Health Plan Task Force Minutes

Tuesday, May 26, 1998
10:00 a.m.-12:00 noon
229 Nolte Center

Present: Richard McGehee (Chair), Linda Aaker, Avner Ben-Ner, Amos Deinard, Robert Fahnhorst, David Hamilton, Priscilla Pope, Harlan Smith, Robert Sonkowsky, Larry Thompson

Absent: Keith Dunder, Matt Maciejewski, Richard Purple

Regrets: Bart Finzel, Judith Gaston, Martha Johnson

Guests: Susan Hoel, Jim Meland

Others: None

[Meeting topics: HealthPartners' Ultimate Choice Presentation, Employee Assistance Program Presentation]

Minutes

The April 14 minutes were approved as presented.

Chair's Report

- There is nothing to report from the State level because the JLMC has not met since the last task force meeting.
- Premium rates for 1999 are not available because DOER has not received information from Deloitte & Touche yet.

HealthPartners' Products Presentation

HealthPartners Background

- HealthPartners has been in existence for over forty years. It started out as Group Health and has changed to Med Centers and finally to HealthPartners.
- HealthPartners is an integrated care system because it owns clinics.
- HealthPartners is, and will always remain, a primary care model. Therefore, the patient's care is coordinated through his/her primary care doctor.
- HealthPartners is the only local HMO that shares information from satisfaction survey results with Keedus.
- The Institute for Clinical Systems Information was developed six years to work towards consistency in care. The Institute works with member physicians, does literature searches, and tests pilot programs in clinics.
- Currently, there are forty-one care guidelines for physicians to follow and about fifteen are added each year.

- HealthPartners only has 300 hundred of their own physicians. The others work on a contract basis.
- There are a variety and networks and products available through HealthPartners.

The three developmental stages of the health care system:

Stage 1: The "open checkbook" phase covered care for illnesses and injuries, but not for preventive care, and the doctor decided if the care would be covered by insurance. Patients and doctors were satisfied because patients had provider choice and doctors could charge for whatever they wanted because no one was monitoring the care that was provided. There were excessive administrative costs which led to the second stage.

Stage 2: Employers started to question the rising cost of health care so HMOs were developed. There was more focus on preventive care because there was a limited number of providers and better coverage was provided (100%). Quality measures began to take place as well as an advisorial relationship between the health plans and the providers. Providers became unhappy because their incomes were cut. Patients were also unhappy because their choices were eliminated. Employers were changing plans to find the best deal. Very little information was made available for consumers outlining the definition of good care, so consumers had to rely on the health plan's judgment for quality care.

Stage 3: "Value-base care" was developed because employers still want cost control, providers want recognition for their services, and members want to keep their physicians. The Ultimate Choice product was developed to meet these needs and stipulates that providers compete on the care they provide and the value they offer, which is defined by the member. As well, a marketable infrastructure, reporting system, and an overall health agenda has been incorporated into the Ultimate Choice product. The employer purchases the product where all the clinics are made available and employees choose which one they want to use. The marketplace is maintained and objective, comparative data is made available. Enrollment, billing, reporting, and provision of materials is handled by HealthPartners. Instead of the employer deciding which health plan their employees will use, the employer works with HealthPartners and each employee chooses which clinic group he/she wants to join.

Ultimate Choice Product

- Ultimate Choice is made up of 44 care systems, 410 clinics, and 7000 physicians.
- In each care system, primary care, specialists, and hospitals are contracted together.
- There is a cost differential among the three tiers of care systems. Cost level one would be the least expensive and employers usually base their contributions of that level and have employees pay the difference if they want to be in a higher tier.
- Cost and quality are not directly related so the lowest tier does not have the worst quality.
- Under this model, providers set their own stipulations, determine their reimbursement needs, and decide how their care system will function.
- The first tier allows access to only those care systems within that tier. However, each family member can choose his/her own clinic, but they must remain at that clinic for a year.

- The second tiers allows access to all of the care systems in that tier as well as all of those in the first tier.
- The third tier allows access to all of the care systems available in the Ultimate Choice product.
- Employers choose the benefit package they want so they can have point-of-service included and have it fully insured if necessary.
- There is a ten percent difference in cost between each of the tiers.
- Each care system is going to have a certain specialist they utilize.
- A HealthPartners' catalog lists all of the care systems and each of their specifics on mental health, primary care clinics, urgent care, and other general information.
- Patients are able to change care systems within their available tiers every month, but they can only change tiers once a year.

Task Force Members' Comments:

- Although the tiers don't offer anything different, some people will pay extra to be in tier three in order to have access to the care systems they want.
- A care system in the third tier may allow patients to select specialists as they choose, while a lower-level care system may not.
- Park Nicollet allows open access to its specialty care, except for Neurology.
- Ultimate Choice will not be available through DOER for 1999 because this is a non-bargaining year and no changes can be made during a non-bargaining year.
- Ultimate Choice is similar to the BHCAG model, but the University can tailor the benefit set as they please.
- There is only one benefit set in BHCAG so if the University joined that group, they would have to adhere to that.
- The BHCAG benefit set includes a $50-75 co-payment for emergency services, there is a fairly high co-payment for prescriptions, office visits have a $15 co-payment.
- BHCAG is not used by any union groups because they are not willing to take that kind of a cut in benefits.
- If employees do not know which care system to join, they are able to go to the HealthPartners' website and research each of the care systems and rank their most important needs. Feedback will be given as to which care system would best serve them.
- People do not switch between care systems unless they dislike their current care system.
- Most people choose their doctors based on the closeness to their homes.
- It is not certain how many primary care physicians from the Twin Cities are part of the Ultimate Choice product.
- Discussions are taking place to find out if University providers can be a part of Ultimate Choice if they can develop a care system.
- Currently, Morris is covered by the HealthPartners' Health Plan and they could become part of Ultimate Choice if they are interested in doing so.
- Coverage in Duluth and Crookston will take place once a service area filing has been approved.
- One of HealthPartners' goals is to provide coverage in every county of Minnesota.
- Some groups are hesitant to join HealthPartners because of the risk and higher utilization the State would bring about.

- HealthPartners would need six to eight weeks if the University were to separate from the State and have the Ultimate Choice product available for employees by 2000.
- It would take longer for HealthPartners to set up Ultimate Choice for the University on a self-insured basis because of the development of the summary plan description and to create an administrative service.
- Ultimate Choice is meant to be a self-standing product that is offered as a replacement.
- Ultimate Choice rates are figured by determining the total revenue for each care system and tier levels are set up with a ten percent difference between them.
- The Ultimate Choice product for the University would be developed by considering the number of employees in each tier level given their current clinic and rates would be set from that.
- Three years ago, sixty percent of University employees who had HealthPartners used the Park Nicollet clinic.
- The Classic network is between the Select and HealthPartners network and is made up of seventy clinics.
- The HealthPartners network has 375 primary care clinics and 4000 physicians.

HealthPartners' Plus

HealthPartners' Plus is a new three tier plan. The first tier is the HealthPartners network which is the core. The second tier is an extended network of direct access to 8000 physicians without a referral but a co-payment or a co-insurance plan is involved. The third tier allows for out of the network services so employees can go anywhere they want but there will be a deductible and 80/20 or 70/30 coverage.

Task Force Members' Comments:

- The out-of-network services in not only for emergencies but for any services that would be covered by HealthPartners if the employee were in the network.
- The out-of-network option has worked well for those who have been away for extended periods of time, but it has very limited preventative services.
- Groups that currently use this product provide coverage for their retirees who are under 65 years-old.
- It is not certain how retirees over 65 could use this product.
- The difference between Ultimate Choice and HealthPartners' Plus is capitation.
- Each clinic group determines which specialists they will use and when they will use them.
- The Plus plan eliminates the referral system.
- The State decides which options will be made available to the University and the Plus product has never been an option so the University has not had access to it.
- If the University had the Plus plan, it would have access to University physicians because of the open referral component.
- Ultimate Choice may not be the best option for the University because flexibility seems to be the main concern, but the care system still determines how things will work.
- The Plus plan offers more flexibility with its different tiers of options so it may be a better choice for the University.

- Benefit design varies among tiers in the Plus plan but does not in Ultimate Choice.
- Ultimate Choice has mostly been used by small employers because unions think bargaining power is lost with this type of model.
- Ultimate Choice may cost slightly less than the Plus product because there is only one rate for the Plus product but there are three for Ultimate Choice and if more people use the lowest tier, the University's costs will be low.
- The Como clinic is part of the Plus plan under the core tier.
- In the Plus plan there are 4000 physicians in the first tier and 8000 physicians in the second, but there is some overlap between the tiers.
- The University must determine what its most important issues are before a plan can be decided upon.
- A point-of-service option can be added to any of the options except for the Classic network.
- The State has been successful in setting the parameter so plans are fairly similar, which limits adverse risks.
- A premium range is difficult to determine without experience information, given the size of the University, because premiums are based on utilization.
- The bidding process can include different scenarios for cost variance.
- If a co-payment is involved, rates can be cut as much as five percent because needless visits may be eliminated since people will give more thought before going to the doctor.

University Employee Assistance Program Presentation

Background

- There are two employee assistance programs at the University.
- The first program developed at the University is the University Employee Assistance Program. It is directed by David Johnson and offers assistance to civil service and bargaining unit employees.
- Another employee assistance program was developed ten years ago to assist academic professionals and faculty.
- These programs are traditional and provide a no-cost benefit for all University employees and members of their families.
- The range of provided services are broad and extend from personal to professional issues.
- Part of the time is spent consulting with units who are having a workplace climate problem.
- The assistance programs are under Human Resources so a strong effort has been made to inform employees that the program is private and confidential.
- There is no relationship between the records maintained by Human Resources and those kept in the Employee Assistance office.
- Long term counseling is rare because there is an equivalent of two and a half full-time staff to cover these programs and there are over 40,000 potential clients.
- The academic professional and faculty assistance office is considered to be a counseling office rather than a diagnosis and referral service.
- The typical number of visits for both programs is between two and three sessions per employee. However, some have been long term in the past.

- The Employee Assistance Office works with all of the health care providers and makes referrals to each of them as necessary.
- Sometimes full psychological testing is done by the Employee Assistance Office and forwarded to one of the mental health providers.
- An up-to-date listing of other area resources where people can be referred is also maintained.
- The mental health needs of University employees are being met depends upon what they are looking for and what they expect.
- The Employee Assistance Office feels that, in those cases where there is a crisis or a serious mental illness, the medical providers provide decent mental health care.
- There is variability in coverage among the providers for those people having problems in various relationships.
- Some providers do not provide any family or marriage counseling unless there is a dependent child who is the focus of the problem.
- Medica provides family or marriage counseling, but they only provide one diagnostic session.
- Mental health care would probably not be provided for those individuals who are dissatisfied with their personal lives and are looking for long term emotional support.
- Health providers use terms like "significant disruption of function," "having a recognized treatment," and "will respond to treatment" as guidelines for providing mental health care to their patients.
- People who want to lobby for more extensive mental health services are going to have difficulty doing so because there is no body of data that proves that treatment is necessary.
- No provider hesitates to provide care to those mental health patients who require medication for their treatments.
- It is difficult to obtain coverage for problems that are considered less severe because the mental health field has not been able to establish the need for treatment.
- Different areas of mental health issues are separated into categories that consider them to be a medical condition, a significant dysfunction, or whether it takes a trained professional to provide the treatment.
- It does not take long to go through the categories to realize there is not sufficient support for an immediate crisis.

Task Force Members' Comments:

- A range of treatments can be offered depending upon the level of disability, which should be considered for less severe conditions so at least the conditions would still be recognized.
- The current system requires that the provider make the initial assessment and refer to a specialist within their system, so the type of treatment depends upon what is available in that plan.
- Data should be made available during open enrollment so employees are aware of the treatment each plan provides as well as their referral patterns.
- As employers are becoming more cost conscious and putting more pressure on health plans to keep costs down, mental health has been purchased on a wholesale basis.

- The quality of mental health care has not decreased since wholesale providers have been implemented, but there has been a diminishment in the range of problem areas that are considered eligible for services.
- The wholesale providers' responses have been prompt and adequate when the most serious categories of mental health needs arise.
- Dispensing medication has not been the way the wholesale providers have dealt with cases.
- It is not clear to what degree counseling helps improve conditions for someone requiring mental health care.
- The Employee Assistance Office can only assist employees in getting referrals to certain specialists by writing letters and providing results from psychological testing.
- Information on patient satisfaction with mental health care presented at this meeting has been from employees using the Employee Assistance Office and not from surveys conducted by the various health plans.
- If there are enough people who feel the services they are receiving are not adequate than that will be reflected in the decisions made about the coverage.
- The Employee Assistance Office does not have any administrative authority to override a health plan's decision about receiving mental health care from an outside source even though it is always the prerogative of the provider to make an outside referral, but the patient must pay for those services.
- Concern should be given to those mental health areas that are not covered at all by any of the health plans.
- Because of society standards, chemical dependency treatment is easily accessible and completely covered by all of the providers within their own networks, but there are no studies on the outcomes.
- All of the health plans agree on providing short term problem solution oriented therapies for mental health problems.
- Co-payments have been eliminated for mental health care because the law requires physical and mental health care be provided in the same manner.
- Health plans can get around not being able to set a specific number of counseling sessions for all patients by incorporating a certain number of visits in each patient's treatment plan.
- Health plans make special mention of children with SED, AAHD, and DED.
- AAHD can be treated with a favorable and immediate outcome by using medication.
- Mental health care will not be provided if a patient does not respond to treatment but that is not the case with physical health.
- There is a difference of opinion among the psychological professionals who are involved in managed care and those who are not. Those psychologists not in managed care claim there are more kinds of available treatments. Psychologists in managed care may know about the different kinds of treatments but they do not want to deal with the costs associated with them.
- There is a vast difference between the provision of service based on practice guidelines for physical health versus mental health.
- Most employees claim the quality of mental health care is very poor.
- Those employees who self-refer may have a very different experience with mental health care than those who help get referrals from the Employee Assistance Office.

- The Employee Assistance Office sees many problems that do not qualify for treatment from the various health plans.
- The goal of the Employee Assistance Office is improve the life of the employees and to help them better function in the jobs.
- If there are employees who need assistance but do not have very much money, the Employee Assistance Office can refer them to places that provide services without high fees.
- It is the responsibility of the Employee Assistance Office to be aware of everything that is available to help all of the employees.
- Most people assume that certain services, such as counseling, should be included in paid medical coverage, but that has not always been the case.
- Some people will exclude the possibility of receiving mental health services if they have to pay for them even though they can afford them.
- People not willing to pay for counseling raises the question of necessity for mental health care.
- Some people will not receive treatment because they do not want it on their medical record.

Adjourn

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