Minutes

HEALTH PLAN TASK FORCE

Thursday, December 18, 1997
12:00-3:00
Nolte Library and 140 Nolte Center

Present: Richard McGehee (Chair), Avner Ben-Ner, Amos Deinard, Robert Fahnhorst, Bart Finzell, David Hamilton, Richard Purple, Harlan Smith, Robert Sonkowsky, Mary Yamashita

Absent: None

Regrets: None

Guests: Matt Maciejewski, Steve Wetzell

Others: Kathy Burek, Judith Gaston, Dave Haugen, Budd Johnson, Julie Sweitzer

[Meeting topics: BHCAG presentation and discussion of health care options]

Approval of Minutes

The November 4 minutes were approved as amended.

Chair's Report

Legislative Hearing

The Committee on Health and Human Services Subcommittee on Health Care Access (chaired by Representative Tom Huntley) held a legislative hearing on November 25 in the Basic Sciences Building. The subcommittee addressed how medical teaching and research and the changing market of health care are affecting one another as well as why University providers were excluded from the state benefits plan that was offered in 1998. Impressions from the hearing were that many legislators understand these issues very well and Kathy Burek wants to address the issues the University is most concerned with so she has been working with University providers and employees.

Relevant Information

In November 1997, 32% of all University employees were with HealthPartners Classic, 29% were with Medica Premier, 16% were with the State Health Plan Select, 14% were with the State Health Plan, and the rest were with the HealthPartners Plan, Medica Primary and the First Plan Select. Although the faculty and academic professionals constitute 37.7% of University employees, 46% of employees enrolled in the State Health Plan and 44.1% of those enrolled in Medica Premier are faculty and academic professionals.

Representation on the State Joint Labor Management Committee (JLMC)

The Oversight Committee of the Health Plan Task Force, with consultation with Carol Carrier, will appoint University representatives to the working group of the JLMC since that group has requested that the University appoint two more people to serve with that group along with Bob Fahnhorst and Kathryn Pouliot. Currently, all members of the group (except the Department of Employee Relations (DOER)) are union representatives that represent various sized groups. The working group will meet every two weeks to determine future health plan options.

It appears the State is considering issues that are most relevant to the University since the JLMC has determined that its main goals for health care benefits are choice and stability of providers, cost, and cost containment. Other goals included surveys for quality of care, fairness of benefits, simplicity of design, and out-of-area benefits (although the unions are more concerned about out-of-area benefits than DOER).

Market Research

Information has been collected from the Buyers' Health Care Action Group (BHCAG) and some of its member companies, local employers, the University of Wisconsin, Penn State University, the City of St. Paul (who only offer only one health plan), MacAlister College, and the University of St. Thomas.

The report will incorporate the problems and questions raised by the task force. The research assistant can determine the risks and costs of alternatives that exist as well as what recourse exists for addressing problems with providers and the consequences of problems with a carrier, but the task force will have to determine whether or not the University can address its concerns by staying with the State Employee Group Insurance Program (SEGIP) or if it should purchase health insurance independently.

The various alternatives that are already known include the University staying with the state and joining BHCAG, breaking away from the state and becoming self-insured by modifying the BHCAG model, considering total replacement with only one health plan, varying the status quo, or extending the current system.

Task Force Members made the following comments and suggestions:

- The final report should include information on the health plans of the top five universities in the country; retiree coverage; the top rated health plans in the country; the main goals of the JLMC; and options like medical savings accounts, flexible benefits plan, or catastrophic coverage.
- Currently, there is no insurance coverage for Domestic Partners.
- Graduate students are part of a separate student plan, that is currently covered by Medica Choice Plus.
- People cannot decline coverage from the State even if their spouse can get better insurance for them.
- The task force should meet with the University of Minnesota Physicians (UMP) because the Academic Health Center is planning to set up a primary care health plan.
- Private employers have not been forthcoming with their health plan coverage.

Open Discussion

Preparation for the meeting with BHCAG

BHCAG represents 24 Twin Cities employers (450,000 employees) and 125,000 employees are currently in the Choice Plus Health Plan. The BHCAG model eliminates the management level but not the services because more responsibility is transferred to the employer so the substantial contract is between the employer and the care system. The State plan is different in that the substantial contract is between the employer and the insurance company.

Currently, the Choice Plus Health Plan includes 19 care systems, but more are continually added throughout Minnesota, although there are none Morris. Care systems are medical groups and their affiliated hospitals that they admit to. Each health care system has the same plan design but the premium of each depends upon which group they chose to be a part of. The different care systems are grouped into three different price categories. A primary physician can only be part of one health care system, but specialists can be part of as many as they want. If the highest option is selected, a person can move to any care system they want, but if they chose the lowest option, they can only select from those systems within that option.

BHCAG is a self-insured model so state mandated benefits do not have to be offered, premium taxes do not have to be paid, and other state insurance regulations do not have to be followed because self-insured companies only have to abide by federal law. BHCAG pays a per member per month fee but every quarter each care system is evaluated to determine the populations that utilize each so risk adjustment can take place. Each member company is responsible for paying the cost of its population, but they can offer the Choice Plus Plan alone or along with other plans that were existing before BHCAG was developed. The premium experience of BHCAG has been better than the general market rates, although premiums did increase by 6% last year, as did everyone else's.

The following comments were made:

- If the University went with BHCAG, the Legislature might take some of the allocation money away from the University.
- Choice is more important than cost even though the individual consumer is interested in the best service for their dollar.

Questions to ask at the presentation:

- Is BHCAG capitated or a fee for service payment?
- Are services outside of standard physician care reimbursed?
- How are employees in greater Minnesota handled?

Final Report

The task force will meet in early January to consider the UMP option, to review the research compiled by the research assistant, and to outline the report since it is due by January. The report that is presented on January 15 may not be final, but something must be reported.

Presentation by Steve Wetzell

Background Information

Initially BHCAG was a self-funded, preferred provider organization that was developed in 1988 and became active as a buying coalition in 1993. BHCAG exists because it has interesting ideas and concepts that can create better incentives and choices in the market for consumers and purchasers. DOER is a member of BHCAG so nearly 10% of the population in Minnesota (including the state) is represented through this buying coalition.

The program operates on a self-insured basis so member employers are responsible for paying their own expenses. Legally, this can be done under a fully-insured basis because BHCAG is not licensed under the rules of the State of Minnesota for insurance. Instead, BHCAG operates under federal law by following the Employee Retirement Income Security Act (ERISA), which exempts BHCAG from state insurance regulation as long as it remains at a self-funded status. Public institutions could join BHCAG, but assets should be set aside to cover off years or protection should be purchased through re-insurance and stop-loss coverage.

BHCAG has acted upon the notion that if this is the best product and that all consumers will chose it over time and it will take care of itself. The trend among member companies has been to eliminate competing managed care programs, but almost every employer still offers a traditional indemnity insurance option along with the BHCAG plan. Each employer sets the standard for indemnity versus a product and does risk adjustment between the plans that they offer.

Reasons for Change

- The market has room for improvement since it's not competing under the right incentives because there are too many players with different goals. The suppliers are the physicians and hospitals who want to develop contracts with as many managed care companies as possible while maximizing reimbursement, and the employees are the customers who want to make sure their doctor is in their network and that someone else is paying the expenses, but the employers and insurance companies are just in the middle but still want to create a margin between what is collected as a premium and what is paid to suppliers
- Consolidation in the provider and insurance communities is increasing because there are three major health plans (Blue Cross, HealthPartners, Allina) that control about 85% of the private market and many employers have gone to a carrier replacement approach, where all business is offered to one carrier in exchange for the best price.

- Customers are not able to choose providers based on what they value because wealth is being redistributed. Less sufficient medical groups are being subsidized by more efficient medical groups.
- There is a third party system in health plans that does not hold providers directly accountable to the customer because cost information, pricing and quality at the medical group level is not provided. There is no inherent incentive to closely manage care provided because there is no inherent incentive to try other alternatives. Bureaucracy has been placed upon the provider community because of this, which has created quality through inspection rather than through incentives, which would make the patients accountable for the delivery system so they can change the system themselves.
- The way providers are paid does not support quality improvement and re-engineering because eliminating waste is only rewarded by lower income. Providers can collect more money while eliminating waste by increasing their margin, lowering their place in the market so they can attract more patients, or by getting paid in the community through capitation, but there is still penalization and the third party system that is present in health care does not make it possible.
- There are continued incentives to compete on risk avoidance in the market place since one of the major drivers in cost is how sick the population is so insurers have transferred insurance risks to providers to control budgets. If there is a fixed budget, margins can be created more easily by eliminating sick people from the program than by managing care efficiently. BHCAG solved this problem by adjusting the budget of each of the providers based on the health of their patients relative to the patients of the other competing groups so their budgets reflect that they attract more sick people. The risk adjustments were applied to the actual cost of care of the different groups to determine efficiency which neutralized the difference in illness burden so they were all measured on a standard population.

Solutions to the Problems

BHCAG is operating on a free market assumption, which can only work if customers have complete information to make informed decisions and barriers to entry are not such that new competitors cannot enter, so it has developed competing provider groups (care systems) by creating a set of standard benefits that all providers compete with and a payment structure for care systems that is a risk adjusted virtual capitation. There is still price competition but it is at the system level instead of the plan level. BHCAG operates with a single administrator that provides claims administration, data analysis, member services, and enrollment. The doctors are paid directly while the HMO administrative infrastructure is paid a flat administrative fee for services provided.

Issues

Care systems are given more discretion than health plans because they are allowed to design their own managed care network and doctors are allowed to organize themselves, set their own rules, and arrange their own specialists. However, care systems must document through affidavits and contracts which providers they have contracted to prove they can provide the different services a person may need as a patient in that system. This model gives employees

more control by allowing them to determine where they want to go to for medical care and more responsibility because the customer has to make the most appropriate choice when a care system is selected.

Under the care system plan, each employer is responsible for setting a base rate, determining coverage for domestic partners, mental health services, and analysis on retirees.

A person is able to move among care systems as long as that person is in the highest cost group because a higher premium allows more flexibility for access to more care systems.. Otherwise, that person must wait until open enrollment to change care systems. For 1997, the suggested template for a person to upgrade to the middle cost care system group would be $8.50 per month for a single person and $19 per month for a family, and the high cost care system group was $17 per moth for a single person and $38 per month for a family. Out of network coverage and co-payments stay the same throughout each level of care systems.

Information that has not been collected in regards to care systems include: how the BHCAG model compares to the other plans that member employers offer (however, the indemnity plan has the most risk because that allows people the most options); the arrangements between physicians and specialists (because this is the only industry where the customer has to ask how employees are being paid by their employers); and how physicians are paid by other systems and what their incentives are.

The only information that is fully disclosed is how the systems are paid because risk adjustment is critical to changing the incentives to serve sick people

This program is unique to this community and does not exist anywhere else in the country so out-of-state branches for member companies offer other health care options. It is difficult to develop a similar plan across the country because each state has different requirements to be licensed as an insurance provider so a national plan could not be purchased unless a company is self-insured.

Patient surveys on quality reflected that there is no correlation between the quality of service and the cost of that service. The largest care systems tend to be the most expensive because they have more patients so employers will pay more to keep them since most of their employees are using them. Doctors are realizing they should consolidate to get the same quality and high fees as large care systems. The east and central metro area have more cost effective provider options.

BHCAG would like to collect data on in order to have several dimensions of quality measurement over time. Since BHCAG cannot produce these statistics on its own the Minnesota Health Data Institute will collect the data from across the state, but that will cost millions that could otherwise go into patient health care. Even though the health care costs are increasing because financial analysts are taking the money out of the market instead of curing diseases, BHCAG believes the expense is worth producing the data because not everyone has the same expertise or access that others may have.

Each employee and their family members can choose their own care systems and the total premium paid is based on the highest cost care system chosen. Although this is not the most ideal premium structure because there should be a price for each individual in a family and then they are added together, there are payroll systems constraints. However, by individuals picking care systems, it allows for boutique (specialized health care) care systems to arise, which is possible since there are no requirement for a network to serve the entire family and their budgets are risk adjusted.

Currently, BHCAG is not capable of acting as an advocate to retain or create certain systems if an employer joins the group and a care system is not available for a certain population of their employees. However, it has more power than small employers or lone purchasers because of the consolidated power from the combined forces of its member groups.

BHCAG has considered adding the University as a competing care system because it wants to make every care system that meets its quality of standard available in order to keep the barrier of entry as low as possible, but there are two things that are keeping this from happening (the added cost of teaching and research and the disproportionate illness burden). However, there is no better message to send to the community than to have the University as a competing care system with a risk adjuster in place, which could adjust budgets based on illness burden and identify public investment in teaching and research and find public dollars to offset the incremental cost for them.

The physician panels and hospital relationships have been very stable, which would make the quality measurements relevant to specific systems if it causes the market to stabilize.

BHCAG is willing to consider issues important to the University and State (such as plan design, co-payments, deductibles, and out-of-network benefits) since both are very large and sophisticated buyers.

Care systems will not merge as they try to consolidate because that would lead to a regulatory solution.

There are three types of care systems that equally divide the market into thirds:

- Independent hospitals who have formed a physician hospital organization where the hospital serves as the primary organizing entity. (Fairview Physician Associates, Health East Care, North Physician Health Organization, Children's Hospital)
- Full, vertically integrated model where everything is owned by one entity. (Allina, HealthPartners, Health System Minnesota, and Mayo)
- Independent primary care physicians subcontracting for hospital and specialty services

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