RFP Plans	HealthPartners	Patient Choice Tier I, II and III	PreferredOne	Definity Health Option 1	Definity Health Option 2	Patient Choice Tier II - Duluth	PreferredOne - Outstate (non-Duluth)
Unique Plan Features	Classic network including 54 Primary Care Clinics in the Twin Cities area. Out-of-network benefits are available only for urgent and emergency care.	Participants may switch between care systems in the Tier selected or in lower Tiers during the year. Out-of-network benefits are available only for urgent and emergency care and guesting (see note).	Open access network model, PCP referrals are not required in-network. Out-of-network benefits apply inside and outside of the network area. Guesting also applies (see note).	Tax-favored account of $500 may be used to pay for services that apply toward deductible and/or certain services not covered by the plan. Unused account dollars are carried over after year-end.	Tax-favored account of $1,000 may be used to pay for services that apply toward deductible and/or certain services not covered by the plan. Unused account dollars are carried over after year-end.	Participants use the Duluth CareNorth Health System (St. Mary's / Duluth Clinic Health System available as Tier III). Out-of-network benefits are available only for urgent and emergency care.	Open access network model, PCP referrals are not required in-network. Out-of-network benefits are available only for urgent and emergency care.
Emergency Care							
• In-Network	• $50, waived if admitted	• $50, waived if admitted	• $50, waived if admitted	• 100% after deductible	• 100% after deductible	• $50, waived if admitted	• $50, waived if admitted
• Out-of-Network	• 80% of first $2,000	• 80% of first $2,000	• 80% of first $2,000	• 70% after deductible	• 80% after deductible	• 80% of first $2,000	• 80% of first $2,000
Urgent Care							
• In-Network	• $5 office visit copay	• $10 office visit copay	• $15 office visit copay	• 100% after deductible	• 100% after deductible	• $5 office visit copay	• $5 office visit copay
• Out-of-Network	• 80% of first $2,000	• 80% of first $2,000	• 80% of first $2,000	• 70% after deductible	• 80% after deductible	• 80% of first $2,000	• 80% of first $2,000
Network Hospital							
• General	• 100% coverage	• $200 admission copay	• $200 admission copay	• 100% after deductible	• 100% after deductible	• 100% coverage	• 100% coverage
• Mental Health	• 100% coverage	• $200 admission copay	• $200 admission copay	• 100% after deductible	• 100% after deductible	• 100% coverage	• 100% coverage
• Chemical Dependency	• 100% coverage	• $200 admission copay	• $200 admission copay	• 100% after deductible	• 100% after deductible	• 100% coverage	• 100% coverage
Network Health Care Services							
• Preventive care	• 100% coverage	• 100% coverage	• 100% coverage	• 100% coverage	• 100% coverage	• 100% coverage	• 100% coverage
• Physician, OB/GYN	• $5 office visit copay	• $10 office visit copay	• $15 office visit copay	• 100% after deductible	• 100% after deductible	• $5 office visit copay	• $5 office visit copay
• Eye and hearing exam	• $5 office visit copay	• $10 office visit copay	• $15 office visit copay	• 100% after deductible	• 100% after deductible	• $5 office visit copay	• $5 office visit copay
• Outpatient / surgery center	• $5 office visit copay	• $75 outpatient copay	• $75 outpatient copay	• 100% after deductible	• 100% after deductible	• $5 office visit copay	• $5 office visit copay
• Outpatient mental health	• $5 office visit copay	• $10 office visit copay	• $15 office visit copay	• 100% after deductible	• 100% after deductible	• $5 office visit copay	• $5 office visit copay
• Outpatient chemical dependency	• $5 office visit copay	• $10 office visit copay	• $15 office visit copay	• 100% after deductible	• 100% after deductible	• $5 office visit copay	• $5 office visit copay
• Chiropractic care	• $5 office visit copay	• $10 office visit copay	• $15 office visit copay	• 100% after deductible	• 100% after deductible	• $5 office visit copay	• $5 office visit copay
• Physical, speech, occupational therapy	• $5 office visit copay	• $10 office visit copay	• $15 office visit copay	• 100% after deductible	• 100% after deductible	• $5 office visit copay	• $5 office visit copay
• Home health care	• $5 office visit copay	• $10 office visit copay	• $15 office visit copay	• 100% after deductible	• 100% after deductible	• $5 office visit copay	• $5 office visit copay
Prescription Drugs • 34 day supply (including insulin) • For brand name drugs when a generic is available, you pay the copay plus the cost difference	• $10 copay for formulary drugs • $20 copay for non-formulary drugs • $35 copay for drugs listed as lifestyle-enhancing	• $10 copay for formulary drugs • $20 copay for non-formulary drugs • $35 copay for drugs listed as lifestyle-enhancing	• $10 copay for formulary drugs • $20 copay for non-formulary drugs • $35 copay for drugs listed as lifestyle-enhancing	• All prescriptions are covered at 100% after deductible	• All prescriptions are covered at 100% after deductible	• $10 copay for formulary drugs • $20 copay for non-formulary drugs • $35 copay for drugs listed as lifestyle-enhancing	• $10 copay for formulary drugs • $20 copay for non-formulary drugs • $35 copay for drugs listed as lifestyle-enhancing

Attachments to agenda for Faculty Senate Meeting; May 31, 2001

RFP Plans (cont.)	HealthPartners	Patient Choice Tier I, II and III	PreferredOne	Definity Health Option 1	Definity Health Option 2	Patient Choice Tier II - Duluth	PreferredOne - Outstate (non-Duluth)
Prescription Drugs (cont.) • For lifestyle-enhancing drugs, your copay does not count toward the annual out-of-pocket maximum	• Annual out-of-pocket maximum: $500 per person, $1,000 per family	• Annual out-of-pocket maximum: $500 per person, $1,000 per family	• Annual out-of-pocket maximum: $500 per person, $1,000 per family	• All prescriptions are covered at 100% after deductible	• All prescriptions are covered at 100% after deductible	• Annual out-of-pocket maximum: $500 per person, $1,000 per family	• Annual out-of-pocket maximum: $500 per person, $1,000 per family
Prosthetics, Durable Medical Equipment	80% coverage, including hearing aids	80% coverage, including hearing aids	80% coverage, including hearing aids	100%, after deductible	100%, after deductible	80% coverage, including hearing aids	80% coverage, including hearing aids
Out-of-Network Care • Hospital • Outpatient • Office visit • Other • Guesting - see notes	Not covered, except for emergency and urgent care, as described above.	• Guesting and ER only • Guesting and ER only • Guesting and ER only • Guesting and ER only • Guesting, see notes	• 70% after deductible or guesting • 70% after deductible or guesting • 70% after deductible or guesting • 70% after deductible or guesting • Guesting, see notes	• 70% after deductible • 70% after deductible • 70% after deductible • 70% after deductible • Guesting not applicable	• 80% after deductible • 80% after deductible • 80% after deductible • 80% after deductible • Guesting not applicable	Not covered, except for emergency and urgent care, as described above.	Not covered, except for emergency and urgent care, as described above.
Deductibles and Maximums • Deductibles • Annual out-of-pocket maximums • Life-time maximum	• None • $2,500 per person, $4,000 per family • $1M to Unlimited	• None • $2,500 per person, $4,000 per family • $1M to Unlimited	• $500 per person, $1,000 per family for out-of-network services only • $2,500 per person, $4,000 per family • $1M to Unlimited	• $1,250 per person, $2,500 per family Note: out-of-pocket costs after deductible are incurred only out-of-network • $2,500 per person, $5,000 per family • $1M to Unlimited	• $2,000 per person, $4,000 per family Note: out-of-pocket costs after deductible are incurred only out-of-network • $4,000 per person, $8,000 per family • $1M to Unlimited	• None • $2,500 per person, $4,000 per family • $1M to Unlimited	• None • $2,500 per person, $4,000 per family • $1M to Unlimited
Estimated 2002 **Employee-Only** Premium (bi-weekly) **U of MN Cost:**	**$ 0.00** **Approx.$125.00**	Tier I: **$ 0.00** Tier II: under **$10.00** Tier III: under **$20.00** **Approx. $125.00**	Approx. **$50.00** **Approx.$125.00**	Less than **$15.00** **Approx.$125.00**	Less than **$15.00** **Approx.$125.00**	**$ 0.00** **Approx.$140.00**	**$ 0.00** **Approx.$190.00**
Estimated 2002 **Family** Premium (bi-weekly) **U of MN Cost:**	Less than **$20.00** **Approx.$300.00**	Tier I: under **$20.00** Tier II: under **$40.00** Tier III: under **$65.00** **Approx. $300.00**	Approx. **$140.00** **Approx.$300.00**	Less than **$50.00** **Approx.$300.00**	Less than **$50.00** **Approx.$300.00**	Less than **$20.00** **Approx.$320.00**	Less than **$20.00** **Approx.$450.00**

Notes:

1. Guesting is access to in-network benefit levels while out of the "network area of residence" but while in other, national network areas (typically large metropolitan areas.
2. "Approximate" costs may be revised pending additional data. "Under" and "Less than" costs may remain as is after receipt of additional data.

DOER Plans	HealthPartners Classic	State Health Plan Select	PreferredOne State Care Team	HealthPartners Health Plan	State Health Plan (POS)
Unique Plan Features	Classic network including 54 Primary Care Clinics in the Twin Cities area. Out-of-network benefits are available only for urgent and emergency care.	BlueCross BlueShield of Minnesota network. Out-of-network benefits are available only for urgent and emergency care.	PreferredOne network. Out-of-network benefits are available only for urgent and emergency care.	Health Plan network. Out-of-network benefits are available only for urgent and emergency care.	BlueCross BlueShield of Minnesota network. Out-of-network benefits apply inside and outside of the network area.
Emergency Care • In-Network • Out-of-Network	• $50, waived if admitted • 80% of first $2,000	• $50, waived if admitted • 80% of first $2,000	• $50, waived if admitted • 80% of first $2,000	• $50, waived if admitted • 80% of first $2,000	• $50, waived if admitted • 80% of first $2,000
Urgent Care • In-Network • Out-of-Network	• $10 office visit copay • 80% of first $2,000	• $10 office visit copay • 80% of first $2,000	• $10 office visit copay • 80% of first $2,000	• $10 office visit copay • 80% of first $2,000	• $10 office visit copay • 80% of first $2,000
Network Hospital • General • Mental Health • Chemical Dependency	• $200 admission copay • $200 admission copay • $200 admission copay	• $200 admission copay • $200 admission copay • $200 admission copay	• $200 admission copay • $200 admission copay • $200 admission copay	• $200 admission copay • $200 admission copay • $200 admission copay	• $200 admission copay • $200 admission copay • $200 admission copay
Network Health Care Services • Preventive care • Physician, OB/GYN • Eye and hearing exam • Outpatient / surgery center • Outpatient mental health • Outpatient chemical dependency • Chiropractic care • Physical, speech, occupational therapy • Home health care	• 100% coverage • $10 office visit copay • $10 office visit copay • $75 outpatient copay • $10 office visit copay • $10 office visit copay • $10 office visit copay • $10 office visit copay • $10 office visit copay	• 100% coverage • $10 office visit copay • $10 office visit copay • $75 outpatient copay • $10 office visit copay • $10 office visit copay • $10 office visit copay • $10 office visit copay • $10 office visit copay	• 100% coverage • $10 office visit copay • $10 office visit copay • $75 outpatient copay • $10 office visit copay • $10 office visit copay • $10 office visit copay • $10 office visit copay • $10 office visit copay	• 100% coverage • $10 office visit copay • $10 office visit copay • $75 outpatient copay • $10 office visit copay • $10 office visit copay • $10 office visit copay • $10 office visit copay • $10 office visit copay	• 100% coverage • $10 office visit copay • $10 office visit copay • $75 outpatient copay • $10 office visit copay • $10 office visit copay • $10 office visit copay • $10 office visit copay • $10 office visit copay
Prescription Drugs • 34 day supply (including insulin) • For brand name drugs when a generic is available, you pay the copay plus the cost difference	• $10 copay for formulary drugs • $20 copay for non-formulary drugs • $35 copay for drugs listed as lifestyle-enhancing	• $10 copay for formulary drugs • $20 copay for non-formulary drugs • $35 copay for drugs listed as lifestyle-enhancing	• $10 copay for formulary drugs • $20 copay for non-formulary drugs • $35 copay for drugs listed as lifestyle-enhancing	• $10 copay for formulary drugs • $20 copay for non-formulary drugs • $35 copay for drugs listed as lifestyle-enhancing	• $10 copay for formulary drugs • $20 copay for non-formulary drugs • $35 copay for drugs listed as lifestyle-enhancing

DOER Plans (cont.)	HealthPartners Classic	State Health Plan Select	PreferredOne State Care Team	HealthPartners Health Plan	State Health Plan (POS)
Prescription Drugs (cont.) • For lifestyle-enhancing drugs, your copay does not count toward the annual out-of-pocket maximum	• Annual out-of-pocket maximum: $500 per person, $1,000 per family	• Annual out-of-pocket maximum: $500 per person, $1,000 per family	• Annual out-of-pocket maximum: $500 per person, $1,000 per family	• Annual out-of-pocket maximum: $500 per person, $1,000 per family	• Annual out-of-pocket maximum: $500 per person, $1,000 per family
Prosthetics, Durable Medical Equipment	80% coverage, including hearing aids	80% coverage, including hearing aids	80% coverage, including hearing aids	80% coverage, including hearing aids	80% coverage, including hearing aids
Out-of-Network Care • Hospital • Outpatient • Office visit • Other • Guesting - see notes	Not covered, except for emergency and urgent care, as described above.	Not covered, except for emergency and urgent care, as described above.	Not covered, except for emergency and urgent care, as described above.	Not covered, except for emergency and urgent care, as described above.	• 70% after deductible or guesting • 70% after deductible or guesting • 70% after deductible or guesting • 70% after deductible or guesting • Guesting, see notes
Deductibles and Maximums • Deductibles • Annual out-of-pocket maximums • Life-time maximum	• None • $2,500 per person, $4,000 per family • $1M to Unlimited	• None • $2,500 per person, $4,000 per family • $1M to Unlimited	• None • $2,500 per person, $4,000 per family • $1M to Unlimited	• None • $2,500 per person, $4,000 per family • $1M to Unlimited	• $500 per person, $1,000 per family for out-of-network services only • $2,500 per person, $4,000 per family • $1M to Unlimited
Estimated 2002 **Employee-Only** Premium (bi-weekly) **U of MN Cost:**	Approx. **$ 0.00** **Approx.$120.00**	Approx. **$10.00** **Approx.$120.00**	Approx. **$50.00** **Approx.$120.00**	Approx. **$65.00** **Approx.$120.00**	Approx. **$80.00** **Approx.$120.00**
Estimated 2002 **Family** Premium (bi-weekly) **U of MN Cost:**	Approx. **$20.00** **Approx.$285.00**	Approx. **$45.00** **Approx.$285.00**	Approx. **$140.00** **Approx.$285.00**	Approx. **$175.00** **Approx.$285.00**	Approx. **$215.00** **Approx.$285.00**

Notes:

1. Guesting is access to in-network benefit levels while out of the "network area of residence" but while in other, national network areas (typically large metropolitan areas. However, guesting has not yet been priced for DOER plans.
2. All cost figures are approximate pending additional data from DOER. Note also that cost figures above apply only in counties where all plans are offered; low cost plans in other counties drive different employee / employer premium share amounts.

REMARKS
Mark G. Yudof, University of Minnesota

EVENT: President's Report to Board of Regents
WHEN: 10:00 a.m., May 11, 2001
WHERE: Regent's Room, McNamara Alumni Center
AUDIENCE: Regents, members of the public
TOPIC: Future of Public Universities

Last weekend I attended a symposium called **"The Changing World of University Leadership and Governance,"** which was held in honor of Clark Kerr, the former President of the University of California System. This was a fitting tribute, because I think that California has been the state that has been closest to "getting it right" when it comes to public higher education. Kerr was a driving force behind UC's successful tiered system with a half dozen or so UC campuses consistently ranked among the best in the nation.

I spoke on the topic of "University Autonomy in the New Entrepreneurial Age," and, in thinking about that topic, a few ideas crystallized for me. And it is this heady matter, the future of public universities, that I wish to comment on today. My comments are addressed to national trends, but clearly have implications for Minnesota. This is not a specific recommendation, but I think we need to be candid about these trends with government leaders and think through carefully what we're doing.

First some context and background about what I see to be driving the debate over public education and education funding across the country (except perhaps in California--is it the water in the hot tubs?): the triumph of demography, the changing nature of business in the modern global economy, the regionalization of higher education within states, an ebbing of the perception of public higher education as a public good, and the tendency to treat all education programs as interchangeable.

Triumph of demography

The most recent census showed that the median age in the US is now 35.3 years old, the highest it has ever been, and that the most rapidly increasing age group has been the population between 45-to-54 years old, which grew by 49 percent over 10 years. At the same time, households with children continued to decline, from about 50 percent of households in 1960, to less than one-third in 2000. Aging populations, like all people, are often more concerned about services that directly affect them, where the internalized benefits are relatively obvious:

- Social security
- Healthcare
- Lower cost prescription drugs

- Nursing homes
- Protection from crime

Then there are the more nuanced public goods where the more generalized benefits must be explained, where the externalities to an aging population, as economists would say, need to be appreciated:
- K-12 and higher education
- Social services and welfare

Many seniors and near-senior citizens also are interested in maximizing disposable income and hence tax reductions. They vote in higher numbers, and it is easier for public officials to feel their pain. Young people's voices are muted by their low voting rates.

Aside: Accountability for public universities is critical; we are spending tax dollars and need to be good stewards, but the hydraulic of many legislative accountability plans sometimes is more reflective of the loss of public good status than a genuine impulse toward efficiency.

Global Enterprises

Even the business community, which relies on an educated workforce and the innovations of research, sometimes is less interested in public higher education today.
- They are increasingly more interested in a tax structure that enhances productivity and profit.
- Corporations are also less rooted in particular communities as mergers and buyouts bounce CEOs and leadership to new homes across the nation and the world and as facilities and employees are spread around the world.
- Executives are nationally recruited and often not products of the communities in which they live and work.
- There has been an emergence of business's own education institutions such as Motorola University, Dell University, or McDonald's more longstanding Hamburger U, which focus on corporate-specific workforce needs and reduce reliance on local higher education institutions.

Regionalization of States

The public flagship research universities view themselves, appropriately, as statewide institutions, and yet regionalization of higher education within a given state is alive and well (Florida, Washington, Minnesota, Wisconsin, Pennsylvania, and Texas, just to name a few).
- This is exacerbated by rural/urban conflicts.
- Community support for regional institutions translates into political support that keeps subsidies in place and undermines the "sink or swim" privatization model that I'll touch on in a moment.

In short, I see across America a gradual withering of the covenant or understanding that the work of public research universities is a public good. Hence the recent reports from the Kellogg Commission calling for a new covenant ("compact" sounds less wrathful).

Privatization of Public Education

A call to a radio show on Minnesota Public Radio, where I was appearing as a guest, encapsulates well this "withering" trend. A man called in and he basically asked me the following (paraphrase):

> "How does the subsidy for higher education benefit me? Why should I support someone else who gets an education and gets a good job--who then might even leave the state? I'm all for research, but from what I hear, most of the money goes to help private industry. Why should I be charged for that?"

This is very similar to the question asked by the "wicked child" at the Passover Seder in Jewish households. The wicked child disassociates himself and excludes himself from the larger community. I will not answer this question at length before this audience, except to say that this is wrong, that higher education is a public good. It cultivates qualities of citizenship, engages in important research on technology and society, creates art and literature, spurs economic growth, maintains and enriches our exogenetic heritage, and helps people to lead fulfilling lives. Education benefits all of us, not just the student and faculty member. This is not a blind faith but reflects the extraordinary achievements of public higher education in this country over more than 200 years, a record that is the envy of the world.

The creeping loss of public good status may be a result of the knowledge revolution, which emphasizes entrepreneurship, dependence on private funds, relations with business, etc. but it also long predates Palm Pilots and dot coms, going back at least 20 years.

Some conservatives embrace the privatization model, attempting to create markets in public higher education: they advocate higher user fees (tuition), quality through competition among universities, and higher financial aid, roughly equivalent to income-adjusted vouchers.

- The University of Michigan is the oft-cited exemplar of this model. North Carolina and Penn State also appear to be moving in this direction.
- High access and low tuition have been traditions in Minnesota (and on this Board of Regents), but that's not reflected in how the state funds us.

Education: an Interchangeable Good?

On the other end of the spectrum, some liberals appear more concerned with democratic (vs. elite) education and ensuring broad access to two- and four-year institutions than in building flagship public research universities. The tendency is to view all education programs and courses as interchangeable,

with no concern for qualitative differences. It is also to ignore the research component of the flagship universities.

Concerns about the Market Models

- What are the challenges posed by a market model? A market system relies on some providers going out of business if they are not competitive. It doesn't work that way if subsidies continue to public institutions that fail to attract enough student dollars.
- The model assumes a free national market that does not exist, e.g., $900 million California public/private investment in research, $1 billion in Michigan over 20 years. That is like making Minnesota farmers play by the market rules when France and Germany are subsidizing their farmers.
- Important aside: some see public universities as an economic engine--hence they need to regulate or guide them *(They want to drive?)*.
  - There is no understanding of curiosity-driven research, which brought us the discovery of the double helix structure of the DNA molecule, among countless other discoveries and innovations.
  - It is very hard to predict where the economy will go. This is why I tend toward focusing on broad clusters of research rather than specific, earmarked proposals.

Neurotic Strategies?

Those of us at flagship public universities could fairly be described as neurotic, if that's your description for repeated strategic behavior that has a dysfunctional outcome.

- Collectively, the public universities like to claim that we compete for faculty with the best of the privates, and in a meaningful sense we do. Yet the compensation gap between public and private universities grows annually (I believe it is about $22,000 at the full professor level in the most recent survey).
- Governing boards, faculty, and administrators constantly press the case that their public university is falling behind in attracting and retaining faculty at competitive salaries. Yet elected leaders rarely perceive this as a race or competition that should cause concern. The relationship between programs and quality faculty is often overlooked.
- Indeed, lower salaries at very good publics are often viewed as evidence that you can do well without being competitive in compensation, that "good is good enough."
- Publics are not as selective as private institutions in admitting students and this affects graduation rates, as do the higher student-faculty ratios in the public sphere.
- Popular rankings of universities are often based on student selectivity and low student faculty ratio (in essence, expenditure per students). Bottom line: In US News and World Report's latest undergraduate rankings, only UC-Berkeley and the University of Virginia cracked the top 20 list.

- Government is often reactive to crises rather than proactive, and much of the public may not view public universities as in crisis--though governing boards, faculty, and administrators, who understand the numbers, do. Government often does not perceive the decline in status of public universities, not understanding the widening of the public/private divide.

Hard Choices

The future then portends a decline in excellence at most great publics or that they must move to a more mixed funding model.

- But high tuition hits middle class hard unless there is substantial financial aid.
- The mixed model erodes some public constituencies, particularly those that benefit from outreach activities that cannot be built into the tuition cost structure--it is hard to charge students for outreach activities. This is the reason why private institutions do less outreach and are less likely to perform functions of traditional land grant institutions.
- There exists a kind of purgatory for public universities outside California, Michigan and Virginia: moderate tuition, not enough public aid, and inability to compete with elite private universities. California is high public subsidy, low tuition. Virginia and Michigan enroll substantially numbers of non-residents as students and they pay very high tuition charges. (At the U of M, many of our non-resident students pay resident tuition rates because of our reciprocity agreements.)

I think that we are being forced into a new hybrid model by degrees, and we have to think about making deliberate and positive choices to avoid the gradual erosion of the great public institutions. If you have looked at the Chronicle of Higher Education, you have seen recent decisions at North Carolina and Iowa; higher tuition at Penn State.

As President, I have tried to be honest with this Board and to let the operations of this university be as transparent as they can be to the state policymakers who have so much to say about our future. I think that all of our cards are on the table, and without a change in public and governmental attitudes, the tradition of a first class public university will wither unless we rethink our strategies.

And I think that you as Regents know better than anyone else how hard we've pushed this legislative session. Short of skywriters and dropping leaflets from the air, we've all been out there lobbying for this year's request. Our colleges and units deserve a great deal of credit for their enthusiasm and support, and our friends and alumni have truly come through for us. With ten days left in the legislative session, we cannot become complacent and give up the gains we may have made. The Senate appropriation would allow us to maintain our momentum, with diminished aspirations. The House bill would not.

But we also have to look beyond current legislative issues to the difficult decisions that await us. All of us need to describe a long-term pathway that is feasible and achieves excellence. I trust that this board will make the right decisions, but the Regents, faculty, staff and administration will all be challenged to create a future we all believe in so deeply, but which our present funding structure does not appear to support.

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BOR Pres Rpt 5/15/01-3rd rev.