HEALTH PLAN TASK FORCE
Thursday, September 3, 1998
10:00 a.m. to 11:30 a.m.
300 Morrill Hall

Present: Richard McGehee (Chair), Linda Aaker, Avner Ben-Ner, Richard Butler, Amos Deinard, Keith Dunder, Robert Fahnhorst, Bart Finzel, George Hoh, Martha Johnson, Matt Maciejewski, Priscilla Pope, Harlan Smith

Absent: Judith Gaston, David Hamilton, Richard Purple
Regrets: Roger Feldman, Robert Sonkowsky, Larry Thompson
Guests: Bob Connor
Others: None

[Meeting Topics: Updates on the FCC/SCFP Presentation, Actuarial Study, and State Developments, Discussion of the Open Enrollment Supplement, and a Presentation on a Potential Employee Survey]

Progress Reports

Chair's Report

Professor McGehee met with the Faculty Consultative Committee and the Senate Finance and Planning Committee to report on the recent activities of the Task Force. He recommended that the Task Force continue, which was endorsed by both committees. The committees also said that if funding is needed, they should be approached again.

At the last Joint Labor Management Subcommittee meeting, it was announced that the Quello clinics are leaving the Medica Primary Health Plan. Unfortunately, there are many University employees who use those clinics so that creates a negative impact on the upcoming open enrollment. However, access to the Quello clinics can still be obtained by University employees because the clinics are becoming part of the Health Partners structure.

Besides that, most of the Joint Labor Management Subcommittee meeting was devoted to discussing the State's request for proposals, which is becoming quite complicated. The State is also requesting proposals for a mental health, pharmacy, and chiropractic carve-out. That way, those areas covered by the carve-out would be like the current dental health plan, which means they are separate from the rest of the health care that is covered.

The timeline that was distributed by the State shows that the RFP for the care systems is scheduled to take place on March 1, 1999. A separate RFP will be sent to administrators and more than one administrator could be selected. After that, clinics will bid on their RFPs based on the administrator they want to work with. Those are due in April and they will be evaluated and reviewed through May when the bargaining process begins.

The State will know sometime in October if the care system approach will work. In case it does not, they are running a parallel process that is similar to the current system. However, the model based on the current system will be different in that health plans will be asked for cost estimates for modifying their current plan and including a point of service option.

Comments:

- It has been discussed that even with a mental health care carve-out, those people who use clinics that have mental health care can use that clinic for that purpose.
- It is not certain if mental health, pharmacy, and chiropractic care will be part of a carve-out until bargaining takes place.
- Although the decision between using a care system approach or staying with a model similar to the current system will not be finalized until bargaining takes place, whether or not it will be feasible will be known when the first responses come back in April.

Actuarial Study

Comments made by Robert Fahnhorst:

- The budget for the actuarial study has run out so the project is on hold.
- Although Deloitte & Touche has provided additional information on Blue Cross and Blue Shield, it has not helpful.
- In order for consultants to evaluate information from providers it must be broken down by class group, but the providers do not have the information in that format.
- The purpose of separating the information by class would be to determine what the impact would be if the non-bargaining units of the University separated from the State.
- The best way to separate information by class groups is to get an ongoing utilization report from the carriers that has University data separated in that way. This will also keep track of utilization among different areas.
- The only way to divide 1997 information into classes is to correlate individuals' names from the carrier with the employees' groups.
- Since the cost of consultants is so much, serious consideration should be given to the idea of having them divide information from 1997.
- Medica and Blue Cross and Blue Shield were able to provide a desired breakdown, but the other plans could not. However, even though the information from Medica and Blue Cross and Blue Shield came from lists provided by the University of social security numbers and associated groups, it is not reliable because there is no consistency between the providers.
- The results requested by the Task Force could be obtained through a random sample, but actuaries would still have to be paid to set it up.
- Information already provided by Deloitte & Touche has not worth the money the University paid and they may not be the right consultants to handle the University's business since they also work with the State and are being asked to develop private information for the University.
- If the University decides to separate from the State, it will have to provide utilization data for the past twelve months in the RFP it sends to various health plans. Therefore, it will

be important to set up an ongoing system that separates class groups. However, it is not certain if there will be a system in place to process 1999 data.
- Currently, the information provided by plans includes an average per member per month cost for claims; inpatient, outpatient, pharmacy, and mental health premiums paid versus the claims that were incurred; and subsections of administrative costs.

Developments at the State

Comments made by Robert Fahnhorst:

- Besides developing an ongoing reporting structure between the State and University, supplemental add-ons have also been discussed. DOER did not want to get into details about the add-ons, but they do want to set up a procedure for obtaining requests for them. It was suggested that there be a way for the University to make a formal request to add additional coverage and a set number of days for the State to respond to the request.
- Although DOER does not see a problem with adding two permanent University representatives onto the Joint Labor Management Committee, they will have has to look into it before doing so.
- The draft agreement between the State and the University will be presented to the task force once Carol Carrier and Kathy Burek have reviewed it. There are certain items in the agreement that are not appealing to the University, such as the notice period for the University to separate from the State since it must be eighteen months in order to allow the State to find out the impact on costs and present their new group numbers to plans. This time period would make it virtually impossible for the University to wait and see how things are going with the State before choosing to separate. However, the notice period has not been agreed upon so that can still be negotiated.

Provider Payment Report

Report by Matt Maciejewski

- The report begins with an introduction which explains that health plans use different payment mechanisms for providers and employees, but that is only one of the many management tools that health plans use to influence how providers go about their business. It would not be possible to outline all of the management tools in a document of this length, so the items that it does incorporate include discounted fee for service capitation, fee for service, physicians paid by salary, and payment adjustments. The four payment methods are defined more fully on page four and an example is given for each one to demonstrate how that would affect the physicians' treatment patterns.
- The table on page three shows how physicians under capitation are paid a certain fee based on the number of people that are enrolled in their clinic. Whereas, physicians who are under fee for service are paid for the services that they provide.
- There is another table on page four that outlines the impacts of payment methods on patient care and referrals. This chart will help lead the discussion from payment methods to payment adjustments. Although the table and text are redundant, most people reading the report will not be familiar with the subject so it is necessary.

- The strengths and weaknesses of the different payment methods are listed on page six while payment adjustments are discussed on page seven.
- The affects the different payment methods used by each health plan have on people are described on pages eleven and twelve and a discussion on the patient's rights and what can be done if there is a complaint follows that.
- The first appendix is a glossary of terms and the last appendix is a list of contacts.

Comments:

- Most of the health plans felt the first draft of the report was very biased against capitation. However, there were lengthy discussions with all of the health plans to communicate clearly that the report is not intended to be misleading or controversial. It has been difficult, though, to keep the meanings and explanations consistent with the definitions and current practice without offending the health plans.
- A relatively new concept among health plans is a retrospective utilization target which offers bonuses to clinics who stay below the parameters set on the percentage of patients seen at the clinics.
- Matt should be commended for his work because he kept the State and health plans well-informed throughout the development of the report and they have had their chance to react.
- Physicians will be able to comment on the report since UMP has been contacted about it.
- Physicians who are paid by salary tend to work for group or staff model HMOs, which have physicians on schedules. Because of that, there may not be a consistent link between the patient and physician because staffing changes according to the schedule. However, patients are more likely to see their regular physician if they make appointments well in advance, but probably not on an emergency basis.
- One of the complaints that has already been addressed by Health Partners is that patients cannot form a relationship with particular physicians.
- The bullet under salary in the table on page six may not be accurate because it is common among all health plans that a patient may not be able to see a certain physician every visit. Instead, it should be stated that it is more difficult to schedule an appointment with a certain physician under that model.
- The report should be mentioned in Brief and every constituency should be asked to advertise the existence of the document. However, it should be made clear that the report was developed by one person who was commissioned by the Task Force to write it since it is so controversial.
- If the report is made into a brochure, it would be easier to distribute to everyone, but it would be less expensive to duplicate and distribute the report as it currently exists.
- The report should not be distributed without a clear disclaimer that there are other things that affect the deliverance of health care.
- The report should make employees aware of the key issues physicians face when making decisions about health care.
- The report will be posted on the Task Force web site and it will be made available to department contacts who receive Employee Benefits information.
- Any suggestions or revisions should be sent to Matt.

Potential Employee Survey

Proposal by Bob Connor

- A survey is being developed to find out why University employees value insurance, how they make decisions between health plans, and why they purchase additional insurance.
- The University will benefit from this survey because it will show what motivates people to choose among the competing health plans and which of the motivatores are most influential.
- The University will also find out if medical savings accounts are an option for the future.
- The theoritical issues to be resolved by the survey include:
- Why do people value insurance.
- What motivates people to take insurance over additional income.
- The health policy issues to be resolved by the survey include:
- What motivates people to choose among competing health plans.
- What types of health plans are valued.
- How medical savings accounts are perceived and compared to traditional health care coverage.

  Comments:

  - In the past 20 years, health insurance has grown into something much more than risk adversion. People are now contracting with an organization to keep them well and not just for emergencies.
  - Some people would be better off taking the money the University pays for dental insurance because there is such a small amount being paid on dental expenses.
  - The survey focuses on health insurance and not other types of insurance because it is Professor Connor's field.
  - The question: "Health insurance is valuable to me because I want the best and most complete health care possible." is intended to get the answer: "In order to get good health care, I have to have insurance beyond reduction benefits."
  - A distinction should be added that shows what coverage people have actually received opposed to what they thought they were going to receive.
  - The survey does not focus on whether or not consumers know what they are getting into when they are trading off money for access and choice, but rather, whatever went into making the decision to go with the health plan they are currently in.
  - The only reason why the issue of medical savings accounts is controversial is because the Republicans are ideologically in favor of them, even though they do not understand insurance and they are misrepresenting their purpose.
  - It is total ignorance that leads anyone to know enough that they need insurance because only the wealthy can prepare to cover possible medical expenses.
  - It is not certain if a medical savings account would allow people to pay possible medical expenses.

- The medical savings account is a reaction to the managed care system since it is not meant to reduce risk, but is an alternative to cooperative purchasing of health care.
- The strategy of the survey is to see if people prefer a medical savings account over regular insurance.
- It has been suggested that the medical savings account piece be dropped from the survey since it is too ambitious, but it can be related to the rest of the information.
- A question on page three would address the issue as to what the threshold would be for people when they make a decision about a health plan based upon its premium.
- It would be helpful to the task force if demographic data such as age, gender, income, and job class, were included in the survey.
- There was another study that was done on the Graduate Assistant Medical Plan and some of the questions are similar to those found in this survey.
- DOER recently conducted an in-house survey to find out how much it would take to switch plans and it showed that there was a $50/month threshold.
- The question that refers to losing $100 for certain or having a one percent change of losing $10,000 is meant to test people's risk levels.
- The same question is later asked, but it includes a reference to insurance, and previous research has shown that people are more risk adverse in this instance.
- The reason the survey has been presented to the task force is to inform the group as well as to gather feedback.
- If the task force were to endorse the survey, those taking it may not necessarily know that.
- The task force does not have to endorse the survey since it is a research project and not a final report. However, the information gathered would be very helpful to the group.
- The survey will be presented in January 1999 and there will be about two hundred participants.
- Participants will be chosen through a random selection process and more will be gathered through a volunteer process.
- The data would be better if the participants were chosen only through a random selection process.

Open Discussion

The next meeting of the group is in two weeks and a meeting schedule for the 1998-99 academic year will be developed at that time.

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