Health Plan Task Force Minutes
Tuesday, April 14, 1998
10:00 a.m.-12:00 noon
229 Nolte Center

Present: Richard McGehee (Chair), Linda Aaker, Avner Ben-Ner, Amos Deinard, Keith Dunder, Robert Fahnhorst, Bart Finzel, Judith Gaston, David Hamilton Martha Johnson, Priscilla Pope, Richard Purple, Harlan Smith, Robert Sonkowsky, Larry Thompson

Absent: Matt Maciejewski

Regrets: None

Guests: Dick Butler, Roger Feldman

Others: None

[Meeting topics: Actuarial Study Update, SEGIP Purchasing Model Rankings]

Minutes

The February 17 and March 17 minutes were approved as presented.

Chair's Report

The Closing of the Family Practice Clinic:

- The Family Practice Clinic will be closing on June 30, 1998, due to certain financial arrangements, conditions that were not met, and the overlap created on some of the contracts.
- The physicians will be distributed among the other clinics of the system, many of them going to Smiley Point.
- Employee Benefits is concerned with the closing because the Family Practice Clinic is one of the key clinics to obtain access to University specialists.
- Currently, there are 500 University employees that have been grandfathered into the Family Practice Clinic through HealthPartners, but it is uncertain where those people will go once the clinic closes.
- An effort has been made to make arrangements for those people who use the Family Practice Clinic to also have access to the Smiley Point Clinic.
- Dr. Deinard said that CUC has provided a flyer in the Family Practice Clinic which lists the services that group can provide.

Reactions to the UMP Presentation:

- Vice President Cerra has confirmed that the top priority of UMP is to get a specialist referral system into place.

- Currently, access to Boynton Health Services can only be obtained through the State Health Plan point-of-service option, but it has been suggested to the Director of Boynton that they should consider becoming part of the potential BHCAG model.
- Boynton Health Services has the capability of becoming a primary care facility that would provide an entry point to University specialists for University employees.
- The Health Plan Task Force will have to make stronger recommendations to Academic Health Center groups if they are to develop a primary care plan for the year 2000.

Actuarial Study

A letter has been sent to Deloitte & Touche and a contract will be developed soon, which will outline the various phases of the project. During the first phase, University data will be separated from the State's data and potential premiums will be determined for the University if it separates from the State and then they will be compared to the State's premiums. Premiums for subcategories of the University population will also be considered. The second phase will entail determining the costs of various models for the University if it were to separate from the State.

Comments

- The models Deloitte & Touche will test could be developed while the first phase is under way because that will not affect the outcome of first phase and it will save time once the second phase begins.
- The State's models will be made available at the next JLMC meeting.

SEGIP Purchasing Model Rankings

General Comments about the Evaluation

- The models that will be ranked include the current purchasing model (managed competition), the BHCAG model, and a single payer model.
- The first three issues that are listed on the evaluation form are most important to both the State and University. They include provider choice, provider stability, and cost.
- The most important issue for DOER is cost.
- The top issues for the unions are provider choice and stability.
- The other issues that are listed on the evaluation have been identified by the task force as also being very important to the University.
- Access to University physicians has been divided into two areas because there is a difference between access to primary and specialty care.
- It is clear that the State will not do anything in regards to coverage for Domestic Partners so the only way for the University to deal with that issue is to separate from the State.

Comments and Concerns of Task Force Members

- Although there are 140 known domestic partners at the University, only 25 of them are in the reimbursement program.
- Since mental health care is a carve-out, it should be considered as separate from other health plan issues.
- HealthPartners Classic does not carve out mental health because they have their own mental health clinics that a consumer can self-refer to. Also, the other HealthPartners option has their own clinics as well as access to other clinics for mental health care purposes.
- Limitations have been put upon unlimited access to providers because of the significant cost increase it would create.
- BHCAG participants use the HealthPartners' clinics for mental health care because they provide administrative support for BHCAG.
- Reconsideration should be given to allowing self-referrals with an 80/20 coverage arrangement.
- If the single payer model is considered the best option, the carve-out option should be included because access to specialists outside the network would be very constrained.
- The State Health Plan has a carve-out for Centers of Excellence, but how they will be handled under the BHCAG model has not been discussed.
- Modifications that will more than likely take place in the current managed care option include risk adjustment, better access to mental health care and carve-out options, more providers, and improvement of out-of-area coverage.
- It is very difficult to accurately evaluate the managed care option while incorporating the possible modifications because the cost is unknown as well as the design and the providers that will be part of the system. Therefore, the managed care option should be evaluated under its current structure because the modifications are uncertain.
- The single-payer model will be the least expensive option, but provider choice will be the most limited.
- Even if there is a single-payer model, that provider could offer different products with different cost levels.
- There are several different issues related to cost, including costs for employees and employers.
- Employers are most concerned about their expenses when cost rises.

Provider Stability

- BHCAG has had some instability at the individual doctor level because doctors are not certain which care system they can get into. However, compared to the other two purchasing models, BHCAG has the best provider stability because there is a possibility that consumers can find their primary health care doctor in one of the care systems.
- Currently, the issue with stability has to do with how many people had to find new physicians because a plan was withdrawn.
- BHCAG will remain stable as long as providers stay within care systems.
- The current purchasing model and the single payer model have the same stability issues because of the renegotiation cycle they possess and the possibility of completely changing providers every time.

- Care systems in BHCAG are unhappy with member employers because they are still maintaining traditional plans along with the BHCAG model and membership in BHCAG is down because of that.
- The University would have an advantage in BHCAG because that would be the only option that would be made available to employees, which would bring a large number of consumers and dependents into BHCAG.
- It would not be possible for the University to offer other plans along with the BHCAG model because it would create too many problems.
- Instability should be raised at the State and with the bargaining arrangements because plans are offered but then withdrawn because of changes in proposed premiums.
- Instability is eliminated in the BHCAG system because of risk adjustment.
- If the BHCAG model is to stay intact companies will have to eliminate their other options and only use BHCAG.
- Single payer models can be made stable by making a long term commitment with the provider.
- Choice is sacrificed for stability under the single payer model and it is very difficult to keep costs down.
- Those companies who want to be a single provider bid low to get the contract and then raise the premium rates a few years later because the real experience data becomes available and expenses must be covered. This creates a rebidding process that never ends.
- The Graduate Assistant health plan is under a single payer model and stability is not an issue. The only issue the group is concerned with is the lowest possible premium rate.
- The State will develop a model similar to BHCAG instead of joining the existing BHCAG system because it does not cover all of the needs of the State.
- In the evaluation, the current model was given an 1, the BHCAG model was given a 3, and the single payer model was given a 0.

<u>Provider Choice</u>

- It is not clear what "choice" is referring to in the evaluation.
- The State has determined that "choice" refers to accessibility to a particular primary care physician.
- Currently, the managed care option has more access to primary care physicians throughout Minnesota than BHCAG does.
- The only way smaller clinics can become a part of the BHCAG model is to join a large care system.
- In the future it may be possible for BHCAG to expand by contracting with every primary care physician in the State.
- Even though the State is not currently using the BHCAG model, care systems exist today so they are being used under the managed care option.
- Change can occur between care systems on the same tier under the BHCAG model. However, the managed care option only allows for change to occur between member clinics of the plan that was chosen by the employee.
- Access to specialists is not considered in the evaluation if "choice" only entails access to primary care physicians.

- In the evaluation, the current model was given a 2, the BHCAG model was given a 3, and the single payer model was given a 1.

Cost

- The reason the single payer model is even a competing option is because of cost.
- All of the purchasing models are expensive so they should not be given a rating above satisfactory.
- In the evaluation, the current model and the BHCAG model were each given a 1, and the single payer model was given a 2.

Access to University Specialists

- UMP believes the single payer model is their best option because the more people they have to deal with the worse off they are.
- It is possible under the BHCAG model to carve-out for access to University specialists and Kathy Burek has suggested developing a fourth tier to handle that issue.
- Every clinic has the ability to refer to University specialists but willingness to do so depends upon the plan and the doctor.
- Patients can self-refer to University specialists, but they may have to pay all of the expenses.
- In the past, the University has had contacts with the various plans to provide certain services, but many of them have been eliminated over the years as each plan has expanded to provide those services themselves.
- Each plan determines which specialist group they will refer to. If a specialist is not part of that group, it is very difficult to get to that specialist.
- BHCAG or the single payer model would have a better chance of providing access to University specialists than the managed care model because that can be incorporated into the design of each of those plans.
- UMP would probably develop a care system if the BHCAG model is chosen as the health care option. However, UMP is not able to create an effective care system because there are more specialists than primary care physicians so there would not be enough referrals into the specialists.
- UMP is operating under the wrong assumption if they think that the single provider will offer more open access.
- It is up to UMP if University employees are able to get access to them through their insurance plans.
- The University has enough leverage at the State to put pressure on including UMP in the BHCAG model and can set up their own contract with UMP if they separate and form their own BHCAG model.
- In the evaluation, the current model was given a 1-, the BHCAG model was given a 1+, and the single payer model was given a 1-.

Access to University Primary Physicians

- Primary care physicians are in UMP but are not accepted by the current insurance options except the State Health Plan point-of-service.
- If the single payer must include UMP, cost would be sacrificed because the lowest bidder would no longer win because UMP would be guaranteed a spot.
- The University is similar to Mayo and that is a very expensive system after adjustment has been made for case mix and the other areas.
- UMP has argued that they have a higher risk due to the nature of the services they provide.
- In the evaluation, all three purchasing models were given a 0.

Out-of-Area (non-emergency) and Unmanaged Care

- HealthPartners provides out-of-area coverage for their patients who leave the state for a certain period of time and require some kind of health care. However, their contract only commits them to covering emergencies, but their definition of emergencies is very liberal.
- The State Health Plan specifically provides out-of-area coverage at the highest co-payment.
- Out-of-area coverage depends upon plan design.
- The single payer model can either demand out-of-area coverage or completely leave it out if it is not wanted.
- The BHCAG model has a point-of-service option across the set of clinics.
- It is clear that out-of-area coverage is getting worse because some options did provide coverage at one time but they do not any longer.
- Out-of-area coverage cannot be done at first dollar coverage because contracts cannot be created with every health care provider in the world. Therefore, a deductible or co-payment will have to be associated with out-of-area coverage.
- Out-of-area coverage will be expensive in all of the purchasing models because a premium will be associated with each of them. However, BHCAG would be somewhat less because cost can be distributed throughout the model.
- The consumer pays more for out-of-network services because they are paying a percentage of the actual expense instead of the negotiated rate.
- No purchasing model will allow consumers to go out of the area and then pay for the entire bill.
- HealthPartners has a product similar to BHCAG, known as Ultimate Choice, that has not been offered to the State thus far. However, the out-of-area coverage issue would be solved if it were added to the State Health Plan.
- The Ultimate Choice plan probably has not been made available to the State because of the structure that has been designed for bargaining in regards to becoming the low-cost provider.
- There would be no benefit in adopting the Ultimate Choice plan instead of a BHCAG model because the insurance would not be eliminated which is the goal of BHCAG.
- In the evaluation, out-of area coverage and unmanaged care were each given a 1 in the current model, a 3 in the BHCAG model, and no mark was given in the single payer.

Spousal Coverage and Cafeteria Benefits

- In the evaluation, spousal coverage and cafeteria benefits were given 0s in all three purchasing models because they are independent of all three models since State determines if spouses can be covered by family policies.

Mental Health/Chemical Dependency

- The mental health issue has to do with access to desired providers and not the amount of coverage received because complete coverage is available, but there is no choice as to who the provider will be.
- Mental health care is not as big an issue for outstate employees as it is for metro area employees.
- The State realizes they will have to reorganize mental health care under the BHCAG model, but nothing has been decided upon so far.
- Under the current system, continuity of care is broken up so the patient has to go to different providers for their treatment which they do not find satisfactory.
- The choices will be better if the employer works directly with the provider (BHCAG model).
- Insurance companies have not provided the mental health care services they have claimed they would.
- The Graduate Assistants are dissatisfied with United Behavioral Services that Medica capitated.
- In the evaluation, all three purchasing models were given 0s.

Pre-65 Retirees

- There is a difference between subsidizing retirees and subsidizing the payment.
- This issue is more plan designed related than purchasing model related.
- Currently, retirees are able to purchase health insurance at the group rates, but they are must pay the entire cost.
- Coverage for retirees is similar to out-of-area coverage but is even more devastating because they are on limited incomes and their premiums are so high.
- Retiree issues are interactions between retiree concerns and all of the other issues.
- The retirees' main concern is to maintain at least the coverage they have now and not necessarily the cost.
- Disabled employees' benefits are not among the list of issues, but they would be similar to the pre-65 retirees' category.
- Since other issues received a rating of 3 for the BHCAG model it will be rated just as high in this category because the issues are the same for retirees.
- In the evaluation, the current model was given a 0, the BHCAG model was given a 3, and the single payer model was not rated.

Post-65 Retirees

- It is not certain if the State will be able to keep current retirees where they are if the State changes purchasing models.
- The State has not given much thought to retirees at this point.

- The only way retirees could be covered under the BHCAG model if the University chose that purchasing model is if the care systems have contracts with Medicare.
- Coverage for retirees over the age of 65 is a supplement to Medicare.
- Currently, most retirees are in the Blue Cross/Medigap Policy, and that should not be disrupted no matter what model is chosen.
- This year the federal government will discontinue some contracts that have been serving University retirees so something needs to be found as a replacement.
- Coverage for retirees varies from company to company in the BHCAG model.
- In the evaluation, the current model was given a 3 and the other two models were not rated.

Comments on the Results

- Given the scores, it is clear that none of the purchasing models can adequately address all of the University's issues.
- Graduate students are able to negotiate their own plan because they are not considered to be University employees, which does not make them part of the State. This is a result of tax decisions and court cases.
- The current plan for Graduate Students was developed in 1989 at a time when they were considering organizing a union and the administration offered an alternative to keep that from happening.
- It would be beneficial to have the graduate students as part of the University population but they would never join because they are a different population, dependent coverage would be added so their premiums would go up, and they would have to change from a single payer model to whatever the entire University chooses.
- Graduate students are able to unionize even though they are not State employees.
- Whatever model is chosen should at least have the same coverage that the current plans offer now.
- It cannot be concluded that the current model will be able to offer the current coverage.
- Universal health coverage should be reconsidered given these figures.
- The final report of the task force should include this evaluation to show that none of the available options are adequate.

Adjourn

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