MINUTES

HEALTH PLAN TASK FORCE (HPTF)
Thursday, April 15, 1999
10:00 a.m.-11:30 a.m.
229 Nolte Center

Present: Richard McGehee (Chair), Linda Aaker, Avner Ben-Ner, Todd Carlin, Keith Dunder, Robert Fahnhorst, Bart Finzel, Harlan Smith, Robert Sonkowsky, Larry Thompson, Gavin Watt

Absent: Richard Butler, Roger Feldman, David Hamilton, Priscilla Pope, Richard Purple

Regrets: None

Guests: Carol Carrier (HR), David Haugen (DOER), Liz Holding (DOER), Bud Johnson (DOER), Pat Peachek (Deloitte & Touche)

Others: None

[Meeting Topics: DOER Presentation about SEGIP Coverage for 2000 and Beyond]

Chair's Report

- The University is developing a contract with Watson-Wyatt to continue the study they started by gathering data from the State and comparing it to the model that was developed for the University.
- The current political situation in St. Paul has created obstacles for DOER to move forward with new plan options in a timely manner.
- Implementation of the new plan has been very complex so a BHCAG-type model will not be implemented for 2000. Therefore, the goal is to develop an interim plan that will help with the transition from one model to the other.
- Medica Primary will not be available for 2000, which effects about 1000 University Employees.
- The costs of the State Health Plan Point of Service are causing it to have financial difficulties.

State Employees Group Insurance Program (SEGIP) Prospects for Year 2000 and Beyond

Presentation by Department of Employee Relations (DOER) and Open Discussion

Modified Status Quo Model

- If the State chooses to go with status quo for 2000 it will be a modified version.

- The modifications to the status quo model depend upon the extent in which the health plans or care systems are held accountable for the financial responsibilities.
- The most visible changes to the status quo model are the loss of Medica Primary, costs will increase, point of service will be available in all plans, Blue Cross would eliminate the plan similar to the State Health Plan, and HealthPartners would probably eliminate the Classic product.
- The State will set itself up to transition to a new model such as a care system model for 2001, but it may choose to stay with the modified version of status quo due to bargaining timelines.
- It will be important that the University administration and DOER realize there will be a fair amount of work to be done in a very short period of time to accomplish whatever strategy is chosen.
- Medica may provide the Premier product to the State if the State assumes all risk. However, the State would have to offer the same option to the other plans, which would be too costly.
- Given the fact that the cost of participants in the Primary product is 60% higher than the cost of those in the Select Product or the HealthPartners products, placing Primary participants into a new product will drive up the costs for all of the remaining selections.
- It is not clear how much the costs will go up since the State has just received the health plan renewals.
- A modified status quo model would incorporate risk adjustment in order to accommodate for less healthy people that will be transferring from Medica Primary to different plans.
- The State has not determined how long the modified status quo model would be able to sustain the State's needs.

Transition to a Care System Model

- DOER has gone through a number of stages to prepare for the care system approach and is at the point of requesting information from the potential providers that outlines the target costs for providing a care system.
- It is impossible to implement a care system model by 2000 because the health plans were not on board when requests were first sent so they were eliminated from the entire process and now it is to late to start the process over for 2000.
- The administrators who bid on the administration part of the care system model would not be ready to implement a program by 2000 because they would need more time to build the reimbursement models.
- The three accepted proposers for the modified care system model are Blue Cross & Blue Shield, HealthPartners, and Preferred One.
- Preferred One is ahead of the other two plans in conforming to a BHCAG-type model since it is currently running a care system.

Remaining Plans in the Managed Competition Model

- There are now only two plans within the current model so it is not certain how much competition there is given the fact that they only have to compete against each other.

- They will be more concerned about cost recovery than maintaining membership because there are no options for the participants.
- If the Select Plan continues to successfully operate, it is not certain how long the higher-cost HealthPartners plan will be able to maintain its membership. However, it will be available for at least another year.

Administrators of the Care System Model

- It is fairly certain that HealthPartners would not provide access to their clinics if they did not administrator the new care system model.
- Non-employers' costs will not increase if there are multiple administrators.
- Blue Cross & Blue Shield said they would act as administrator for the entire model while HealthPartners said it could only handle the metro area and Preferred One will provide whatever administrative support is necessary but they cannot do it alone.
- The ideal situation would be to have only one administrator, but the modified care system necessitates more than one so the State is currently deciding what would be best for the modified care system model.
- The only way to maintain three administrators is by allowing the various health plans to interact with more than one care system. Otherwise, there could only be two administrators.
- It is more of an incentive for administrators to have more care systems so the same plan could offer the same product and price it differently to get into more tiers.
- The original model included exclusive care systems to an administrator, but that has created difficulties for Fairview because it owns most of Preferred One and is also a part of Blue Cross.
- The State is hoping there will be many care systems and that they will be willing to work with as many administrators as possible.

Single Premium Care System Model

- A single premium plan would be self-insured and pool financially comparable plans together.
- Some of the accountability would be passed back to the contracted care systems.
- It is not clear if the plans would prefer risk adjustment during the first year.
- Much like status quo, the employer contribution would increase because the premiums of the two plans would level out.

Differential Pricing Care System Model

- The differential pricing model would vary from the BHCAG model in that the health plan would assist the care system in determining costs and determining an appropriate bid.
- The tiers would be determined by DOER, BMT, and JLMC, but it is certain that there will be at least three tiers since the State believes in reasonable access.
- The State would determine the price tiers by considering access within each care system.
- The employee cost, including dependent costs, in the first tier would be no or the lowest cost to the employees.

- Employees can only move within the tier they choose or any tier below their tier.
- Maximum flexibility would be available to those in the highest tier.
- The care systems will bear some risk under this model and will be held accountable for performance.

Movement within the Care System Model

- Ultimately, the State would prefer a negociator that would allow employees to move within a tier and between the various administrators.
- Some of the issues around movement is the ability of the administrator to track employees' co-payments, deductibles, co-insurances; the State and University being able to handle the transition; and agreeing upons rules during bargaining.
- Care systems do not want people moving among the tiers because it is difficult to track that movement and costs would increase.
- The ability to have a totally flexible model with mutliple administrators is not something the State will be able to provide by 2000.
- It is currently not possible to track movement between tiers and systems which is why movement is not possible across plans.

Traditional Plans with the Care System Model

- The State has tried to develop a traditional health plan under a one-sided model.
- Most of the modeling that has been done suggests the traditional model would follow the point of service plan if it were to be offered with any existing care systems within the plan.
- Some members of BHCAG offer health plan options alongside the care system model, but they are national employers so the health plans are used in areas other than the metro area.
- For those clinics that do not want to be part of a care system, they will still be sloted into a tier given their price structure to determine the employer contribution.

Outstate Care Systems

- If there is only one care system within a county, the employer contribution will fall into whatever tier that care system would be placed and the employee would have access to the other care systems within that tier as well as the tiers below it.

Point of Service Option

- The point of service offering under the care system model would be offered by all of the plans, but that would add 3% to the entire program cost since everyone will have access to it.
- The point of service option would solve the selection issue because everyone would be able to go outside of their care system to seek care.
- Employees would not be expected to have a 70/30 payment plan with a point of service option.

- The point of service issue always falls to bargaining so its fate will be decided during negociations, but the option is not beneficial to most of the unions because most union employees do not work outside of their covered area.
- There are enough employees who would still want a point of service option even if there were a separate health plan for out-of-area coverage because they want complete freedom to choose where the go for care.
- Coverage for dependents out of state would fall under a separate health plan that will be reasonably priced but there would be no options within it.
- The projected cost of incorporating a point of service option should not be as high as it is because the majority of the people who have that option do not utilize it.
- Three percent of the employees in the point of service option do utilize outside care and the co-payment does not completely offset the cost.
- Currently, employees in the point of service option who do not seek outside care still incur greater costs than those not in the option.

State's Preferred Model

- The State is working most on mofidying the tiered care system model to determine how to administer and communicate the function of the model.
- None of the options are less favorable then the others.
- Information on the cost of the modified status quo model is not available, which is a major factor in deciding whether or not it is a viable option.

More Plans in the Status Quo Model

- Another plan has not entered the status quo model because the State has not sent out any requests and no plan would be willing to enter an existing model where another plan has lost over $30 million.
- In order to add health plans to the status quo model, the RFP process would have to begin and that is not possible while the State is developing the care system model.
- Plans have asked to participate in the current program, but the Statehas felt none of them have been able to be cost competive with the current plans so they would not be able to survive in the managed competition model.

Tier Placement

- In the BHCAG model, care systems bid and do not know which tier they will be in. Similarly, the health plans will present bids for the modified care system model and not know which tiers their clinics will fall into.
- If the plans feel they have been placed in the wrong tier they can negociate with the State about being placed into a more appropriate tier.
- The State works with the unions when determining the low-cost carrier and the same approach would be taken when working with the care system model.

Mid-Year Changeover

- It would be difficult to implement a new plan mid-year that would have a eighteen month contract rather than a calendar year contract so DOER has decided to stay with the standard open enrollment dates and current model for the next calendar year.
- System transitions would not be able to handle a mid-year changeover.
- Medica will not continue the Primary product for six months so that would disrupt a mid-year changeover.

Withdrawal of Medica Primary

- Medica has indicated that it would like to continue working with the State, but they have lost over $30 million in the last three years.
- The information Medica provided to the State showed a 34% increase in costs for the current year based on the 1999 figures.
- Medica has provided cost figures for those people left in their Primary plan, but it has not been separated by State and University.
- The data shows how many patients have been lost and evidence that those still in the plan have high costs.
- Apparently, Medica was providing a product similar to HealthPartners Classic to those remaining in their network so the choices were fewer which would drive costumers to other plans with more clinics.
- It is not certain how many displaced Medica costumers will go to HealthPartners and Blue Cross, but estimated figures have been provided to both plans so they can project costs.

Implementing a New Model in 2001 vs. 2002

- The State could implement the modified status quo model immediately and use it through 2000 and implement the care system model in 2001.
- If the State is not comfortable with switching to the care system model in 2001 it can wait until 2002.
- The State's comfort level for changing models is not good given Medica's lack of providing data because it is very difficult to target bids or project risk adjustment for a care system without data.

Adjournment

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