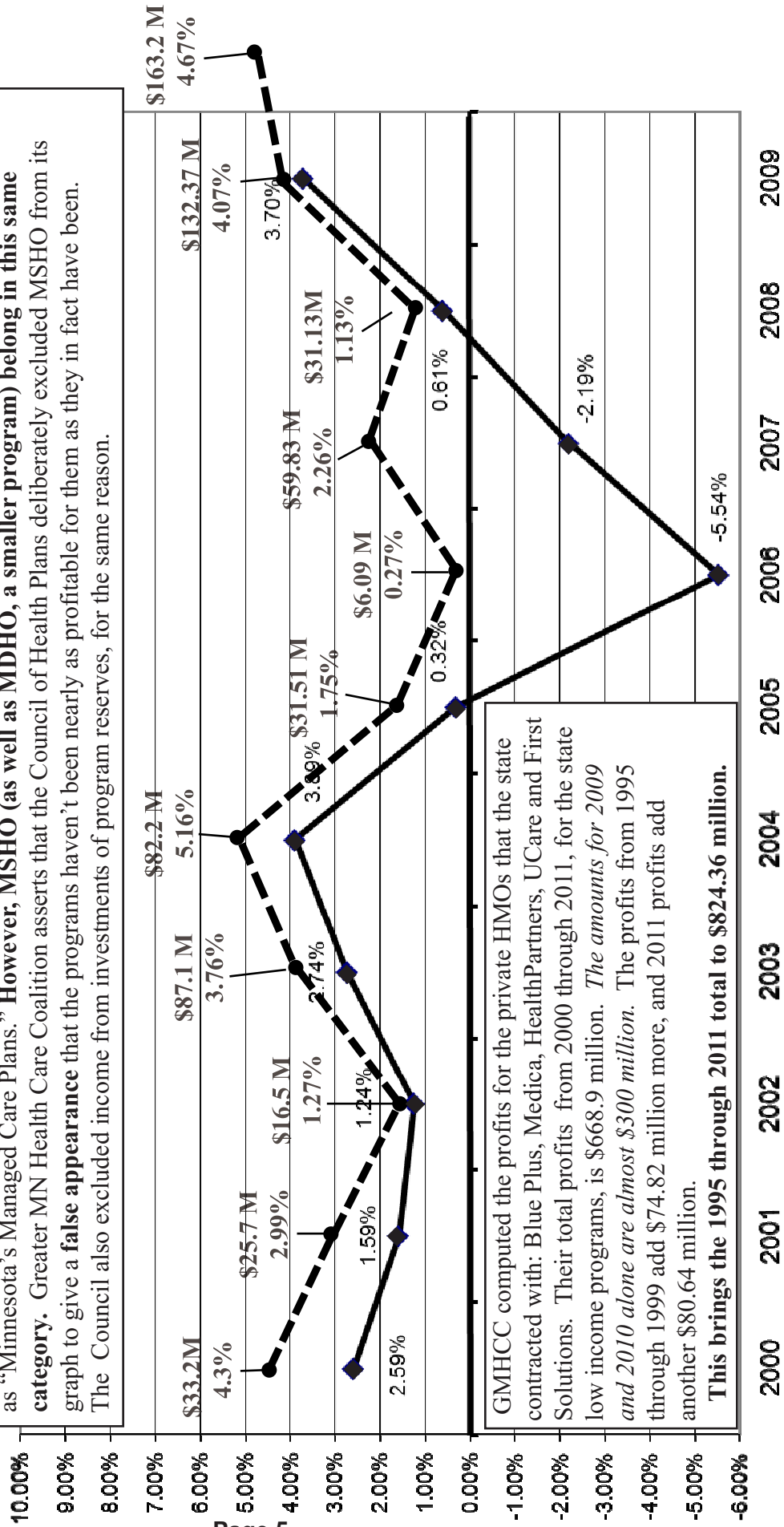
The key difference as to why the GMHCC dotted graph line show no losses at all, and much higher profits than the HMOs claim, is because GMHCC is including the very large and lucrative program that the Council's graph excludes: MN Senior Health Options.

Net Operating Gain/Loss on GAMC, MNCare and PMAP for Minnesota's Managed Care Plans 2000-2009

10-year Average Operating Gain/Loss as a % of Revenue = 0.91%

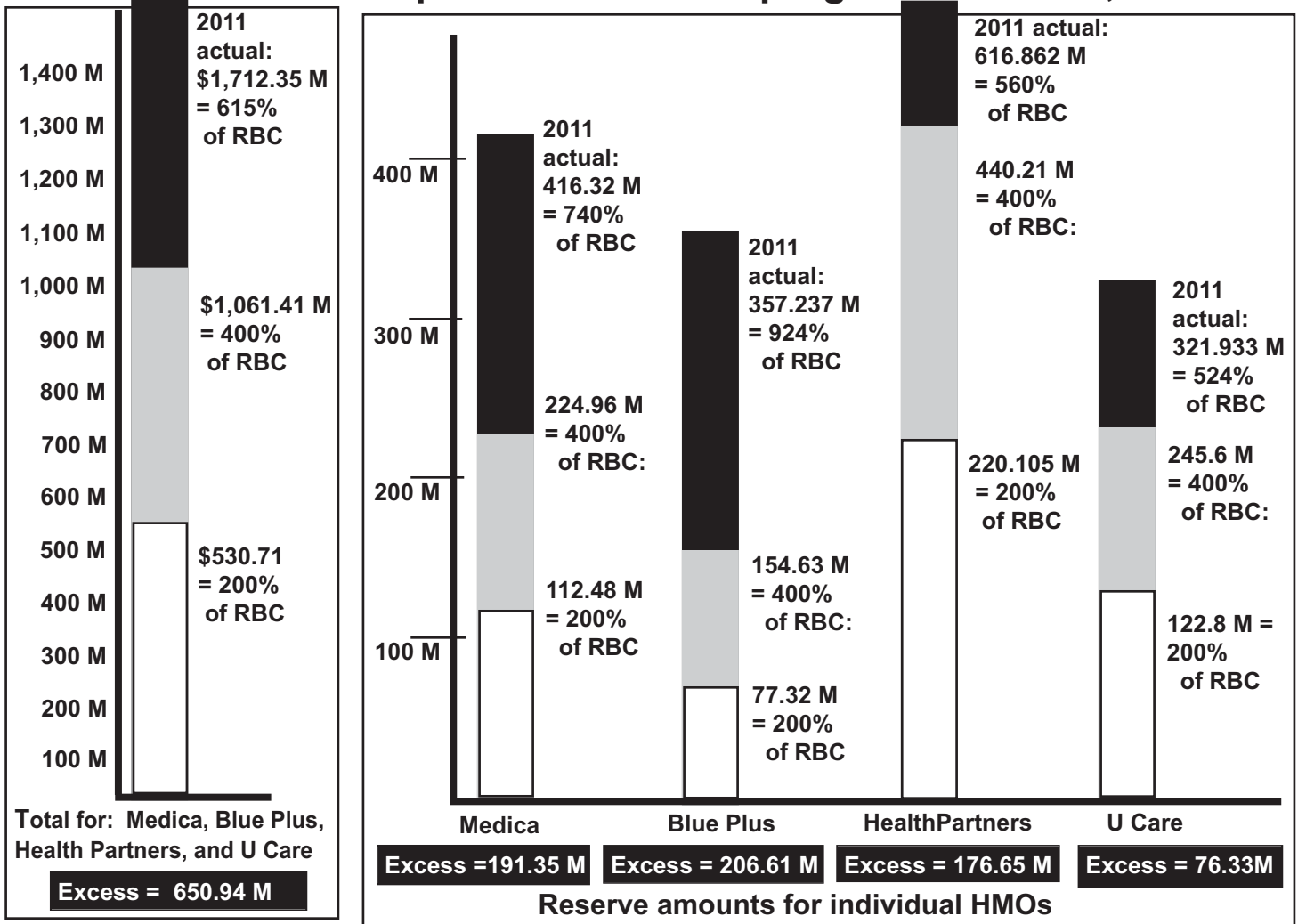
GAMC = General Assistance Medical Care
 PMAP = Prepaid Medical Assistance Program
 MSHO = Minn. Senior Health Options
 MDHO = Minn. Disability Health Options

Note that the original chart, with the solid graph line, from the Council of Health Plans only lists GAMC, MNCare and PMAP as "Minnesota's Managed Care Plans." However, MSHO (as well as MDHO, a smaller program) belong in this same category. Greater MN Health Care Coalition asserts that the Council of Health Plans deliberately excluded MSHO from its graph to give a false appearance that the programs haven't been nearly as profitable for them as they in fact have been. The Council also excluded income from investments of program reserves, for the same reason.



GMHCC computed the profits for the private HMOs that the state contracted with: Blue Plus, Medica, HealthPartners, UCare and First Solutions. Their total profits from 2000 through 2011, for the state low income programs, is \$668.9 million. The amounts for 2009 and 2010 alone are almost \$300 million. The profits from 1995 through 1999 add \$74.82 million more, and 2011 profits add another \$80.64 million. This brings the 1995 through 2011 total to \$824.36 million.

Excess Financial Reserves of Private HMOs with Minnesota public health care program contracts, 12/31/2011



- Actual reserves on Dec. 31, 2011 which are in excess of 400% of RBC
 - 400% of Risk Based Capital, a reasonable upper limit. ¹
 - 200% of Risk Based Capital (RBC), the NAIC level which triggers regulatory intervention. ²
- NAIC = Nat'l Assoc. of Insurance Commissioners

All figures, in millions of dollars, are calculated from National Assoc. of Insurance Commissioner Annual Statements for 2011. The UCare amount is after their giving \$30 million given back to the state in 2011.

Medica, Blue Plus, Health Partners, and U Care are four key Health Maintenance Organizations (HMOs) that Minnesota contracts with to run the state programs: Medical Assistance, MinnesotaCare, GAMC, MN Senior Health Options, and MDHO.³ These HMOs have financial reserves far in excess of what is needed for insurance solvency. The excess, which is over \$650 million, is due to the large profits that they amassed from their state program contracts. The reserves and excess would be even higher, by about \$150 million or more, if the HMOs had not been using their public program profits to cover some losses in their private business lines, and given away very large amounts as charitable donations.

¹ 400% of RBC is **twice** the NAIC floor for regulatory intervention, and **four times** the amount the NAIC considers to be a "hypothetical minimum capital level." A 2008 report by the Blue Cross Blue Shield Assoc. states that reserves above 375% of RBC are an adequate amount to avoid triggering "early warning" internal monitoring by the Association.

² A July 2010 Consumers Union report calls the NAIC formula flawed, and higher than necessary for solvency.

³ MDHO is MN Disabilities Health Options.

expenses just in case of a bird flu epidemic or similar catastrophe. Yet, they fail to mention the likelihood that federal Centers for Disease Control or Federal Emergency Management Agency resources would be deployed in such a circumstance.

C. Misleading financial reporting

Misleading financial reporting by the HMOs has occurred on several levels. Most blatant is the practice of presenting a lower profit picture than actual from the state's public programs by excluding the MSHO program, and also excluding the investment income on program reserves – which originated, after all, from the surpluses provided by the state's payments. DHS used to support this misleading reporting, but the practice was changed by the Dayton administration which correctly includes MSHO, and tallies up the profits (contribution to reserves) both with and without the investment income.

In addition, GMHCC is currently looking into discrepancies in the figures reported in some of the HMOs' IRS Form 990s and their Annual National Assoc. of Insurance Commissioners reports. We have identified some large discrepancies in reported salaries, executive compensation, and donations, as well as failures to indicate "doing business as" arrangements, and apparent disguising of donations.

An even larger issue is the question, which needs to be answered by adequate external auditing, of the accuracy and veracity of the numbers which the HMOs provide in the MN Supplement Report and other documents. This question applies to the total amounts of expenses and profits that are reported for each HMO; possibly inflated expenses; plus the distribution of expenses and profits among the state program versus commercial products, and even among the various state programs themselves. The Feb., 2008 Office of Legislative Auditor (OLA) report stated that: "Health plan officials told us that their allocations of expenses and interest earnings among the programs is sometimes imprecise." (p. 41, OLA report) *How extensive, and how deliberate, is this "imprecision"?*

To illustrate, we computed the per-person net medical expense total (which includes several sub-categories) for the contracted Medical Assistance program, for the four HMOs, from 1995 through 2011, on the MN Supplement Reports. One would expect these amounts, on average and over time, to be roughly similar among all four HMOs, since the enrollee populations are very similar, and this in fact is the case. However, GMHCC also computed separately the specific line item for hospital and physician expense, and found that the amounts are similar for Blue Plus, Medica, and HealthPartners; **but the amounts of all three are consistently about 80% above those of the fourth HMO, UCare, starting in 2001.** This does not seem to make sense, unless one considers the theory that the other three falsely reported quite high amounts for the public programs, by re-allocating expense from their commercial products. UCare is the only one that cannot juggle its books in that way, since it does not have large commercial products like the other three have. UCare, meanwhile, reports vastly higher amounts than the other three HMOs in the "Other Professional Services" line item. These odd discrepancies should be seen as red flags that merit detailed investigation. [See charts A and B on page 8]

Cost contracts disguised as risk contracts: A critical aspect of the payment system to the HMOs is the basic nature of the DHS contracts. There are two main categories of possible contracts: "Cost contracts," in which the HMO is reimbursed for the actual medical expenses it pays for, plus administrative service; and "Risk contracts," in which the HMO is paid a flat per-person amount per month. With a Risk contract, the HMO is at risk of losing money if the pre-paid, set amount was not enough; but could also make a profit the amount was more than enough. The DHS contracts with the Minnesota HMOs were officially "Risk contracts," and they were given per-person pre-paid payments from the state. In reality, however, DHS made up for any losses by increasing the payment the following year, and also included a built-in profit (contribution to reserves) in each contract, except for GAMC. The state, not the HMOs, was actually bearing the financial risk. Governor Dayton stated on MN Public Radio on July 17, 2012 that "they were basically cost-plus contracts."

Why, then, hadn't the state just set these up as Cost contracts instead of writing them up as Risk

Chart A: Prepaid Medical Assistance Program, 1995 through 2011, average per person net Total Hospital and Medical expense, as reported by each HMO to the MN Dept. of Health, on Minnesota Supplement Report forms. As expected, this shows roughly similar amounts for each of the four HMOs.

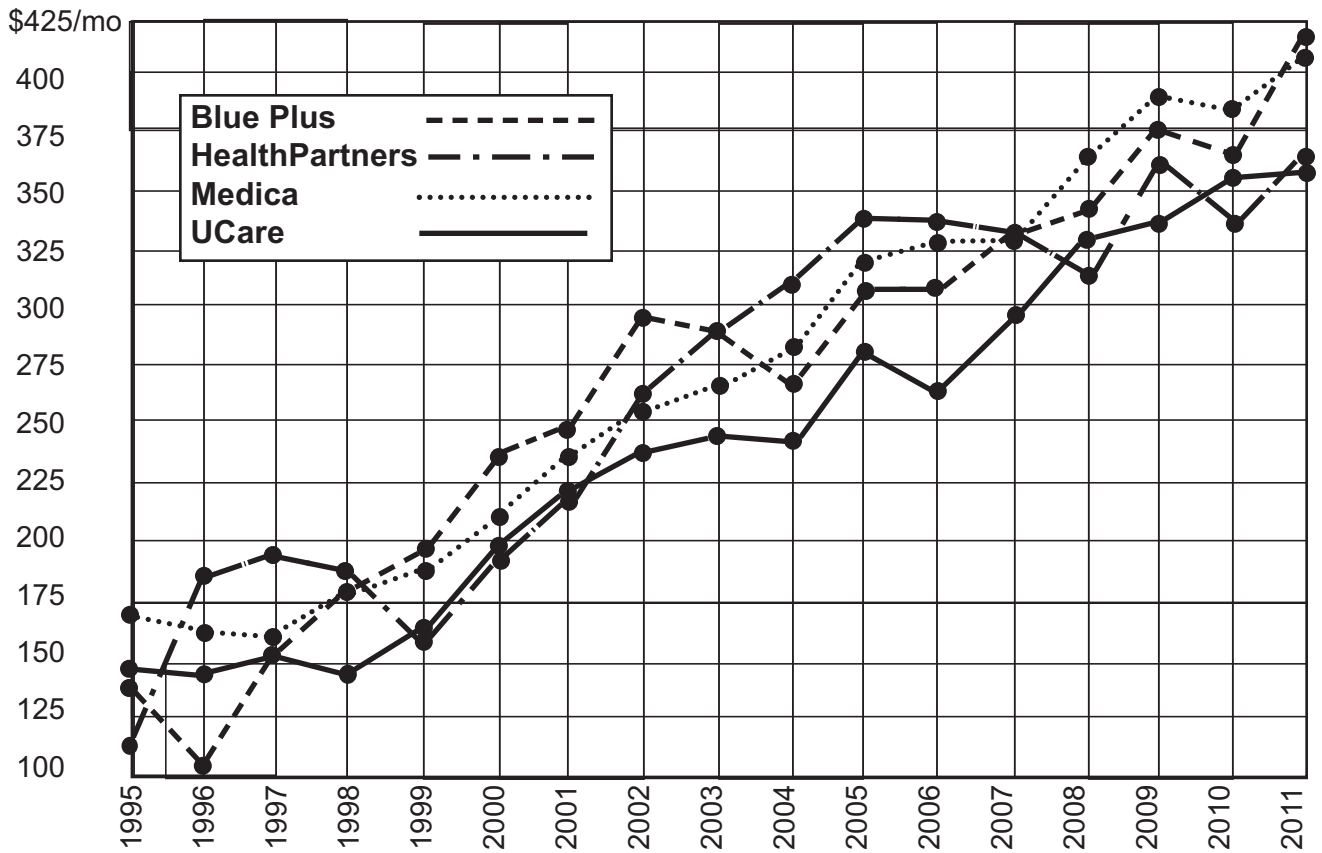
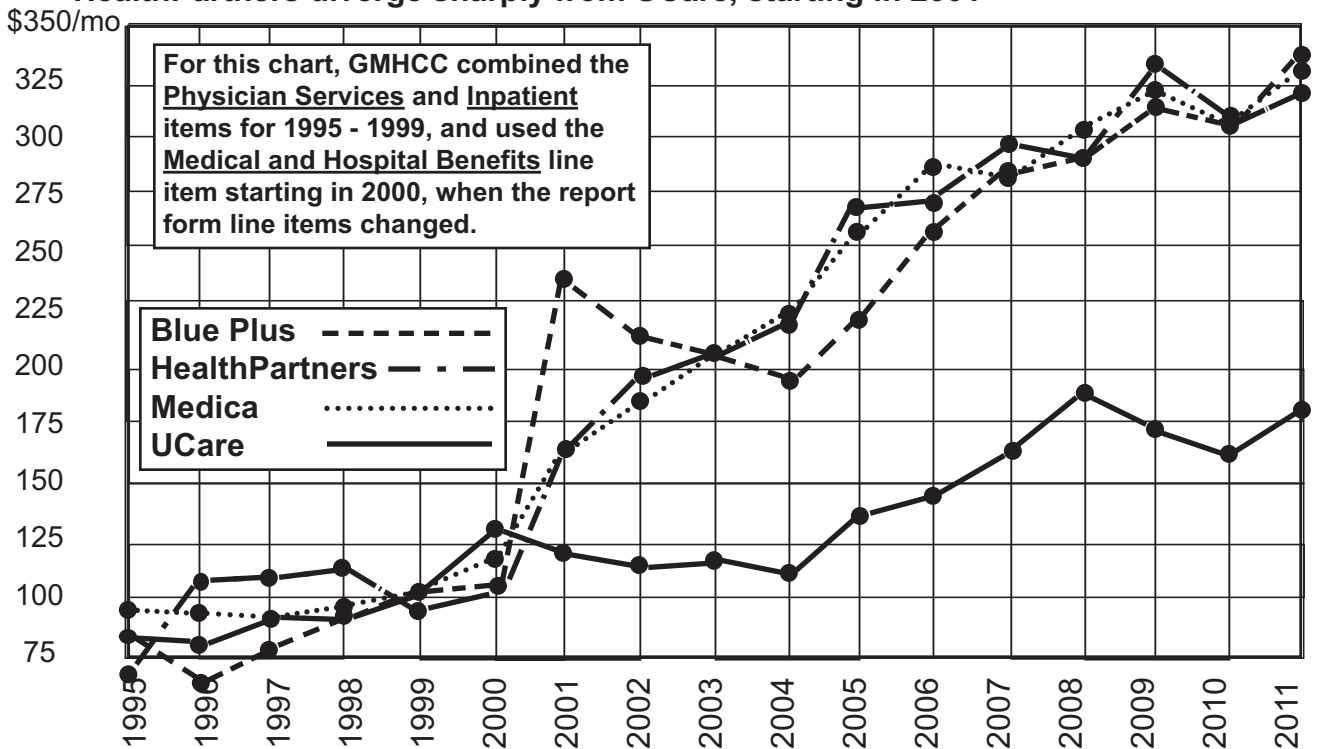


Chart B: Prepaid Medical Assistance Program, 1995 through 2011, average per person physician and hospital expense line item, as reported by each HMO to the MN Dept. of Health, on Minnesota Supplement Report forms. Note how Blue Plus, Medica, and HealthPartners diverge sharply from UCare, starting in 2001



contracts, since they were actually paying the HMOs on a cost-plus basis? The answer, we believe, is twofold: (1) **Cost contracts require strict auditing, while Risk contracts do not; therefore, using the Risk contract format allowed for significant juggling of the books without any scrutiny;** and (2) The concept of Risk contracts includes a pre-determined annual total level of payment to the HMOs, and this provided the legislature an advance measure of budgetary certainty, whereas true Cost contracts imply an open-ended total expense. Improperly using Risk contracts as a disguise for what are really Cost contracts is likely a violation of federal law, and this needs to be addressed.

D. Evidence of public money subsidizing other products

GMHCC found that in the case of Medica, over \$55 million of profit from the state's public programs, in effect, subsidized losses in Medica's commercial products, in the years 1996, 1997, 1999, 2005, 2008, and 2010. In each of these years, profits from the state public programs fully or partly covered losses in the commercial products, according to the numbers on Medica's own reports to the state. In no year did profits from commercial products ever cover losses in Medica's public programs. There was only one year, 2006, in which Medica reported any loss at all from the package of state programs.

GMHCC also found that UCare used \$19 million in profits (\$16 million in direct transfers and \$3 million in a loan) to subsidize reserves and losses in its Medicare Advantage policies in Wisconsin, sold by its shell corporation subsidiary, UCare – Wisconsin, to the general population of Medicare enrollees. Why are Minnesota public program profits subsidizing Wisconsin policy holders?

E. Questions about donations originating from public program overpayments

Since the HMOs in Minnesota are required to be not-for-profit corporations, and serve a public purpose, it has been traditionally considered acceptable for them to make some charitable contributions for health care related organizations and programs. However, there have never been any guidelines or standards set as to what might constitute an excessive amount of contributions. This question is especially important when it is excess profits from state and federal funds that are the source of the donations. Should excess state and federal payments for public programs be given away, at an HMO's discretion, in the form of large charitable donations?



This is a critical question for one of the four HMOs which contracts with the state: UCare. UCare has, from 1995 through 2011, given away at least \$76 million in charitable contributions. In some years, this has represented from 1% to 3% of total revenues. Most significant, at least \$66 million of these contributions and special payments are to the U of Minnesota medical system, which UCare contracts with directly for medical services. Some of this money is identified by UCare's accountants at Larson-Allen "as a result of under-funding of services for state programs and uninsured patients." This implies that the U of M medical services were receiving a special extra subsidy unavailable to other medical providers, via UCare's generous contributions, possibly amounting to illegal cross-funding. Some U of M Community University Health Care Center and U of M Physicians Clinics officials sit on UCare's Board of Directors. UCare claims that the U of M is not its "parent" corporation, yet U of M medical system personnel have controlling votes on UCare's Board.

UCare reported net profits of \$50.9 million from sources - mostly Medicare Advantage plans --other than the state programs, from 1995 through 2011. This is far less than the \$76 million that UCare gave in donations, plus its \$19 million subsidy to Wisconsin policies (= \$95 million total). In other words, at least \$44 million of UCare's "extracurricular" expense came from Minnesota public program profits.

F. The dental care access problem

It is well known in parts of Greater Minnesota, at least, that dental care is extremely hard to come by for Medical Assistance and MinnesotaCare enrollees. The benefits paid for by taxpayers do not materialize very much, due to a serious lack of participating dentists. That lack is due in turn to the fact that payment rates from the HMOs (just a small amount above the Fee For Service rates) are far below the dentists' cost of doing business. As a result, enrollees frequently go to hospital emergency rooms to treat dental pain and infection. A study cited by Dr. Amos Dienard at the U of M asserts that this kind of ER expense is 10 times what the cost would have been for routine dental care that would have avoided the problems seen in the ERs. In late 2009, GMHCC did a direct survey of dentists in St. Louis County whom the HMOs claim to be participating in Medical Assistance and MinnesotaCare, and found that only 40% of these actually accept new public program patients, and with restrictions in many cases. 24% were not participating at all. This is another example of the HMOs not providing accurate information, and it conveys a false sense of greater participation and access to care than exists.

G. The County-Based Purchasing alternative

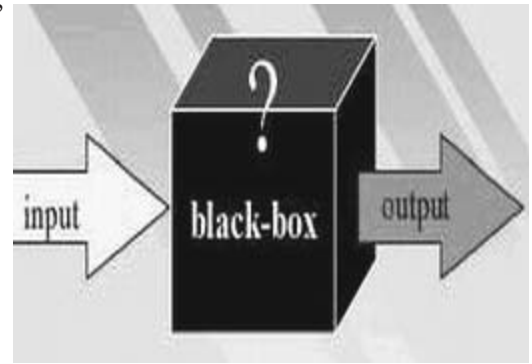
GMHCC gathered extensive information about the three County Based Purchasing (CBP) systems in the state: Itasca Medical Care (IMC), Prime West (PW), and South Country Health Alliance (SCHA). IMC is a one-county unit, while PW covers 10 counties and SCHA covers 14 counties. They obtain the equivalent of HMO licensure from the state, and contract with DHS for the public programs, just like the private HMOs do, on the same financial basis. Their operations differ substantially from those of the HMOs, in the following ways: Fully open financial information (nothing held as proprietary); positive partnership arrangements with health care providers; CEO salaries a tenth or less of those of the HMOs; better payment for dentists; close coordination with county social services and public health systems; and local control and accountability. In addition, they do not hold onto big reserves. PW set its own upper limit on reserves at 450% of RBC. GMHCC's research uncovered that in counties that participate in CBP, the rate of emergency room expense for dental pain and infection, that can be avoided with routine care, is half of that in the other counties. This connects to the fact cited above regarding higher payments to dentists compared to what the HMOs provide. Many more counties have expressed desires to use the CBP method, but have been thwarted over the years by antagonistic attitudes at DHS and MDH, the legislature, and Governor Pawlenty. The private HMOs have actively pressed DHS, successfully, to limit the CBP's "market share" of the public programs. GMHCC also believes that when SCHA added five counties in 2009, the HMOs provided falsely under-estimated risk computations in order for DHS to authorize unrealistically low per-person payments, which resulted in SCHA losing money and fueled a false narrative of CBP financial inability or incompetence.

H. Analysis of the problems

It is evident from GMHCC's research that the state has historically overpaid the HMOs, at least in terms of excess profit above the target rates. We can add to that the questionable nature of contributing anything to insurance reserves given that the state was essentially not holding the HMOs at financial risk, overall. A very significant question is whether the actual profits from the public programs might be much larger than what the HMOs have reported. Their ability to arbitrarily allocate expenses, as well as investment income, between the public programs and other product lines may have resulted in overstating the actual expenses, and understating the investment income. Both instances would result in profits actually being much higher than what were reported. And since the actual payment amounts to

health care providers have been closely guarded “trade secrets,” the potential exists that the aggregate amounts of medical expenses reported by the HMOs are also inflated.

It is noteworthy that UCare shows on its reports higher profit percentages from the state’s programs (over 4% annual average) than do the other three. UCare does not have the large commercial product lines that the others do, and so the cross-allocation opportunities are not there as they are for the other three. Blue Plus, Medica and HealthPartners have the ability to inflate on paper the expenses for the state programs while



reducing the expenses for their commercial products. An additional opportunity for cross-allocation exists for HealthPartners, which owns its own clinics and hospitals which receive third party payments from other sources. This provides another avenue to report artificially high medical expenses for the state’s public programs, especially since HealthPartners uses its Group Health Plan affiliated entity in unusual ways, such as paying HealthPartners staff out of Group Health accounts. A different kind of cross-transfer exists in the case of Medica, which subcontracts most of its administrative work to its former parent company, the giant UnitedHealth, based in Minnetonka, which is not allowed to contract directly with the state because it is a for-profit company.

The cost-allocation process which has the most serious legal implications is the alleged practice of deliberately padding the prepaid Medical Assistance rates, in order to gain a larger total amount of federal reimbursement in order to reduce the total level of state funds to be used for the GAMC program, which was state-funded only. This practice was referred to in the March 21, 2011 letter from UCare CEO Nancy Feldman to Sen. David Hann. It was also referred to on page 43 of the Feb., 2008 Office of Legislative Auditor report: “DHS staff acknowledged that they have **regularly set GAMC’s rates lower than the program’s anticipated costs**, with the expectation that the health plans will negotiate lower rates with providers, help clients transition from GAMC to MinnesotaCare, or **cover their losses with surpluses from other programs.**” (emphasis added)

The essence of the scheme that we believe went on for over the past decade is as follows:

- 1) DHS wrote Risk contracts on a yearly basis with the HMOs instead of Cost contracts. Doing so automatically gave an exemption for full, independent auditing. But in reality, they were Cost contracts.
- 2) A critical component of setting the per-person pre-paid rates (known as “capitations”), were the risk adjustment factors, which means the estimates of the enrollees’ health status and need for services in the coming year. DHS let the HMOs undertake the risk adjustment computations, without verification.
- 3) The biggest three HMOs -- Blue Plus, Medica, and HealthPartners -- apparently inflated their expectations of physician and hospital expenses in the contracts, resulting in artificially high payments.
- 4) In addition, DHS built into the capitations a “contribution to reserves” (profit) target, but never considered whether an increase of overall reserves was merited in any given year. Plus, DHS never wrote in any provision for return of profits which accrued above the target levels in the contracts.
- 5) At each year’s end, Blue Plus, Medica and HealthPartners apparently put in their MN Supplement Reports not the actual medical expenses for the public programs, but instead artificially inflated ones, by re-allocating expenses from their commercial products, thereby falsely reporting the expenses in order to match the originally falsified projections. UCare, meanwhile, likely hid their large subsidies to the U of M system in the “Other Professional Services” line item. DHS, in each subsequent year, set capitations which covered all reported expenses, plus new contributions to the reserves.

For this scheme to work, it was critical that the HMOs’ actual financial data never be audited, because that would expose both the artificially high risk expense projections, and the artificially high end-of-year reported medical expenses. The original rationale for the HMOs’ need to have payments to providers be “proprietary trade secrets” was to enable the HMOs to effectively negotiate with providers, and play them off against each other, to obtain significant discounts from their normal charges. However, recent

testimony to the legislature has shown that this process was not being used, and instead the HMOs merely set up payment schedules which took the DHS publicly published rates for Fee for Service Medical Assistance, and added a couple of percentage points. **This means that the original rationale for secrecy does not exist.** The reason for the HMOs' vehement defense of secrecy for their data is therefore due, GMHCC believes, to the need to hide the fact that they gave falsified data to the state.

Finding out the truth and the full dimensions of all aspects of the cross-allocations and the true profit picture from the public programs can only be done via full audits that are completely external and independent. Hundreds of millions of dollars, perhaps even billions, are at stake. Such retrospective audits would likely document numerous clear instances of fraud, which would provide the legal basis to recover or "claw back" the excess payments.

3. What GMHCC did with this information

A. Provided our analyses to state officials

In February of 2011, GMHCC representatives met with the Commissioner of Health and the Commissioner of Human Services, explaining our findings regarding profits, reserves, and related issues. We shared our research and analyses, helping the new Commissioners to understand the nature and extent of the problem. The new Administration in fact acknowledged the problem of overpayment, and addressed that in terms of contract payments going forward, and using a bidding process for the first time in the hope of squeezing down profits. Since then, we have repeatedly communicated with the Departments, and also met with the Commissioner of Commerce in the summer of 2011. We have shared new research and analyses with these Departments as we continue to generate them.

B. Provided our analyses to federal officials

In June of 2011, we communicated with a federal Centers for Medicare & Medicaid Services (CMS) official in charge of State Medicaid Waivers, and provided the same information that we previously gave to the Administration officials. We also informed the state officials that we had done so. Recently, GMHCC wrote to Senators Franken, Klobuchar, and Grassley, providing them with the information we have gathered. We also wrote to all of Minnesota's U.S. Representatives, offering to provide our information and assistance.

C. Testimonies we gave to state legislative committees

In 2007, GMHCC testified twice to the Senate Health Care Committee regarding the issue of the overpayments to the private HMOs. In 2010, we testified at the Chair's request to the House Health Care & Human Services Policy & Oversight Committee, and in 2012 we testified to the Health & Human Services Reform Committee. We have sent a number of our reports to state legislators, and provided our analyses of the HMOs' public program profits and their reserves to all members of the House and Senate Health Committees.

D. Information we gave to the Office of Legislative Auditor

GMHCC's testimonies in 2007 helped spark the Legislative Audit Commission to authorize an evaluation report by the Office of Legislative Auditor (OLA) on the financial management of the health care programs. We provided detailed information to the OLA on things we believed should be looked into, and one of our staff had a lengthy conversation with the OLA staff working on this. The report, which was issued in Feb., 2008, revealed that there was no auditing being done of the administrative

expenses of the HMOs for the public programs, with no verification of the numbers nor any established standards for what would be reasonable amounts. The report mentioned that profits (“contributions to surplus”) were usually much higher than the target percents that DHS specified in the contracts.

However, the release of the report was accompanied with a perception or “spin” that supposedly vindicated the HMOs, and put the CBPs in a negative light in comparison. This public impression was not supported at all by the facts detailed in the 126-page report. Some legislators mistakenly thought that the report confirmed that the private HMOs have very efficient, low administrative expense percentages. Unlike the private HMOs, the CBP systems, being public entities, have completely open books available for inspection. The OLA report clearly stated that the low administrative amounts self-reported by the HMOs had not been independently verified at all. In other words, the state did not know what the true numbers are.

4. What the Legislature should do

A. External auditing

In the 2012 session, the Minnesota Legislature mandated, for the first time, external, independent audits of the contracted-out public program expenses. The new law puts oversight of this in the hands of the OLA. However, the auditing is delayed until 2014 revenues and expenditures. GMHCC believes that the legislature should have used 2012 as the starting year, and created a requirement that the only firms that should be hired would be ones that work exclusively for state and federal government contracts. There are only a few firms which fit that description, but the importance of getting expertise that is not tainted by being hired by insurance companies, HMOs or medical systems, is very critical due to the highly complicated nature of this kind of accounting. A fall-back position would be to only contract with firms that have not been hired by an insurance company or HMO during the past three or five years.



B. Require retrospective auditing

The legislature should also require retrospective auditing, going back to the start of the DHS contracts with the private HMOs. **This is necessary, in order to uncover what GMHCC believes is the deliberate deception in the financial reporting which constitutes fraud and provides the legal basis for recovering hundreds of millions of dollars of overpayments.** GMHCC’s own research has uncovered what we believe is definite evidence of fraud. The federal investigations which are currently underway are likely to find significant fraud. In any event, the numbers previously submitted are highly questionable. Reliable historical information is needed to understand the true costs of these programs.

5. What the Administration should do

A. Use its existing statutory and contract powers for retrospective audits

The state needs to get to the bottom of the true story of what has happened to the billions of dollars poured into the “black box” of our managed care programs. We need to know how much public money the HMOs have spent for actual health care; whether administrative and other expenses have been reasonable or not; whether public funds have been used for inappropriate purposes; what amount of excessive financial reserves derive from excessive public program profits; what incorrect financial reporting has been done; and whether it has been done deliberately to disguise the facts. The

Commissioner of Health has strong statutory powers [See MN Statutes 62 D] to perform auditing to answer these questions regarding the HMOs. Blue Cross Blue Shield of MN also needs to be audited because it owns the Blue Plus HMO which contracts with the state. The Commissioner of Commerce has statutory power to audit Blue Cross [See MN Statutes 62 C]. Both Commissioners have the right to require the companies being audited to pay for reasonable audit costs. In addition, the contracts that DHS signs with the HMOs have extensive auditing powers granted to the Commissioner of Human Services as terms of the contracts. All three agencies should use the powers they have to conduct the investigations that are needed. The state agencies have the power, if the situation merits, to place any or all of the HMOs under “administrative rehabilitation,” which means replacing the top management and Boards of Directors with new people and reforming the company’s practices. On July 17, Gov. Dayton stated on MN Public Radio that “I think that the last ten years should be audited.”

B. What to do in regard to reform measures it is pursuing, such as ACOs

The state administration has chosen to try the competitive bidding route to squeeze down excess payments and excess profits. It remains to be seen how well this will goal will be accomplished, and how it will lead to reforming the HMOs’ practices. The concern about not creating too much disruption for the public program enrollees can lead to not generating as much competitive pressure as might provide stronger results in improved efficiency. Another reform idea coming into prominence is the Accountable Care Organization (ACO) model. Although the ACO model is intended to put health care provider groups in the driver’s seat, there is a big question as to how much they might need to rely on the HMOs for management of financial risk; and how much, in turn, that can result in the HMOs controlling the money flow and being able to manipulate payments to maximize their own profits.

6. What the State Attorney General should do

A. Powers as Medicaid Fraud Control Unit

The Office of Attorney General (OAG) can play a large role as well, in its function as the official federally-designated Medicare Fraud Control Unit. Much of the Unit’s funding is federal, and so there is an obligation to pursue fraud, including administrative fraud on the part of the HMOs, in the interest of the federal government as well as the state government. The allegations of fraud that have been brought to the surface by GMHCC and others – especially David Feinwachs, former attorney for the MN Hospital Assoc. -- merit that the AG’s office employ its fraud investigative mandate and resources.

We note that the OAG, back in 2001, performed the only external audit ever done, which showed that Medica’s true administrative expenses were **over twice** what Medica had reported to the state.



7. Policy implications

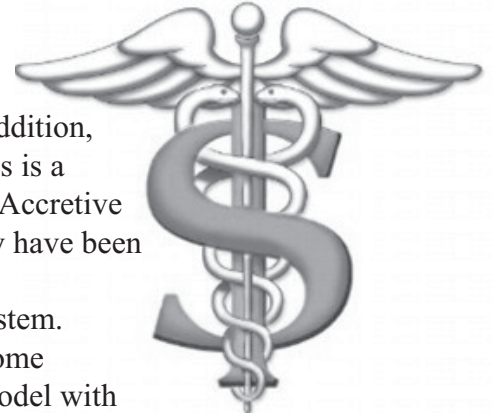
A. Move away from HMO contracting

GMHCC, and many others, believe that the 20-year experiment to see if contracting out the public programs would save the state money has been a failure. The idea of giving prepaid, per-person amounts to an HMO has the attraction to legislators of providing predictability for the total expenditure for the budget biennium being discussed. In theory, this was supposed to save the state budget from the “blank check” syndrome of the previous Fee For Service (FFS) system, whereby

providers were reimbursed on a procedure-by-procedure basis. In reality, the pre-paid system could have worked efficiently and without the vast, mistaken and unnecessary overpayments that in fact occurred. But, to do this, it is obvious in hindsight that very tight and energetic state regulatory oversight was needed. One thing that hampers this kind of needed oversight to occur is the very close relationship that developed over the past two decades between the HMOs and the people who are charged with regulating them. Evidence of this is clear in the “revolving door” of high level people switching between the HMOs (and their auditing firms) and the state agencies. It played out in the mantras “we assume they’re being honest and filling out all the forms correctly” and “there’s no need for us to even look at the reports and data they file with us.” The legislature assumed that because the HMOs are not-for-profit and are required to pursue a public purpose, therefore they in fact operate that way. The track record shows otherwise.

The state can consider other models. One that it is considering now is the Accountable Care Organization model, which is discussed above, and regarding which we mention some important pitfalls. In addition, the recent scandal about Fairview’s contracting with Accretive services is a cautionary tale. Some are unaware that Fairview was planning to use Accretive to manage its ACO, and we can now assume that patients would likely have been financially mistreated in some ways.

The state could also consider some modified version of the FFS system. Prior authorization for more expensive procedures could help avoid some unnecessary utilization. This year, Connecticut started using a FFS model with medical homes and care coordination fees. Oklahoma has been doing so for several years. Also, the state could consider negotiating annual global budgets for hospitals for their public program patients.



B. Assist and Encourage County Based Purchasing to expand

Another direction, which would use existing methods while getting away from HMO control, would be to expand the County Based Purchasing (CBP) model. As mentioned above, the expansion has been hindered by administrative action by the state agencies in the past. Also, in 2009 Olmsted County and others wanted to start a CBP operation (with involvement of the Mayo Clinic system), along with neighboring counties, and they sought a few legislative changes to help their competitive position vis-a-vis the HMOs. These were defeated, at the insistence of the HMOs and the DHS leadership at the time.

In order to encourage CBP, and to help it flourish, the legislature should change the laws so that a CBP operation, which demonstrates that it can succeed, would be free of competition from the HMOs for market share. There is also a federal requirement that in urban counties, there must be more choice than one managed care system. The state can specify that there would only be one competitor to the CBP system. And, instead of having the “competition” be a private HMO, it might be permissible to the federal government for the alternative to be a FFS system with primary care case management for the affected enrollee population.

Two other ways that the state could assist and encourage CBPs would be to: (1) Streamline and consolidate the administrative reporting they are required to do, to remove duplicated reporting; and (2) Provide financial assistance (low or zero interest loans) for the initial start-up costs, which are typically recouped within 5 or so years of operation.

C. Public option

The CBP model has the potential to expand beyond the low income state programs, and offer coverage to other residents. Prime West has already begun doing this, with a separate program called “Values Health” for lower-paid workers in businesses that can’t afford to provide employee coverage.

In this way, the county system uses the network and relationships it has created with local health care providers to take care of the needs of others who are severely disadvantaged in the small employer and individual health insurance markets. With its lower administrative overhead and very positive partnerships with providers, the CBPs have the ability to provide coverage at lower prices than what is comparatively offered by the HMOs and insurance companies. In other words, this constitutes a competitive “public option” at the local level. It can provide a model for a public option offered to the general public by the state. One scenario could be for CBP-run public options to gradually link up and consolidate into a statewide public option, via an organic process from the grassroots up.

A note on sources:

All of the financial numbers used in this report are taken from the following public document sources: Minnesota Supplement Reports (annual revenue, expenses, and net income); National Association of Insurance Commissioners Annual Statements; CPA audit reports on file with the MN Dept. of Health; IRS Form 990s; and the Feb., 2008 Office of Legislative Auditor report titled: “Financial Management of Health Care Programs. For specific information on how the numbers were extracted and compiled, contact GMHCC.

Related GMHCC materials available upon request:

1. GMHCC Analysis of Office of Legislative Auditor Report Aug., 2008
2. GMHCC Memo on County Based Purchasing Oct., 2009
3. GMHCC Comments on DHS Feb., 2009 Report Feb., 2010
4. GMHCC Memo on Medica Internal Subsidy Apr., 2010
5. GMHCC Memo on Private HMO Profits Feb., 2011
6. GMHCC Overview of HMO Accountability Issue Feb., 2011
7. GMHCC Memo on State Statute Citations Feb., 2011
8. GMHCC Memo on HMO Financial Reserves June, 2011
9. GMHCC Memo on UCare Charitable Contributions, and Wisconsin Subsidy June, 2012
10. GMHCC Memo on per-person medical expenses July, 2012

8. Greater MN Health Care Coalition background

A. Description and history

The Greater Minnesota Health Care Coalition (GMHCC) is a grass roots, non profit, non-partisan and charitable 501 c 3 organization, headquartered in Mora. It has four organizational members: Northern Lakes Assoc. (based in Virginia); MN Citizens Federation – NE (based in Duluth); Seven County Senior Federation (based in Mora); and Central Minnesota Senior Federation (based in St. Cloud). Each of these groups is over 35 years old, and altogether they have 3,000 individual members. The organization represents the interests of low and middle income health care consumers, and is dedicated to the goal of affordable health care for all. Each of the four member organizations helped found, in 1976, the statewide Minnesota Senior Federation. They left the MN Senior Federation and founded GMHCC in 2003.

GMHCC’s member groups have over 35 years of public policy advocacy experience at the state level, and some involvement in federal and local health care policy as well. Co-Coordinator Buddy Robinson (Staff Director of the MN Citizens Federation – NE) and Tim Burkhardt (Staff Director of the Seven



County Senior Federation) have respectively, over 30 years and over 20 years of experience with Minnesota health care policy advocacy. In addition to its public policy work, GMHCC's groups created and operate two programs which provide affordable health care access to low income people: (1) Senior Partners Care, in which over 1,000 low income people on Medicare receive health care from participating health care providers who accept Medicare A and B's reimbursement as payment in full; and (2) Prescription Partnership Program, which is a mail order arrangement with a Canadian pharmacy so that people can purchase brand name medications at about half the US price.

B. GMHCC's goals regarding Minnesota's public health care programs

GMHCC believes that there a number of things the State of Minnesota can do to reform the operation of the low income programs to improve efficiency, services to enrollees and treatment of health care providers; and further, to help make health care for affordable for all residents regardless of income. For the state's low income programs, the state can transition away from administration by the HMOs, into other forms mentioned above: County Based Purchasing, global budgets for hospitals, and modified Fee For Service. If the state were to continue to contract with private HMOs, then much more intense and serious regulatory oversight is needed to correct the current abuses and prevent them from recurring. The state may, in fact, need to resort to its legal powers of administrative rehabilitation to change the top management of the HMOs and provide supervision of their mission.

The state can generate greater financial efficiency by consolidating the administration of the separate health care program areas that it now operates, and maximize its buying power in the market. The low income programs, state employee health coverage, legislators' health coverage, and corrections system health coverage could be consolidated to varying degrees. A related measure would be for the state to create a statewide buying pool for prescription drugs, which could negotiate in bulk directly with drug manufacturers, and/or make arrangements for purchases via importation (this latter item is already offered as an option for state employees).

The state can also expand coverage options for other groups, by allowing businesses to buy into MinnesotaCare coverage, and by creating a statewide public option to be sold on the new Insurance Exchange in 2014, available to all households and to all businesses.

Finally, the state can pursue the step of creating a universal health care administration system for all residents, such as is provided for in the Minnesota Health Plan legislation which has gone partway through the legislature. Individual premiums would be on a sliding scale in relation to household income. (Note that the MinnesotaCare system already uses a sliding-scale premium.) Under this proposal, self-insured corporations would not likely be able to be forced to use the health care coverage, because of ERISA laws. However, if they are required to pay a payroll tax to help fund the system, then they probably would voluntarily want to have their employees use the state coverage. The savings in administrative cost, especially for health care providers, would be huge. This was demonstrated in the recently-released, well-researched study conducted by the Lewin Group for the Minnesota group Growth & Justice . Under the rules established in the Affordable Care Act, the state could apply in 2017 for a waiver to implement such a state-administered system in lieu of the Insurance Exchange model.

C. Credibility and track record

GMHCC's groups have a long track record of helping, as part of the MN Senior Federation, to achieve important health care reforms, including a number of affordability improvements to nursing home Medical Assistance, in-home care Medical Assistance (Alternative Care Grants), and prohibition of Medicare Part B balance billing. Over the past six years, GMHCC's work has focused on alerting the legislature to the problems of the state's overpayments to the HMOs, and promoting, in contrast,

the value of the County-Based Purchasing (CBP) model. GMHCC has emphasized the fact that the successes of the CBP model, largely unknown to Minnesota's legislators or public, represent a practical, honest, accountable, cooperative, and efficient model; and that this approach from rural parts of the state is precisely what is needed for health care reform for all of Minnesota, urban and rural alike.

GMHCC's unique, original research into the HMOs' reports on the public health care programs and other related documents has unveiled and revealed critical truths that the legislature, media and public were unaware of. As mentioned above, our work helped prompt the Feb. 2008 OLA report, which in turn set in motion attention on the accountability and transparency issue. Our work has also helped encourage whistleblowers to come forward and to bring federal attention to this issue. Dayton Administration officials have found our research and analyses to be very useful and helpful to them. Our on-going research is now in the process of uncovering additional documentation and information pointing to improper operations by the HMOs and specific evidence of fraud.

GMHCC's Board Officers:

President: Lila Skramstad, Mora; (Seven County Senior Federation)
Vice-President: Lloyd Adams, Grand Rapids (Northern Lights Association)
Secretary: Jerry Challman, Duluth (Minnesota Citizens Federation - Northeast)
Treasurer: Mary Mayer, St. Cloud (Central Minnesota Senior Federation)

GMHCC's Co-Coordiators:

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