Comparison of Health Insurance Purchasing Alternatives

Final Report

submitted by
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Table of Contents

Executive Summary

The Task Force on Health Insurance of the Faculty Consultative Committee at the University of Minnesota commissioned this report to investigate alternative health insurance purchasing strategies to the current partnership with the State of Minnesota. This report addresses a variety of models for the committee to consider and also reports on health insurance options that other organizations provide for their employees. The other organizations include Macalaster College, the University of Wisconsin, Penn State University, Medtronic, Toro, and the City of St. Paul. Three member companies of the Buyers Health Care Action Group are discussed briefly. Retiree benefits for several Big Ten Universities are also discussed.

There are a variety of models which are considered in this report. The main options are as follows:

- **Adoption of the BHCAG model** - this option would be for the University to join BHCAG with the state to supply health insurance to their employees. This option should reduce costs, but will also decrease choice and has insurance risk.
- **Addition of the BHCAG model to conventional plans** - this option would allow the University to join BHCAG and also offer other conventional plans. This option would allow for more choice, but will not offer as much cost reduction and it has insurance risk.
- **Independent adoption of BHCAG model with the State** - this option allows the University and the state to directly contract with care systems to provide health care for their employees. This option has possible cost reduction benefits, yet increases insurance risk.
- **Adoption of BHCAG model without State and BHCAG** - this option would allow the University to directly contract with care systems to provide health

care for its employees. The pool of employees would be smaller and thus the bargaining power less and the insurance risk increased.

- **Total replacement** - this option involves obtaining health insurance from only one health plan. The cost should be reduced by placing all employees in one plan, yet the choice for employees would be dramatically reduced.
- **Remain in current partnership with the state** - this plan would maintain the status quo in how health insurance is offered to employees of the University.
- **Remain in current system without the state** - this plan would offer the University the option to negotiate with insurance plans and choose plans which better meet the needs of the employees of the University. The costs might increase with a smaller pool of employees, but choice would be better fitted to University employees.
- **Medical Savings Account** - this plan allows the employees access to a flexible spending account which they use to choose their health insurance. This offers the employees more control over the insurance options they purchase, but it may lead to negative effects on employee purchasing decisions and employee health.

Final Report to the Task Force on Health Insurance

Introduction

Employers in the Twin Cities market engage in a variety of health insurance purchasing strategies to respond to recent consolidations of health plans, hospitals, and providers. Faculty and staff at the University of Minnesota have the opportunity to adopt or modify these strategies to meet their own health insurance needs. The withdrawal of the Medica Premier health plan and the dramatic increase in total premiums for the State Health Plan were the two most recent, unexpected changes that the State and the University would like to avoid in the future. These adverse changes prompted the Senate Committee on Faculty Affairs, the Faculty Consultative Committee, and the American Association of University Professors to explore alternative health insurance purchasing strategies. To this end, a number of alternative purchasing strategies are reviewed, and profiles of employers using each strategy are discussed.

In its attempt to understand and respond to recent changes in health benefits, the Task Force on Health Insurance posed three critical questions which motivate this report:

1) Can concerns of the University faculty and staff be addressed by continuing to purchase health insurance with the State Employee Group Insurance Program (SEGIP)?
2) If not, should the University purchase health insurance independently?
3) What alternatives exist for the University to consider independently or in conjunction with the State?

The first and second questions should be addressed by the University faculty and staff themselves. Limited information is presented to address the first question by comparing the advantages and disadvantages of maintaining a relationship with SEGIP and other purchasing strategies. These comparisons can

also provide indirect evidence for the second question. An answer to the second question can only be provided by the Task Force on Health Insurance, the Faculty Consultative Committee, and the Senate Committee on Faculty Affairs. Full consideration of the third question is the focus of the remainder of this report. It should be noted that evaluation of purchasing strategies is purely qualitative.

The University of Minnesota spent $47,286,492 on health insurance for 14,463 faculty and staff in 1997. Employees' premium contributions totaled $5,108,492, while employer premium contributions totaled $42,178,452. The State Employees Group Insurance Program (SEGIP) charges the University an administrative fee of $1.70 per month per participant as of July 1, 1997 to cover costs of negotiating and purchasing health benefits. The University has been in a purchasing partnership with SEGIP since 1967, and faculty concerns about the effectiveness of this relationship have arisen in the past. Recent, adverse changes in 1998 health benefits are related to both the SEGIP purchasing process and health care market trends. It is unclear if the University would have greater control over health benefit changes by separating from SEGIP. University faculty may be able to obtain health benefits that meet their needs, but most likely at greater cost. Alternative strategies should be evaluated according to the values, goals and principles that University faculty and staff hope to realize in their health insurance offerings.

There are two cross-cutting issues that must be considered in order to choose the purchasing strategy that satisfies the values and goals of University faculty and staff. The first issue - financing arrangement - has two considerations:

- self-insurance versus conventional insurance
- total replacement versus multiple health plans.

"Self-insurance"[1] would require the University to finance employee medical expenses out of University funds, and require the University to carry the "insurance risk". Conventional insurance is represented by the current health plan offerings to University employees in which the multiple, participating health plans carry the insurance risk for the employees they enroll. Total replacement would require a single health plan that is offered to all employees to take on the insurance risk for all University faculty and staff. These two financing considerations have associated with them benefits and costs which will be addressed below in the context of each larger, purchasing strategy.

The second issue that must be addressed is the decision-making body that is responsible for choosing which health plans are offered to University faculty and staff. Here, there are three options:

- ⋄ membership with BHCAG
- ⋄ action independent of the State
- ⋄ continued collaboration with the State

The Task Force on Health Insurance is particularly concerned with the implications of the second and third alternatives, and they will be addressed below in the context of each purchasing strategy.

Each purchasing strategy has several issues, such as administrative costs and "insurance risk", that are transparent to the employee, and some issues that affect the employee as much as the employer. These issues can be summarized in four questions that are addressed for each strategy and are listed in Figure 1 below.

Figure 1. Questions to Evaluate Each Purchasing Strategy

1) *Where do the risks lie in each option?*
2) *What are the costs of each option?*
3) *What recourse exists for addressing problems with providers?*
4) *What are the consequences of problems with a "carrier"?*

[1] Note that throughout the text there are insurance terms which may be unfamiliar. Terms in quotes are defined in a glossary at the end of the report.

The first question above is based upon two factors: 1) how the employer pays for incurred medical expenses, and 2) how contracted providers are paid. If the employer self-insures employee medical expenses, then the insurance risk lies with the employer. The State Health Plan and the State Health Plan Select options are currently financed this way. All other health plans are fully insured and the risk lies with the carrier (e.g. HealthPartners). Providers may also take on risk by being capitated. In this case, providers receive a fixed dollar amount per member per month and must manage the patient's care to ensure that expenses are lower than the per member per month capitation rate. The handling of the insurance risk is the important aspect of this question.

The second question has three components: 1) total premium cost, 2) employee premium cost, and 3) employer administrative cost. The greater concern to both the employer and the employee is the total premium, because the total premium determines how much the employer will contribute which, in turn, determines how much the employee must contribute for each health plan. The employee premium cost will influence health plan enrollment decisions by employees, and this dollar amount is clearly of grave concern to University faculty and staff. The last cost, which is more transparent to employees than other costs, is the administrative expense of each purchasing strategy. In the current relationship with SEGIP, the University pays an administrative fee which is probably a fraction of the cost that the University would incur if health plan negotiation and administration was done in-house. This last cost cannot be ignored by University faculty and staff, because any change in the current relationship with SEGIP would most likely introduce new administrative costs that were formerly subsumed by the Department of Employee Relations (DOER).

The third question about providers focuses on the problem-resolution process that employees can rely upon during the contract year. Some purchasing strategies provide better solutions to provider problems than others. For example, if employees of BHCAG member companies are dissatisfied with

their physician in the Choice Plus network, they can seek care with another care system provider. This flexibility is one tremendous advantage to employees that does not exist in some of the other purchasing strategies.

The last question about carriers focuses on the stability of costs over time. In the total replacement strategy, if the University was dissatisfied with the one carrier that insured all faculty and staff, the University might be required to change carriers if the relationship was irreparable. These considerations will be important in considering any change to the current purchasing partnership with SEGIP. Stability can be enhanced by increasing employer purchasing power and by increasing the competitiveness among health plans.

These four questions will be discussed below in the context of each purchasing strategy. Prior to that discussion, the current shortcomings of the current strategy are presented, and trends in the health care market are discussed.

Current Shortcomings in Plan Design and Process

These questions are prompted by several shortcomings with the existing benefit design of health plans offered to University faculty and staff for the 1998 contract year.

These shortcomings include:

- provision of services to University employees in Crookston, Morris, and Duluth that matches services available in the Twin Cities,
- improved out-of-area coverage for dependents, faculty on sabbatical, as well as retirees who live in other states,
- inclusion of the University of Minnesota Physicians (UMP) in more than one health care network,
- improved access and coverage of mental health services,
- rationalization of benefits for domestic partners and people with family coverage, and
- continuity of coverage and health plans over time.

Premiums are constant across all campuses, yet University faculty and staff at the three outstate campuses have fewer alternatives than are available at the Twin Cities campus. A change in the current purchasing relationship with SEGIP may have more significant effects for outstate faculty and staff than employees at the Twin Cities campus. Choosing one of the possible options - "winner take all"/total replacement - would result in the loss of HealthPartners Classic and/or Medica Primary in some counties. Every purchasing arrangement discussed below has implications for outstate counties equal or less significant than this case of total replacement. This first shortcoming is primarily an issue of access and quality of care for employees at outstate campuses.

The next three shortcomings all represent more expensive additions to the current benefits designed for the 1998 contract year. Only one of the six health plans - State Health Plan - covers medical services received outside of Minnesota. For faculty on sabbatical or employees with college-age dependents living in other states, coverage is only provided on an emergency basis for all health plans except the State Health Plan. The State Health Plan's provision of out-of-area coverage is one source of "adverse selection" that the health plan would experience because University employees with dependents in college would choose this plan. The inclusion of University of Minnesota Physicians will unquestionably increase the cost of any and all health plans that add UMP to their networks of eligible providers. University employees have lost the convenience of seeing on-campus providers, unless they incur the sizable out-of-pocket cost of the State Health Plan. Similarly, better coverage for mental health services will only come at increased cost, which can only be mitigated with some type of utilization review or cost-sharing (e.g. copayments, deductibles and coinsurance) is required.

The fifth issue - greater rationalization of benefits for domestic partners and people with family coverage - can only be addressed by making administrative changes at the University and SEGIP levels. Current problems with rationalization include the requirement that all employees have University

health insurance and duplication of benefits if University employees are covered under a spouse's family coverage plan outside the University. No discussion or resolution to these types of problems are addressed in this report, but are listed for consideration by the Committee alongside the other issues.

The sixth and last issue deals with the long-term stability of existing relationships with providers. With the loss of Medica Premier in particular, 31% of all University employees were required to establish new relationships with different health plans and, potentially, with new providers. As one of many actors in the Twin Cities health insurance market, the University is limited in the degree of stability it can bring to the market. The University and SEGIP must instead strengthen relationships with existing health plans, and encourage the formation of new competitors than can meet the needs of University faculty and staff. The changes in 1998 health benefits were largely not in the control of SEGIP and the University. Even if the University had not been purchasing health insurance with SEGIP, premium increases probably would have occurred because Twin Cities employers saw premiums increase across the board. No employer or purchasing strategy was immune from premium increases in 1998, with the exception of the City of St. Paul (see page 27).

Before addressing each purchasing option, recent and expected trends in the Twin Cities health care market are presented.

Trends in the Health Care Market

With the consolidation of the health care market in recent years, the range of health plan choices open to University faculty and staff is expected to remain fairly limited. Three carriers currently have 85% of the Twin Cities' health plan market share. Blue Cross, Allina, and HealthPartners are the only major health plans in the Twin Cities, and Blue Cross is the only carrier that provides insurance products in every county of the state. This consolidation motivated employers to take a more proactive role in purchasing health insurance.

In the first half of this decade, health insurance premiums per month were increasing by at least 10% per year. Between 1994 and 1995, total premiums increased less than 2% for the state's largest HMOs, and by less than 1% between 1995 and 1996. In 1997, total premium increases for Blue Plus, HealthPartners, and Medica averaged between 9.0 and 9.5% (MDH, October 1997). Total premiums for the SEGIP health plans will rise by 9.7%, on average, in 1998.

The primary reason that total premiums are increasing so dramatically after several years of moderate growth is that revenues have not kept pace with expenditures for the major carriers. The previous two years of relatively flat premium growth were driven by employer purchasing strategies and competitive pricing by health plans to gain market share. These pricing policies are not sustainable, as carriers seek to raise premium revenue to match rising medical expenditures (MDH, October 1997). Medical expenditures increased in recent years due to employee utilization of physician and outpatient services that was greater than the expected utilization.

Employers can try to restore more moderate premium increases by aggressively managing their health benefits and adopting different purchasing strategies. The two most widely used purchasing strategies (that will be discussed in detail below) are total replacement and self-insurance. In 1993, most Minnesota employers with 100 or more employees offered only one health plan (MDH, 1995). Much has changed since that time, but total replacement remains a popular purchasing approach that limits premium cost increases. The City of St. Paul is replacing a Medica health plan with a HealthPartners plan for 1998 and will see total premiums actually decline by 6.5%.

BHCAG has introduced a new organizational approach to Twin Cities and Duluth markets by contracting for services directly with providers and hospitals. They have also been successful at keeping premium increases below the market average for the past several years with this combination of "direct

contracting" and self-insurance. However, premiums for the 1998 contract year have increased significantly and will likely increase further in coming years.

Self-insurance is the other popular purchasing strategy, particularly among private sector and large employers. In 1995, forty-six percent of all private sector employees were enrolled in self-insured plans, and 62% of enrollees in firms with 100 or more employees were in self-insured health plans. The total number of people enrolled in self-insured plans in Minnesota roughly doubled from 700,000 in 1991 to 1,500,000 in 1995. In 1996, 1,600,000 people were enrolled in self-insured health plans in Minnesota (Baumgarten, 1997). The number of private sector employees enrolled in self-insured plans is heavily influenced by the self-insured BHCAG member companies. Even public sector firms have used self-insurance as a means to contain health care costs. SEGIP self-insures its State Health Plan and State Health Plan Select products, which enroll 30% of University faculty and staff.

The success of these various purchasers can be seen in Table 1 below that compares the two major purchasing pools in the state - SEGIP and BHCAG - with the rate of growth in premiums of HMO commercial products.

Table 1. Percentage Premium Changes by Group, 1990-1997

Year	State Employee Group Insurance Program	Buyers Health Care Action Group	HMO Commercial Products
1990	13.7%	n/a	16.9%
1991	9.6	n/a	14.5
1992	6.3	n/a	7.5
1993	5.9	-11.0%	5.8
1994	3.0	4.2%	4.2
1995	-1.7	3.8%	-0.6
1996	-2.5	4.0%	n/a
1997	7.0	4.0%	n/a

As Table 1 illustrates, both major purchasers have been fairly effective at containing premium increases. Total premiums will, however, continue to increase as long as premium revenue is below incurred claims, which has been

the case for the past two years. A more detailed discussion of other purchasing strategies and premium costs for 1998 are addressed in the next section.

Alternative Models of Health Insurance Provision

Each purchasing option discussed below is a different combination of the financing and decision-making alternatives outlined above. The options are as follows:

A. Membership with BHCAG via SEGIP
    1. Adopt the BHCAG model only
    2. Addition of BHCAG model to conventional plans
B. Independent Adoption of the BHCAG model
    1. Adoption of the BHCAG model with SEGIP
    2. Adoption of the BHCAG model without SEGIP
C. Total replacement with one health plan
D. Variations on the Status Quo
    1. Current system with the State (Status Quo)
    2. Current system without the State
    3. Medical Savings Accounts and Cafeteria Benefits

The comparative benefits and challenges of each approach are addressed in turn, starting with joining the Buyers Health Care Action Group.

A. Membership with BHCAG via SEGIP

The State Employee Group Insurance Program (SEGIP) has been an associate member of BHCAG since 1995. BHCAG was organized in 1988 and by 1993 became the second largest purchasing pool in the state, with SEGIP as the largest pool. Enrollment in SEGIP has remained fairly constant in the past five

years, reaching 60,000 employees in 1997. University faculty and staff were 14,279 of the 60,000. The total of 156,000 employees, dependents and retirees were eligible for health benefits sponsored by SEGIP. Enrollment in BHCAG has increased from 90,000 in 1994 to 125,000 in 1997. The total eligible population of employees, retirees, and dependents in BHCAG member companies reached 425,000 in 1997. As the two dominant purchasers of health insurance in the state, SEGIP and BHCAG share similar interests and concerns about changes in the health care market.

BHCAG is currently a coalition of 28 large, self-insured employers representing 425,000 employees, retirees, and dependents. 120,000 employees in these 28 employers enroll in Choice Plus. The 28 employers that are full members of BHCAG as of December, 1997 include:

- AMEX Financial Advisors
- Bemis
- Cargill, Inc.
- Carlson Companies, Inc.
- CENEX, Inc.
- Ceridian Corporation
- Cub Foods
- Dayton Hudson Corporation
- Dayton's
- Edina Realty Group/AmerUS
- First Bank System
- General Mills
- Honeywell Inc.
- Jostens
- Land O' Lakes, Inc.
- MERVYN'S
- Minnegasco
- Minnesota Mutual
- Northern State Power Company
- Norwest Corporation
- Pfizer Inc.
- The Pillsbury Company
- Rosemount Inc.
- BF Goodrich Rosemount Aerospace
- SUPERVALU INC.
- Target Stores
- Tennant
- 3M

BHCAG's approach to purchasing medical services by "direct contracting" represents the latest employer response to organizational changes in the Twin Cities market. Physicians, clinics, and hospitals organized into nineteen different Care Systems that bid to provide services to employees of BHCAG member companies. The physician network for Choice Plus is based primarily upon the hospitals and physicians with whom HealthPartners had ongoing

contractual relationships. Most employers offered employees the Choice Plus health plan in addition to one or more pre-existing indemnity and managed care plans, while four employers offered Choice Plus exclusively. The majority of employers that offer more than just the Choice Plus plan are phasing out their other managed care plans to eliminate duplication in provider networks. Indemnity plans continue to be offered for employees who prefer non-managed care plans, although these plans tend to have significant cost-sharing.

The BHCAG model combines self-insurance of employee health insurance with direct contracting with physicians for medical services. Direct contracting is defined as a contract for health care services offered by a provider sponsored organization, such as a Physician-Hospital Organization (PHO), to an employer in which the PHO accepts the risk for utilization of health care services above the anticipated level. The direct contracting that BHCAG employs is slightly different than the arrangement defined in a recent state report on direct contracting. In February 1997, the Departments of Commerce and Health submitted a report on direct contracting to the Legislature entitled "Direct Contracting for Health Care Services". This report cited several possible advantages of direct contracting:

- counter to trends toward consolidation and to encourage increased competition in the health care market,
- increased consumer choice and information,
- increased reporting of provider accountability and incentives for cost-effective, high-quality care,
- depending on state regulation, employers provided exemption from mandated benefits, premium taxes, and other insurance laws on par with ERISA exemption in self-insurance.

Several possible disadvantages were also cited:

- decreased assurance that enrollees have access to adequate services,
- less consumer protection in areas of contract disagreements, quality control, utilization review, marketing, disclosure,
- increased, rather than decreased, administrative costs
- increased consumer exposure to risk of provider insolvency.

Published information by both BHCAG and the Minnesota Department of Employee Relations (DOER) indicate a strong interest by DOER in offering BHCAG's Choice Plus product. Adoption of the BHCAG model would require the University to self-insure the risk for University faculty and staff, as BHCAG member companies do for their employees. The University population probably is large enough to minimize any risks that the University would face in self-insurance.

If DOER becomes a full member and the University remains with BHCAG, then the University has two ways to approach this decision, corresponding to two ways that BHCAG member companies structure their employee health benefits. Several member companies offer only the Choice Plus health plan, while several other member companies offer the Choice Plus plan as well as multiple, conventional health plans that were offered prior to BHCAG's formation. Each approach has unique costs and benefits, although most employers are moving towards offering the Choice Plus health plan exclusively.

A.1. Adopt the BHCAG Model Only

The University may want to consider joining BHCAG with the State and obtain health insurance by "direct contracting" and "self-insurance". Should the University decide to join BHCAG via SEGIP, the experience of member companies that offer only the Choice Plus plan and the experience of member companies that offer additional plans should be compared.

Employers with BHCAG Care System Model only

Four BHCAG member companies, including the Carlson Companies, offered only the Choice Plus health plan to their employees. These employers replaced their previous plan offerings with Choice Plus which offered employees a choice of 19 different sets of multispecialty groups and hospitals to choose from. This replacement was undertaken to simplify the health benefits

offered to Twin Cities employees which, in turn, reduced Carlson Companies' administrative costs.

Carlson Companies Inc. offers employees only the BHCAG Choice Plus health plan and charges monthly employee premiums that increase with each Cost Group. Employee premiums for single coverage are $10.64, $17.56, or $24.48 for Cost Groups I, II, or III, respectively. Employee premiums for family coverage are $54.66, $63.66, or $75.43 for the three respective Cost Groups. Total premiums were not available from Carlson Companies Inc. See Appendices 5 and 6 for more comparison information.

Lessons from these employers can be applied to the University's health benefits offerings. The possible advantages and disadvantages of offering only the Choice Plus health plan are listed in Table 2 below.

Table 2. Comparison of Offering Only Choice Plus

Advantages	Disadvantages
◇ partnership with a stable organization that has established relationships with providers in the community,	◇ increased risk to the University by self-insuring entire population,
◇ savings generated by purchasing power of a large, pooled population,	◇ University of Minnesota Physicians are not an integral part of any care system but acts as a tertiary care referral network,
◇ care systems in Duluth area exist in current Choice Plus health plan,	◇ no care systems are currently available to the Crookston and Morris campuses
◇ exemption from state mandated benefits, premium taxes, and other insurance regulation by self-insuring	◇ University would have a much smaller voice than in its current relationship with SEGIP

These are the possible advantages and disadvantages of replacing the multiple health plans currently offered with Choice Plus exclusively. The last consideration of this purchasing strategy has to do with the four questions that should be asked in evaluating all the purchasing strategies. These questions were first mentioned on page 3 and are listed again here:

1) *Where do the risks lie in each option?*
2) *What are the costs of each option?*
3) *What recourse exists for addressing problems with providers?*
4) *What are the consequences of problems with a carrier?*

In the BHCAG model, the insurance risk lies with the employer since each employer self-insures the risk of its own employees. The degree of liability the University would be exposed to can be limited by working with a reinsurance company that takes responsibility for all claims above $50 million, for example.

The costs of total replacement with the Choice Plus plan cannot be specifically assessed without detailed actuarial data. The weighted average total premium for single coverage in 1998 is estimated to be $176.39, and the corresponding total premium for family coverage in 1998 is $440.51. These premiums are averaged over all University employees enrolled in health plans available at the Twin Cities campus. Total premiums for single and family coverage, as well as employee premiums, are likely to be higher in a Choice Plus plan for employees that currently enroll in the lower cost health plans, but lower for employees that enroll in the State Health Plan. Administrative costs are likely to be comparable or lower since only one health plan with three different cost groups would have to be administered. No dollar figures can be provided for any of these costs. BHCAG and SEGIP would need to be contacted to obtain the actuarial data necessary to provide these figures.

Problems with providers would be simplified in the BHCAG model because the purchasing power of SEGIP would be greatly enhanced by adding the clout of the BHCAG member companies. Care systems have to compete with one another for enrollees and would have to be responsive to University needs to remain competitive. Problems with the carrier are not relevant in this self-insured arrangement because the employer is the carrier. In this approach, the University would have a much smaller voice because it would represent only 15,000 of 125,000 employees enrolled in the Choice Plus health plan, instead of representing 25-33% of all enrollees in the purchasing partnership with SEGIP. The most important pieces of information needed to evaluate this arrangement, which is not currently available, are the total premium and administrative costs to the University.

A.2. Addition of BHCAG Model to conventional plans

The decision to join BHCAG and to offer their Choice Plus health plan in no way precludes the University from continuing to offer existing health plans to faculty and staff. This option provides both flexibility and diversity in health plan offerings, allowing the University and SEGIP the freedom to compare the experience of the two models directly. The University and SEGIP benefit from the negotiating power of BHCAG and can use this power to influence the outcome of annual negotiations at the Joint Labor-Management Committee.

Employers with Care System and Conventional Health Plans

Several other employers in BHCAG maintained their prior, conventional health plan offerings (comparable to the seven plans at the University), and simply added the Choice Plus health plan. Cargill and Jostens are the two BHCAG member companies that offered one health plan in addition to the Choice Plus plan that were contacted for information.

Cargill employees with single coverage had to pay $10.00, $20.00, or $30.00 as a per month employee premium contribution for Choice Plus Cost Groups I, II, or III, respectively. Employees with family coverage had to pay $45.00, $70.00, or $95.00 as a per month premium contribution, respectively. The two other options available to Cargill employees were indemnity plans called Unicare Options One and Two. The single coverage employee premiums per month were $30.00 and $15.00, respectively. The family coverage employee premiums per month were $105.00 for Option One and $30.00 for Option Two.

These sizable employee premium differences were based on differences in deductibles and annual out-of-pocket maximums between the two indemnity plans. The Unicare Option One has a $250 single coverage deductible and a $600 family coverage deductible, while Option Two has a $500 single coverage deductible and a $1000 family coverage deductible. The single and family annual out-of-pocket maximums are $2000 and $4000 for Option One and $3000

and $6000 for Option Two, respectively. All other features of the Unicare plans, including covered benefits, are the same for the two Options. Benefits are covered at 80-90% for most services, including hospitalizations, mental health, and physician office visits. These benefits are less generous than the Choice Plus in-network coverage, but more generous than the Choice Plus coverage of out-of-network services. See Appendices 5 and 6 for more comparison information.

Jostens also offers one indemnity health plan alongside the Choice Plus plan managed by BHCAG. Nine hundred and seventy nine employees are eligible to enroll in these plans, and all but sixty nine employees have some type of health insurance. 704 of the 910 enroll in the Choice Plus plan. The indemnity plan, called MedCare 500, has total premiums per month of $171.00 for single coverage and $509.00 for family coverage. The employee portion of the total premium is $9.00 for single coverage and $36.00 for family coverage. This indemnity plan requires a $500 and $1000 deductible for single and family coverage, respectively. All other services are covered at 80%. Again, these benefits are less generous than in-network services, but are more generous than coverage for out-of-network services in the Choice Plus plan.

The total premiums per month for the Choice Plus are $177.00, $182.00, or $188.00 for single coverage in Cost Groups I, II, or III. Total premiums per month are $531.00, $546.00, or $564.00 for family coverage in Cost Groups I, II, or III. The employee portions of the premium for single coverage per month are $15.00, $20.00, or $26.00, and the employee premiums per month for family coverage are $58.00, $73.00, or $91.00. These employee premiums are significantly higher than the indemnity plan's premiums, even for the lowest Cost Group I. Deductibles and annual out-of-pocket maximums are lower in the Choice Plus plan which explains a large part of this difference. The Choice Plus plan also covers preventive services, eye/ear exams, and chiropractic care that are not covered in the indemnity plan.

The advantages and disadvantages of this strategy include the following:

Table 3. Comparison of BHCAG and conventional plan strategy

Advantages	Disadvantages
◇ broad range of choices for faculty and staff	◇ complicated comparison of benefits and costs in the conventional and care system models
◇ greater leverage in negotiating health benefits with existing health plans	◇ risk adjustment in care system model would have to be dropped or extended to existing plans
◇ ability of employees to move across care systems in Choice Plus plan	◇ health plans may actually increase premiums in first few years because of uncertainty in expected enrollment
◇ possibly greater dispersion of risk and selection to reduce burden in SHP	◇ Choice Plus and current managed care plans would be duplicative to some degree

The answers to the four questions about risk, costs, provider problems and carrier problems are similar to the previous discussion of replacing the existing plans with Choice Plus, but adds a level of complexity. The Choice Plus plan has several features that are dissimilar to the current arrangement that would add administrative costs, in particular the self-insurance of Choice Plus and the risk adjustment mechanism that is used to determine payments to each care system. All BHCAG member companies self-insure their employees enrolled in Choice Plus and the University would initially face uncertainty in setting total and employee premiums in this plan because of the uncertainty in forecasting expected medical expenses that would be paid with University funds. Underestimating the expected medical expenses would expose the University to potentially significant costs, while overestimating expenses and total premiums might make the Choice Plus plan unattractive to faculty and staff.

If risk adjustment was not applied to the non-Choice Plus health plan offerings, the adverse selection that the State Health Plan might expect to receive would not be reflected in its revenue. Care systems in this combined strategy would not face the same risk of enrolling a relatively more costly population, because the increased risk would be reflected in their payments and this inconsistency would place the State Health Plan on a more uneven playing field

than current exists. Implementing a risk adjustment system could be costly in terms of personnel and computer resources.

Employees might benefit in the case of problems with providers and carriers because employees could buy into the flexibility in providers that is offered in the Choice Plus plan. In addition, the current health plans might be forced to charge lower total premiums to avoid losing premium revenue to the care systems in Choice Plus. To better understand the cost effects of this combined purchasing strategy, the experience of BHCAG member companies that have a similar arrangement (e.g. Cargill and Jostens) would need to be explored. See Appendices 5 and 6 for more comparison information.

B. Independent Adoption of the BHCAG Model

B.1. Adoption of the BHCAG Model with SEGIP

A variant of joining BHCAG is to adopt the BHCAG model to satisfy the particular needs of State and University employees. SEGIP represents 156,000 State of Minnesota and University employees that is large enough to bid directly with the care systems that were established to respond to the BHCAG proposal. The advantages and disadvantages of this independent adoption of the care system model are listed in Table 4.

Table 4. Comparison of Adopting the Care System Model

Advantages	Disadvantages
✧ University can design plan to faculty and staff needs	✧ Significant costs to starting a new model and negotiating with care systems
✧ Current shortcomings that are also not addressed in BHCAG plans can be fixed	✧ Loss of purchasing power by working with BHCAG
✧ Faculty and staff can switch providers or systems more easily than in current system	✧ UMP does not currently have its own care system which faculty and staff would want

If the University chose to adopt the care system model with SEGIP independent of BHCAG, it would face a number of new issues whether it added Choice Plus to the current offerings or replaced the current offerings with Choice

Plus. The total and employee premium cost implications are uncertain at this time, because actuarial data on the medical experience of the University is unavailable. Cost estimates of this approach can only be estimated with assistance from SEGIP and possibly HealthPartners, the health plan administrator of BHCAG's Choice Plus health plan. The University would have to self-insure all costs of enrollees that joined a Choice Plus-type product because the care systems are not in the business of insurance and are not currently prepared to take on this responsibility. Administrative costs would increase slightly, but the University and SEGIP would have much greater control over the design and structure over health benefits than if SEGIP joined BHCAG as a full member.

Current shortcomings in the benefit design could more easily be addressed because the University and SEGIP would, in essence, be the carrier and could include any benefits agreed upon in the Joint Labor-Management Committee. In this purchasing strategy, the University would merely have to negotiate with SEGIP on design changes and not with the full BHCAG steering committee, on great advantage to this approach. This independent adoption strategy would not take advantage of the greater purchasing power that would be available by joining BHCAG directly. In particular, the University of Minnesota Physicians could be added more easily than if the SEGIP joined BHCAG because all parties have expressed an interest in improving access to University providers.

B.2. Adoption of BHCAG Model without SEGIP

The final variant on the BHCAG model would be to strike out independently and to adopt the BHCAG model for use by University faculty and staff in the Twin Cities, Morris, Crookston, and Duluth. Self-insurance of just the University faculty and staff would introduce an array of benefits and risks that are not currently relevant in the current purchasing partnership with

the state. The advantages and disadvantages of this purchasing strategy are listed below in Table 5.

Table 5. Comparison of Independent Adoption of BHCAG Model

Advantages	Disadvantages
✧ Not required to provide mandated benefits, pay premium taxes, and comply with other insurance regulations	✧ A few high cost cases can drive the University insurance account into a deficit
✧ University could obtain a benefit design that better matches needs of faculty and staff	✧ Loss of purchasing power without State employees
✧ The State might be more willing to meet University needs if this is seen as a realistic option	✧ UMP may not be able to create a (primary) care system to address identified need for one
✧ BHCAG model gives employees freedom to move across care systems in a cost group	✧ new set of administrative costs would have to be taken on by the University

This purchasing strategy would entail the same risk of self-insurance as all previous BHCAG options. However, there are several unique aspects to this purchasing strategy. The University would have to self-insure a smaller group than the full SEGIP population which would decrease the predictability of medical expenses. This strategy would provide the greatest flexibility and freedom in benefit design to address the shortcomings of the existing plan offerings. This freedom would come at some cost, however, because the University would lose some of the purchasing power it currently enjoys by buying health insurance with SEGIP. If the faculty was the only group to separate from SEGIP, its purchasing power would shrink simply because the group would be one-twelfth of its current size. The University would also have to take on the full costs of establishing and administering health benefits that are currently taken on by the Department of Employee Relations. These costs may be justified if the University faculty is willing to tradeoff potentially higher total and employee costs for greater freedom in plan design.

C. Total Replacement

The most radical option would be to scrap the current system in entirety and to obtain health insurance from only one health plan. More large,

Minnesota employers use total replacement than any other purchasing strategy. Seventy percent of employers in the metropolitan area offer one health plan to employees (Kathy Burek, Testimony, November 1997).

This purchasing strategy has several possible benefits and costs that should be considered carefully, particularly because of this strategy's implications for outstate employees. These benefits and costs are in Table 6.

Table 6. Comparison of Total Replacement

Advantages	Disadvantages
◇ "Winner take all" approach forces carriers to bid aggressively to insure the entire eligible population	◇ Many employees may have to switch providers every time there is a change in carriers
◇ Administrative costs and responsibilities of managing and negotiating health benefits are simplified by dealing with only one carrier	◇ Considerations for outstate employees will significant narrow the range of feasible options, and may actually drive the outcome
◇ Stability of provider network	◇ There is no intra-employer competition amongst carriers to keep premiums low
◇ The University will have one carrier dedicated to serving the needs of faculty/staff	◇ Retirees not enrolled in Medicare may have problems

The insurance risk in a total replacement strategy can either be borne by the University or the carrier, depending upon whether or not the University self-insures the sole health plan. The greatest cost savings in this purchasing strategy comes during the bidding process, when health plans try to offer the lowest total premium to win the University's entire population. The obvious downsides are the fact that the University is locked into a relationship with only one carrier and loses the benefits of having multiple health plans competing for enrollees. Adoption of the total replacement strategy would also require many faculty and staff to switch providers if the new health plan did not add them to its provider network. Both Macalaster College and the City of St. Paul employ this purchasing strategy and their total premiums are a bit higher than the weighted average total premium faced by University faculty and staff. Administrative costs would be simplified for the University and SEGIP by only having to deal with one carrier, but problems with providers and the carrier might be more difficult to resolve than in some of the other purchasing strategies.

D. Variations on the Status Quo

D.1. Current System with the State (Status Quo)

The University could maintain its current relationship with the State. In this case, health benefits for University employees would be determined by the Joint Labor-Management committee which recently increased University representation from one to two members. There is an array of costs that are required in other alternatives that are minimized by continuing to purchase health insurance with the state. This is the strongest argument to maintain the status quo. The argument that the interests and concerns of University faculty and staff are not well represented at SEGIP may be weakened if the State increases the University membership from two to three.

The University will still have little control over organizational changes in the Twin Cities market and changes in health plan offerings, but remaining with the state will continue to give the University the greatest possible purchasing power. In light of the increase in University representation on the Joint Labor-Management Committee, there are several advantages to maintaining the existing relationship. The differing objectives of University and non-University members of the Joint Labor-Management Committee may still be a problem. The advantages and disadvantages of this strategy are listed in Table 7.

Table 7. Comparison of Status Quo

Advantages	Disadvantages
✧ Greatest possible purchasing power available, with the exception of BHCAG, which translates into lower premiums	✧ Issues specific to University faculty are not reflected in current health plan design (e.g. out-of-state coverage for sabbatical)
✧ The University does not directly take on the administrative costs and responsibilities of managing and negotiating health benefits	✧ Outcome of negotiations are primarily union-driven; issues for union are in some respects different than our issues
✧ Increased representation in 1998 will provide direct faculty/staff input	✧ University cannot offer separate plans that would address shortcomings
✧ Some of faculty and staff needs are also concerns of labor unions	✧ We have access to data on our experience for internal analyses

D.2. Current System without the State

In a similar vein, the University could part ways with the State and actively negotiate health insurance with multiple health plans. By negotiating health benefits directly for University faculty and staff, current shortcomings in the current purchasing strategy with the state can be addressed more directly. If the University population is a higher average risk than the total SEGIP population, and the size of the purchasing pool is reduced, higher premiums for the same plan may result. In addition, a host of administrative costs and responsibilities would be incurred by the Employee Benefits Division that are currently handled by SEGIP. The full array of advantages and disadvantages to this approach are listed in Table 8 below.

Table 8. Comparison of Separating from SEGIP

Advantages	Disadvantages
◇ Specific needs of faculty and staff can be directly addressed in plan design ◇ UMP (and Boynton) can be added to any and all networks via RFP process ◇ Greater control over the outcome and more likely to get plans that meet most needs ◇ University has greater freedom to join BHCAG or pursue new strategies that State doesn't pursue because of union constraints	◇ Potential increase in premiums from increase in average risk and decrease in size ◇ New administrative costs and responsibilities for Employee Benefits ◇ University will have lower purchasing power than in current relationship with state ◇ Negotiations will be complicated because of need to address needs of outstate employees

Answers to the four questions about risk, costs, and problems with providers and carriers for this strategy are similar to the answers for adopting the BHCAG model without SEGIP (see page 20). The insurance risks in this strategy would still lie with the carriers that offer the managed care plans (e.g. Medica/Allina and Health Partners). The University would become directly responsible for self-insuring faculty and staff that enroll in the State Health Plan and the State Health Plan Select. To the degree that these enrollees were higher cost than non-University enrollees, the total and employee premiums for these two health plans would increase. The administrative costs of separating from the State and having to contract directly with these health plans would be

significiant. Several human resources personnel would have to be hired to take over responsibilities that are currently handled by the Department of Employee Relations (DOER).

There are a number of advantages to this purchasing strategy. Problems with providers, carriers, and benefit design would be easier resolve because the Joint Labor-Management Committee would no longer be the decision-making body for health benefits. Access to University of Minnesota Physicians and out-of-area coverage could easily be added to the existing benefit design. The University would also be able to implement a domestic partners policy and possibly rationalize the duplicate coverage that some employees experience if both spouses work at the University. As mentioned earlier, these benefit improvements would come at greater cost, but the University would have greater flexibility in consideration these changes than is currently possible under the Joint Labor-Management Committee process.

D.3. Medical Savings Accounts and Cafeteria Benefits

The last purchasing strategy represents a change that several public and private purchasers are experimenting with. Medical savings accounts (MSAs) are tax-exempt accounts, similar to existing flexible spending accounts, which can be established to 1) allow for payment of out-of-pocket medical expenses (e.g. coinsurance, deductibles, uninsured care like eyeglasses), and 2) allow for the accumulation of savings to pay for future medical expenses (MDH, January 1996). MSAs are designed to be used in conjunction with high-deductible health plans, which are not commonly offered by managed care companies like Allina and HealthPartners. This type of insurance arrangement is currently available to a more limited extent with the health care reimbursement account/flexible spending account available to University faculty and staff. The advantages and disadvantages of the MSA/FSA approach are the following:

Table 9. Comparison of Medical Savings Accounts

Advantages	Disadvantages
✧ More employee control over health spending	✧ People may forgo preventive services
✧ Greater cost-consciousness in use of medical services	✧ MSA users will probably have to enroll in non-managed care plans to enjoy benefits
✧ Lower health plan administrative costs because fewer insurance claims submitted	✧ University will face higher administrative costs to process more MSA claims
✧ More direct choice of physicians	✧ Employee pool may be further segmented

The University does not currently have the administrative and computing capability to establish a medical savings account program, nor would these accounts be exempt from taxation under current Federal regulation. Greater education and employee use of flexible spending accounts is a feasible variation to this option. This option could someday address the need to rationalize coverage for families who currently are required to have University health insurance even though they are covered by a spouse's plan. To date, the University does not have a full-fledged flexible benefit program in which health insurance dollars could be spent on other benefit options. Work on developing these options must first be undertaken by the Office of Human Resources before these benefits can be offered to University faculty and staff.

Profiles of Other Employers - Current Employees

To provide some comparison and context for the University's current health plan offerings, a group of seven large employers were asked to share information on their employee health insurance benefits. This group included one local academic institution (Macalaster College), local non-BHCAG employers (Medtronic and Toro), and two Big 10 Universities contacted for this study (Wisconsin and Penn State). The City of St. Paul was also contacted to provide a perspective from an employer that offers only one health plan (or total replacement).[2] Three BHCAG member companies - Carlson Companies Inc.,

[2] It should be noted that the sample of employers was drawn in an arbitrary way. Macalaster College was chosen to represent academic institutions in the same market area that would face similar employee issues as the University of Minnesota (e.g. sabbatical). Medtronic and Toro

Cargill, and Jostens - were discussed above and are included in the Appendices at the end of the report.

Macalaster College

One HealthPartners health plan is offered to Macalaster College faculty and staff. The monthly total premium for single coverage is $156.15 for the 1998 contract year, and the monthly total premium for family coverage is $427.91. The employee contributes nothing for single coverage, and $271.76 per month for family coverage. One interesting feature of Macalaster's health benefit is the freedom that employees have to opt out of the health plan and to receive $50.00 per month in flexible dollars to be spent on other benefits in a cafeteria plan (e.g. flexible spending or dependent care accounts). Employees can also receive these funds as a taxable cash benefit.

This HealthPartners plan has 100% coverage for services sought in-network, and 80% coverage for most services obtained out-of-network. Preventive dental services are the only dental services covered in this plan. The network of mental health providers is quite extensive, and mental health services are covered in an inpatient and outpatient setting. Retirees are not eligible for health benefits of any kind after retirement. Employees on sabbatical are responsible for the full cost of health insurance they obtain to cover medical expenses incurred outside of the Twin Cities. See Appendices 5 and 6 for more comparison information.

Medtronic

Medtronic offers one Medica plan and one Health Partners product to their employees. The monthly total premium for single coverage for Medica is $154, and $463 for family coverage. The employee contributes $39 per month for

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were chosen to represent large, non-BHCAG employers that would face similar issues as member companies of BHCAG. The University of Wisconsin and Penn State University were chosen as Big 10 Universities that would compete for faculty.

individual coverage and $116 per month for family coverage for the Medica plan. The total monthly premium for the HealthPartners plan is $123 for an individual and $377 for family coverage. The employee contribution for the Health Partners product is $26 a month for individual coverage and $76 for family coverage.

The Medica plan has deductible for out-of-network individual ($300 a year) and family ($600 a year) coverage. Most of the other services are covered after a small copay. The Health Partners plan has no deductibles for either in-network or out-of-network coverage. Both plans are similar in coverage and only accidental dental coverage is covered in both plan.

Medtronic allows employees who retire before the age of 65 to maintain their health insurance at the same cost as when they were employed. However, after age 65, the employees must pick up Medicare to cover their health care costs. See Appendices 5 and 6 for more comparison information.

Toro

Toro employees in the Twin Cities are offered two health plans. The first health plan is offered to all Toro employees in the U.S. and is provided by the Mutual of Omaha Companies. The total and employee out-of-pocket premiums are quite similar in the two plans. The total premium per month for individual coverage in the Mutual of Omaha plan is $123.30, with the employee premium set at $24.66 in 1998. The total family premium is $368.63 with the employee premium set at $73.73 in 1998. The Mutual of Omaha plan has costs for in-network and out-of-network costs. There are no in-network costs for individuals and families, and the rest of the coverage seem to be very generous. The out-of-network deductibles are $250 for individual and $500 for family, with a maximum yearly cost of $1,000 per individual and $3,000 per family. For more specific information see appendix 1 of the Toro booklet for details.

The second health plan for Toro employees is the HealthPartners Choice plan which is a point-of-service HMO product. The total premium per month

for single coverage in this plan is $129.11, with an employee premium for $30.47 per month. The total family premium per month is $386.00, with an employee premium set at $91.10 per month. This plan requires co-payments for office visits, emergency care, prescription drugs, and home health care within the HealthPartners network. Out-of-network charges are 80% covered after deductible has been paid. (See appendix 2 of the Toro booklet).

The two health plans are similar in design and cost. The HealthPartners plan is a little more expensive, although it has a wider selection of physicians within the Twin Cities metro area. The Mutual of Omaha plan is carried by all Toro facilities nationwide so has a lower total premium by enrolling a larger number of employees. See Appendices 5 and 6 for more comparison information.

The University of Wisconsin

The University of Wisconsin and its affiliate campuses use the same purchasing model as the University of Minnesota. University faculty and staff receive the same health plan options as other state employees, and the State of Wisconsin's Department of Employee Trust Funds negotiates with bidding carriers in every county. The number of health plans available in each county varies from three to eight.

The total premiums for a given health plan are constant across counties, but the employer contribution varies across. Monthly total premiums for single coverage range from $167.58 to $305.28 and total premiums for family coverage range from $421.50 to $752.00. In all counties, the health plan with the lowest total premium requires no employee contribution, but most other plans require some employee contribution. The high premium plan, called Standard Plan, is an indemnity plan administered by Blue Cross Blue Shield of Wisconsin and is available in every county of the state. This plan allows freedom of provider choice anywhere in the world. The health plan with the second highest premium, called Standard Plan II, is also an indemnity plan administered by

Blue Cross Blue Shield of Wisconsin and has the same characteristics of the Standard Plan. The total premium in this plan is slightly lower because the deductibles and copayments are higher in the Standard Plan II. All other plans are managed care plans, either PPO or HMO plans with restricted provider networks and less generous out-of-network coverage. All HMO and PPO plans offer uniform benefits, but the indemnity plans have slightly better coverage for out-of-network services. This includes coverage for care of dependents in other states and coverage for care while travelling and on sabbatical.

Outpatient mental health care is covered and up to $1800 per calendar year, and inpatient mental health care is covered up to 30 days or $6300, whichever is less. No dental services are insured by the HMO health plans, but the indemnity plans do offer preventive dental care for children. See Appendices 3 and 4 for more comparison information.

Penn State University

The health plans offered to Penn State faculty and staff vary by geographic region the way health plan offerings vary across the four University of Minnesota campuses. All Penn State employees are offered an indemnity plan called Plan A, a PPO (preferred provider organization) plan called HealthPass, and at least one HMO. In major academic centers like State College, five HMOs compete alongside the PPO and indemnity plans for enrollment.

Penn State has a website (www.ohr.psu.edu/benefits/ttc/health.htm) which provided the data for this discussion. The only premium information available was the employee premium contribution amounts. For single coverage, the employee premium in 1997 for the PPO, indemnity, and HMO plans were $38.00, $52.00, and $8.00, respectively. Total premiums for single coverage in 1997 were $191.14, $220.06, and $123.60 or more depending upon the HMO. For family coverage, the employee premiums were $75.00, $101.00, and $16.00, respectively. The total premium for the three types of plans for family coverage in 1997 was $373.64, $428.28, and $323.49 or more, depending upon the

HMO. The indemnity plan - Plan A - has a specific design feature to provide health insurance for faculty travelling or on sabbatical in other states or countries. The PPO and indemnity health plans cover 80% of all medical expenses and freedom of provider choice. Employees are required to satisfy a deductible and pay 20% of remaining charges to contain costs. The HMO plan has complete coverage for services obtained at a participating Primary Care Physician and relies on this gatekeeping mechanism to contain costs.

City of St. Paul - Total Replacement

The City of St. Paul offers only one HealthPartners health plan to all 2900 of its employees, and has been able to keep its premiums fairly low. Total premiums for the HealthPartners plan in the 1998-1999 contract year are 6.5% lower than 1997 premiums. The single coverage monthly total premium will be $178.95 and $458.13 for family coverage. The employee contribution towards the total premium varies by bargaining unit, although the average contribution is close to $68.00. This reduction was obtained by, however, only by changing carriers. Medica was the carrier for the past six years, but lost the contract by offering a bid that was 16% higher than the HealthPartners bid.

Several coverage benefits were improved by switching to HealthPartners, including:

1) a reduction in the prescription drug copayment from $9.00 to $8.00,
2) elimination of the $5.00 preventive dental copayment,
3) the addition of an Extended Network of physicians to supplement the HealthPartners physician network and out-of-network coverage, and
4) improved coverage of home health care and skilled nursing facilities from 80% to 100%.

Clearly, the increase in benefits and decrease in employee premiums represents tremendous gains obtained by the total replacement strategy. However, many employees have had to switch providers, or receive coverage at a lower level if they remain with their physicians that are not at one of HealthPartners' in-network clinics. The addition of coverage for the Extended Network, which is

basically a preferred provider organization (PPO), is meant to minimize the employee costs of the change in carriers. It should be noted that the University of Minnesota Physicians are not available to City of St. Paul employees, except in the case of tertiary care. See Appendices 5 and 6 for more comparison information.

Profiles of Retiree Benefits at Other Universities

University of Minnesota retirees not eligible for Medicare are required to pay the total premium if they want to continue their health insurance coverage. This University policy is also followed at several large research universities around the country. Other universities do continue to subsidize the health insurance of faculty and staff upon retirement. The universities that are compared include the University of Washington, the University of Michigan, Purdue University, the University of Illinois, Penn State University, the University of Wisconsin, and the University of Iowa. The Toro company is a local employer that was also included because of its novel retiree premium policy.

The University of Washington offers nine health plans to retirees who are not yet eligible for Medicare. These are the same plans available to active University employees. Retirees are responsible for the total premium which ranges from $118.47 to $162.43 per month for single coverage and from $317.82 to $438.71 per month for family coverage. See Appendices 7 and 8 for more comparisons of retiree premiums.

The University of Wisconsin and Purdue University make available several health plans to their retirees, but provide no premium subsidy. Retirees are required to pay the total premium themselves if they choose to continue their coverage. The University of Wisconsin offers an indemnity plan, an HMO plan, and a PPO (preferred provider organization) plan. Total premiums are $185.00, $135.00, and $153.00 for single coverage, respectively. Total premiums are $483.00, $330.00, and $360.00 for family coverage, respectively. Purdue

University offers an indemnity plan and an HMO plan. The total premiums for single coverage are $146.00 and $123.00, and $292.00 and $146.00 for family coverage.

The University of Michigan, Pennsylvania State University, the University of Illinois and the University of Iowa do subsidize the total premium for retirees. The University of Michigan offers an indemnity plan, an HMO plan, and a PPO plan. The total premiums for single coverage are $57.00, $116.00, and $150.00, and employee premiums for the three plans are $0.00, $47.00, and $81.00. At Penn State University, retirees can enroll in an indemnity or an HMO plan. The total premiums are $124.00 and $54.00 for single coverage, and $250.00 and $112.00 for family coverage. The employee premiums for the two plans are $6.00 for single coverage and $14.00 for family coverage. The University of Illinois has an indemnity plan, an HMO plan, and a PPO plan. The total premiums for single coverage are $249.00, $170.00, and $182.00, and do not have any employee premium. The total premiums for family coverage are $596.00, $430.00, and $430.00. The employee premiums are $155.00, $108.00, and $108.00, respectively.

The University of Iowa offers three indemnity plans, primarily because managed care plans do not have significant market penetration in Iowa. The first indemnity plan covers 90% of all medical costs. The second indemnity plan covers 90% of all costs, but also has an $800 deductible. The third indemnity plan covers 80% of all costs. Total premiums for these plans range from $69.00 to $194.00 for single coverage, and $69.00 to $388.00 for family coverage. The University contributes $85.00 towards single and family coverage premiums.

Toro, a local employer, was also included because it has a hybrid retiree premium policy this is notable. Toro employees who have work at least 10 years are eligible for health benefits upon retirement. Until they reach age 62, retirees are responsible for paying the entire total premium of the health plan they choose. Between ages 62 and 65, retirees are required to pay only the employee premium contribution and Toro pays the employer portion as they would for active employees.

To remain competitive with other large research universities, the University may want to consider subsidizing health premiums for retirees across the board or using some variant of Toro's hybrid policy. See Appendices 7 and 8 for more comparison information on retiree premiums at other major universities.

Data Requirements for Further Analysis

This report represents the most basic analysis possible, providing the simplest forms of premium and coverage data obtainable without actuarial analysis. In order to reliably estimate the total premiums per month that the University faculty and staff would face, several types of data would be needed that were not available at the time of this report. These data requirements include the following:

- ◇ demographic profiles of University faculty and staff enrolled in each health plan currently offered,
- ◇ medical claims experience by age and gender cells for each health plan,
- ◇ estimates of costs for medical procedures covered in the projected health plan design, and
- ◇ cost-sharing parameters (e.g. coinsurance, deductibles, annual out-of-pocket maximums, copayments) in the health plan design.

The medical claims experience data is controlled by the Department of Employee Relations and is not broken out separately for University and non-University employees. The only way to generate reliable premium estimates in different scenarios (e.g. total replacement, BHCAG model) would be to obtain the University's claims experience and to run actuarial models with the four sets of factors identified above. Without these data elements, any estimate of the projected premium expense to the University faculty and staff would be highly suspect. However, an actuarial analysis of the University's experience is the logical next step if the faculty and staff want to be fully informed in moving from its current purchasing partnership with SEGIP. This report represents the

first step in a larger evaluation of the benefits and costs of alternative purchasing arrangements.

Summary

The current health insurance purchasing strategy is being evaluated for its effectiveness in meeting the needs and goals of University faculty and staff. There are several alternatives to the current partnership that the University has with the State Employee Group Insurance Program, including maintaining the status quo. The Task Force on Health Insurance, in conjunction with the Faculty Consultative Committee and the Senate Committee on Faculty Affairs, can use this report and any subsequent actuarial analysis to determine which purchasing strategy would provide the best coverage at the lowest cost. The greatest freedom in benefit design is afforded by separating from SEGIP, but this freedom would probably only come at greater premium and administrative cost. The lowest cost strategy may be to join BHCAG with the State, but this strategy would reduce the University's voice in decision-making.

The Task Force on Health Insurance may want to consider the risk and cost implications of its preferred alternative, as well as the way in which provider and carrier problems are resolved. The Appendices provide snapshots of premiums and benefits of employers using the different strategies for purchasing health insurance. These employers have managed their health benefits aggressively in response to consolidation in the Twin Cities health care market. Reliable cost estimates of moving to another purchasing strategy can only be generated by actuarial analyses that are beyond the scope of this report.

The needs of University faculty and staff have recently become of greater importance to State Employees Group Insurance Program, and the efforts of the Task Force on Health Insurance may be enough to motivate a change. However, the University is just one of many players in the local health care market. Improvements in benefit design and premiums will require a continued

Glossary of Terms

Adverse Selection - Adverse selection arises due to asymmetric information because individuals have a better sense of their risk than the company that insures them. Adverse selection is said to occur when individuals are able to purchase health insurance at rates which are below actuarially fair rates plus administrative costs.

Business risks - Risks that arise in the organization's conduct of its business. These risks generally refer to the risks involved in remaining profitable or in avoiding bankruptcy. For example, Medica Premier might have charged the right premium for the University population it covered (it got the *insurance risk* right), but might have been unprofitable because it spent too much of the premiums on administrative costs or suffered a huge liability from an unexpected lawsuit.

Carrier - An organization such as an insurance company, that provides or administers programs that arrange for medical, dental, life, or other insurance services. All of the companies that offer medical, dental, life, and optional insurance through the State Employee Group Insurance Program may be called carriers.

Direct Contracting - Direct contracting refers to a contract for health care services offered by a provider sponsored organization, such as a Physician-Hospital Organization (PHO), to an employer in which the PHO accepts the risk for utilization of health care services above the anticipated level. Direct contracting between an employer and a PHO eliminates the health plan as the bearer of *insurance risk*, and substitutes the employer and the PHO as the bearer of insurance risk.

Insurance risk - Risk arising from the pooling of risks and the advance funding of expected average costs. These are risks associated with matching the actual and expected medical costs of a given insured population.

Self-insurance - Employer acceptance of insurance risk for its employees by paying for all incurred expenses. Also referred to as self-funding.

State Employee Group Insurance Program - The health insurance purchasing arrangement organized by the State of Minnesota Department of Employee Relations. In the 1997-1998 contract year, SEGIP represented approximately 60,000 State and University employees. Health insurance is negotiated by representatives of DOER, AFSCME representatives, and representatives of the participating carriers. The University offers the health plans that result from these negotiations.

Comparison of University of Minnesota Health Plans, Family

Health Plan Name		University of Minnesota HP Classic	University of Minnesota HP Plan	University of Minnesota Medica Primary	University of Minnesota State Health Plan	University of Minnesota SHP Select	**Projected 1998 Weighted Ave. Premium for Twin Citie faculty and staff**	**Projected 1998 Weighted Ave. Premiums for Twin Cities faculty and staff excluding State Health Plan**
Emergencies		100%	100%	100%	100% + $30	100% + $30		
Hospital		100%	100%	100%	100%	100%		
Outpatient		100%	100%	100%	100%	100%		
Mental Health		100%	100%	100%	100%	100%		
Chiropractic		100% + $5	100% + $10	100%	100%	100%		
Home Health		100% + $15	100% + $15	100%	100%	100%		
Prescriptions		$7.00	$8.00	$8.50	$8.00/$14.00	$8.00		
Durable Med Equip		80%	80%	80%	80%	80%		
Preventive		100%	100%	100%	100%	100%		
Out-of-Network		Not Covered	Not Covered	Not Covered	70%	Not Covered		
Total Premium		$420.98	$461.72	$431.56	$593.17	$404.30	**$440.51**	**$419.72**
Employee Premium		$40.95	$81.68	$51.52	$213.14	$24.27	**$60.48**	**$39.31**
Deductible		N/A	N/A	N/A	N/A	N/A		
Annual OOP Max		N/A	N/A	N/A	N/A	N/A		
1997 Twin Cities Enrollment		2810	621	537	898	2511		

Appendix 1

Comparison of University of Minnesota Health Plans, Single

		University of Minnesota	University of Minnesota	University of Minnesota	University of Minnesota	University of Minnesota	**Projected 1998 Weighted Ave. Premiums for Twin Cities faculty and staff**	**Projected 1998 Weighted Ave. Premiums for Twin Cities faculty and staff excluding State Health Plan**
Health Plan Name		HP Classic	HP Plan	Medica Primar	State Health Plan	SHP Select		
Emergencies		100%	100%	100%	100% + $30	100% + $30		
Hospital		100%	100%	100%	100%	100%		
Outpatient		100%	100%	100%	100%	100%		
Mental Health		100%	100%	100%	100%	100%		
Chiropractic		100% + $5	100% + $10	100%	100%	100%		
Home Health		100% + $15	100% + $15	100%	100%	100%		
Prescriptions		$7.00	$8.00	$8.50	$8.00/$14.00	$8.00		
Durable Med Equip		80%	80%	80%	80%	80%		
Preventive		100%	100%	100%	100%	100%		
Out-of-Network		Not Covered	Not Covered	Not Covered	70%	Not Covered		
Total Premium		$168.39	$184.69	$172.86	$237.27	$161.72	**$176.39**	**$167.17**
Employee Premium		$6.67	$22.97	$11.14	$75.55	$0.00	**$14.51**	**$5.61**
Deductible		N/A	N/A	N/A	N/A	N/A		
Annual OOP Max		N/A	N/A	N/A	N/A	N/A		
1998 Twin Cities Enrollment		2146	581	534	867	2714		

Appendix 2

	A	B	C	D	E	F	G	H	I
1			University of	University of	University of	University of	University of	University of	Penn
2			Wisconsin	Wisconsin	Wisconsin	Wisconsin	Wisconsin	Wisconsin	State
3	*Health Plan Name*		Dane Health Plan	GHC - S Centra	Physicians Plus	Unity - UW	Standard Plan	Standard Plan II	Plan A
4									
5	Emergencies		100% + $25	100% + $25	100% + $25	100% + $25	100%	100%	
6									
7	Hospital		100%	100%	100%	100%	100%	100%	
8									
9	Outpatient		100%	100%	100%	100%	100%	100%	
10									
11	Mental Health		$7000/year	$7000/year	$7000/year	$7000/year	100%/90%	100%/90%	100% + $20
12									
13	Chiropractic		??	??	??	??	100%	100%	
14									
15	Home Health		100% < 50 visits	100% < 50 visits	100% < 50 visits	100% < 50 visits	100%	100%	
16									
17	Prescriptions		$8.00	$8.00	$8.00	$8.00	$8.00	$8.00	
18									
19	Durable Med Equip		80%	80%	80%	80%	80%	80%	
20									
21	Preventive		100%	100%	100%	100%	100%	100%	
22									
23	Out-of-Network		Not Covered	Not Covered	Not Covered	Not Covered	??	??	
24									
25	Total Premium		$528.24	$505.46	$541.90	$526.74	$752.00	$652.04	$428.28
26									
27	Employee Premium		$0.00	$0.00	$11.17	$0.00	$221.27	$121.31	$101.00
28									
29	Deductible		$0	$0	$0	$0	$25	$25	
30									
31	Annual OOP Max							$500	
32									
33									
34	NOTE: University of Wisconsin plans are for Dane County, WI (other counties not shown); Penn State premiums are for 1997								

Comparison of Employer Health Plans, Family

	J	K
1	Penn	Penn
2	State	State
3	Healthpass	HMO
4		
5	80%	100%
6		
7	80%	100%
8		
9	80%	100%
10		
11	50%	100% + $20
12		
13	80%	100%
14		
15	80%	100%
16		
17		80%
18		
19		??
20		
21		100%
22		
23	70%	??
24		
25	$373.64	$323.49
26		
27	$75.00	$16.00
28		
29	$100	
30		
31	No limit	
32		
33		
34		

Comparison of Employer Health Plans, Single

		University of Wisconsin	University of Wisconsin	University of Wisconsin	University of Wisconsin	University of Wisconsin	University of Wisconsin	Penn State
Health Plan Name		Dean Health Plan	GHC - S Central	Physicians Plus	Unity - UW	Standard Plan	Standard Plan II	Plan A
Emergencies		100% + $25	100% + $25	100% + $25	100% + $25	100%	100%	
Hospital		100%	100%	100%	100%	100%	100%	
Outpatient		100%	100%	100%	100%	100%	100%	
Mental Health		$7000/year	$7000/year	$7000/year	$7000/year	100%/90%	100%/90%	100% + $2
Chiropractic		??	??	??	??	100%	100%	
Home Health		100% < 50 visits	100% < 50 visits	100% < 50 visit	100% < 50 visits	100%	100%	
Prescriptions		$8.00	$8.00	$8.00	$8.00	$8.00	$8.00	
Durable Med Equip		80%	80%	80%	80%	80%	80%	
Preventive		100%	100%	100%	100%	100%	100%	
Out-of-Network		Not Covered	Not Covered	Not Covered	Not Covered	??	??	
Total Premium		$210.28	$201.16	$215.74	$209.68	$305.28	$265.40	$220.06
Employee Premium		$0.00	$0.00	$4.52	$0.00	$94.06	$54.18	$52.00
Deductible		$0	$0	$0	$0	$25	$25	$0
Annual OOP Max							$1,000	$0
NOTE: University of Wisconsin plans are for Dane County, WI (other counties not shown); Penn State premiums are for 1997								

Comparison of Employer Health Plans, Single

Penn State Healthpass	Penn State HMO	
80%	100%	
80%	100%	
80%	100%	
50%	100% + $20	
80%	100%	
80%	100%	
	80%	
	??	
	100%	
70%	??	
$191.14	$123.60	
$38.00	$8.00	
$50		
$2,000		

Appendix 4

Comparison of Employer Health Plans, Family

								Buyers
		Macalaster	City of St. Paul	Medtronic	Medtronic	Toro	Toro	Cargill
Health Plan Name		HealthPartners	HealthPartners	Medica	HealthPartners	M of Omaha	HealthPartners	Unicare I
Emergencies		100% + $40	100% + $40	100% + $50	100% + $75	100% + $40	100% + $40	80% coverage
Hospital		100%	100%	100% + $100	100% + $100	100%	100%	80%
Outpatient		100% + $10	100%	100% + $10	100% + $10	100% + $10	100% + $10	80%
Mental Health		100%	100%	100% + $10	100% + $10	100% + $10	100%	80% < 40 days
Chiropractic		100% + $10	100% + $10	100% + $10	100% + $10	100% + $10	100% + $10	80% up to $50
Home Health		100% + $15	100% < 120 day	80%	100%	??	100% + $10	80%
Prescriptions		$8.00	$8.00	$10	$10	$9.00	$8.00	$8
Durable Med Equip		80%	80%	80%	90%	80%	80%	80%
Preventive		100%	100%	100% + $10	100% + $10	100%	100%	90%
Out-of-Network		80%	70%	70%	70% covered	80%	80%	N/A
Total Premium		$427.91	$458.13	$463.00	$377.00	$368.63	$386.00	
Employee Premium		$271.76	$300.13	$116.00	$76.00	$73.73	$91.10	$105.00
Deductible		$0	$0	$0	$0	$0	$0	$600
Annual OOP Max		$5,000	$400	$2,000	$3,000	$3,000	$3,000	$2,000

Appendix 5

Comparison of Employer Health Plans, Family

Health	*Care Action*	*Group*		
Cargill	Cargill	Jostens	Jostens	Carlson
Unicare II	Choice Plus	MedCare 500	Choice Plus	Choice Plus
80%	100% + $10	80%	100% + $10	100% + $10
80%	100% + $100	80%	100% + $100	100% + $100
80%	100% + $10	80%	100% + $10	100% + $10
80% < 40	100% + $10	100% + $15	100% + $10	100% + $10
80% up to $50	100% + $10	Not Covered	100% + $10	100% + $10
80%	100%	??	100%	100%
$8	$10	$12	$10	$10
80%	100%	??	100%	100%
90%	100% + $10	Not Covered	100% + $10	100% + $10
N/A	70%	N/A	70%	70%
		$509.00	$531 - $564	
$30.00	$45.00 - $95.00	$36.00	$58.00 - $91.00	$54.66 - $75.43
$1,000	$0	$1,000	$0	$0
$6,000	$3,000	$10,000	$3,000	$3,000

Appendix 5

Comparison of Employer Health Plans, Single

Health Plan Name		Macalaster HealthPartners	City of St. Paul HealthPartners	Medtronic Medica	Medtronic HealthPartners	Toro M of Omah	Toro HealthPartners	*Buyers* Cargill Unicare I
Emergencies - Hosp		100% + $40	100% + $40	100% + $50	100% + $75	100% + $40	100% + $40	80% coverage
Hospital		100%	100%	100% + $100	100% + $100	100%	100%	80%
Outpatient		100% + $10	100%	100% + $10	100% + $10	100% + $10	100% + $10	80%
Mental Health		100%	100%	100% + $10	100% + $10	100% + $10	100%	80% < 40 days
Chiropractic		100% + $10	100% + $10	100% + $10	100% + $10	100% + $10	100% + $10	80% up to $50
Home Health		100% + $15	100% < 120 day	80%	100%	??	100% + $10	80%
Prescriptions		$8.00	$8.00	$10	$10	$9.00	$8.00	$8
Durable Med Equip		80%	80%	80%	90%	80%	80%	80%
Preventive		100%	100%	100% + $10	100% + $10	100%	100%	90%
Out-of-Network		80%	70%	70% covere	70% covered	80%	80%	N/A
Total Premium		$156.15	$178.95	$154.00	$123.00	$123.30	$129.11	
Employee Premium		$0.00	$110.95	$39.00	$26.00	$24.66	$30.47	$30.00
Deductible		$0	$0	$0	$0	$0	$0	$250
Annual OOP Max		$3,000	$400	$1,000	$1,500	$1,000	$1,000	$4,000

Appendix 6

Comparison of Employer Health Plans, Single

Health	*Care*	*Action*	*Group*	
Cargill	Cargill	Jostens	Jostens	Carlson
Unicare II	Choice Plus	MedCare 500	Choice Plus	Choice Plus
80%	100% + $10	80%	100% + $10	100% + $10
80%	100% + $100	80%	100% + $100	100% + $100
80%	100% + $10	80%	100% + $10	100% + $10
80% < 40	100% + $10	100% + $15	100% + $10	100% + $10
80% up to $50	100% + $10	Not Covered	100% + $10	100% + $10
80%	100%	??	100%	100%
$8	$10	$12	$10	$10
80%	100%	??	100%	100%
90%	100% + $10	Not Covered	100% + $10	100% + $10
N/A	70%	N/A	70%	70%
		$171.00	$177 - 188	
$15.00	$10 - 30	$9.00	$15 - 26	$10.64 - 24.48
$500	$0	$500	$0	$0
$6,000	$1,500	$5,000	$1,500	$1,500

Appendix 6

Retiree Health Benefits, Family

Health Plan Name	University of Michigan Indemnity	University of Michigan HMO	University of Michigan PPO	University f Wisconsi Indemnity	University f Wisconsi HMO	University of Wisconsin PPO	University of Illinois Indemnity	University of Illinois HMO	University of Illinois PPO	Penn State Indemnity
Emergencies - Hosp										
Hospital										
Outpatient										
Mental Health										
Chiropractic										
Home Health										
Prescriptions										
DME										
Preventive										
Out-of-Network										
Total Premium	$114.00	$232.00	$300.00	$483.00	$330.00	$360.00	$596.00	$430.00	$430.00	$240.00
Employee Premium	$0.00	$95.00	$163.00	$483.00	$330.00	$360.00	$155.00	$108.00	$108.00	$14.00

Penn State HMO	University of Iowa Indemnity	University of Iowa Indemnity	University of Iowa Indemnity	University of Washington Options	University of Washington Pacificare	University of Washington Pierce County	University of Washington Qual-Med	University of Washington SelectCare	University of Washington Skagit County
$112.00	$388.00	$69.00	$95.00	$416.18	$375.34	$438.71	$427.27	$404.54	$420.79
$14.00	$303.00	$0.00	$10.00	$416.18	$375.34	$438.71	$427.27	$404.54	$420.79

Retiree Health Benefits, Family

University of Washington Uniform Med	University of Washington Virginia Maso	University of Washington Whatcom Med	Purdue University Indemnity	Purdue University HMO
$429.79	$317.82	$350.19	$292.00	$146.00
$429.79	$317.82	$350.19	$292.00	$146.00

Retiree Health Benefits, Single

		University of Michiga	University of Michigan	University f Michiga	University f Wisconsi	University f Wisconsi	University of Wisconsin	University of Illinois	University of Illinois	University of Illinois
Health Plan Name		Indemnity	HMO	PPO	Indemnity	HMO	PPO	Indemnity	HMO	PPO
Emergencies - Hosp										
Hospital										
Outpatient										
Mental Health										
Chiropractic										
Home Health										
Prescriptions										
DME										
Preventive										
Out-of-Network										
Total Premium		$57.00	$116.00	$150.00	$185.00	$135.00	$153.00	$249.00	$170.00	$182.00
Employee Premium		$0.00	$47.00	$81.00	$185.00	$135.00	$153.00	$0.00	$0.00	$0.00

Retiree Health Benefits, Single

Penn State Indemnity	Penn State HMO	University of Iowa Indemnity	University of Iowa Indemnity	University of Iowa Indemnity	University of Washington Options	University of Washington Pacificare	University of Washington Pierce County	University of Washington Qual-Med	University of Washington SelectCare	University of Washington Skagit County
$124.00	$54.00	$194.00	$69.00	$95.00	$154.24	$139.39	$162.43	$158.27	$150.01	$155.92
$6.00	$6.00	$109.00	$0.00	$10.00	$154.24	$139.39	$162.43	$158.27	$150.01	$155.92