Minutes

HEALTH PLAN TASK FORCE

Tuesday, March 17, 1998
10:00-12:00
229 Nolte Center

Present: Richard McGehee (Chair), Linda Aaker, Amos Deinard, Keith Dunder, Robert Fahnhorst, Judith Gaston, Harlan Smith, Robert Sonkowsky, Larry Thompson

Absent: Avner Ben-Ner, David Hamilton

Regrets: Bart Finzel, Matt Maciejewski, Richard Purple

Guests: Konrad J. Friedemann, Thomas B. Mackenzie

Others: None

[Meeting topics: Health Care Legislation, Mental Health Issues]

Minutes

The November 20 and December 18 minutes were approved as presented.

Chair's Report

- The actuarial study is still not underway due to complications. Apparently, a team from the School of Public Health is unable to work with the task force because of conflict of interest concerns. Outside contractors may have to be contracted and bids accepted.
- Professor McGehee will meet with Vice President Bruininks to determine where the task force should be at with its recommendations in July and who will provide funding in order to reach that point.
- At the last SEGIP meeting, current health care plans said they plan to address the mental health care issue.

State and Federal Health Care Legislation-Presentation by Konrad Friedemann

Background

- Mr. Friedemann works for the Fredrickson and Byron Law Firm. The firm represents all sides of health care, but the core group is the providers and payers.
- Mr. Friedemann represents practice groups at the University as well as UCare so he is very familiar with the University system.
- Even though employers are the most represented groups, rarely is there a dispute over the legality of insurance because of the HMO system and the uniqueness of the health care industry.

- An actuarial study is critical to consider managed care and self-insurance options and the State should be contacted for all of the necessary information since they already have it.
- Mental health care is a major concern at the federal level. Senator Wellstone helped see a bill pass on January 1 that creates parity in health care coverage so mental health and other expensive areas cannot be eliminated from plans.
- There are certain types of health care that resurface in managed care since cost control is always an issue.

Comments on the Research Report

Access to University Providers

- The task force has no control over gaining access to University providers since the Academic Health Center (AHC) ultimately decides who to provide services to. There must be a mutual desire between University employees and the AHC in order for the AHC to provide services to University employees. However, demand is the best way to get them to provide their services.
- There should be no concern about separating from the state because 15,000 employees is a large enough number that health plans will negotiate with the University.
- The University of Minnesota Physicians was organized on January 1 and will be better organized in the future. Once reorganization takes place, this group will be the best providers for University employees.
- Becoming self-insured or joining BHCAG will not eliminate cost concerns, but it will solve the access issue.
- UCare should add a commercial product so their product is available to University employees.

Out-of-Area Coverage

- All of the current health care plans cover out-of-area emergencies.
- University employees do require more out-of-area coverage than other state employees because of sabbaticals and children away at college. Therefore, the University should consider a supplemental plan, contact nationwide companies since they have a similar problem, or create network access agreements with health plans so coverage is provided all over the country.
- The ability to manage care across an entire country will be considerable in cost since the coverage will have to be uniform throughout.
- A health plan cannot be designed to include out-of-area coverage unless it is an indemnity plan.

Non-managed Care Option

- Out-of-area coverage under a non-managed care option has the same stipulations as those already mentioned.

- Proposed federal regulations include an HMO Bill of Rights that would affect all of the current plans and any future plan that is designed. However, the University should not wait for proposed federal regulations to take affect by July.
- The price of a non-managed care option may be out of reach for the University.
- Current health plans are aware that patient choice is the largest concern among consumers, but they are caught between the price they must charge to remain competitive in the market and the price consumers are willing to pay.

Coverage for Domestic Partners

- Although actuarial figures have not been obtained, coverage for domestic partners may improve the risk pool because a younger, healthier population is being brought into it.

Possible Options for the Task Force

- 15,000 employees is a good size pool so do not hesitate to break away from the State.
- It is commonplace for companies similar in size to the University to be self-insured.
- The University would be a major member in BHCAG since there are 15,000 employees, but BHCAG is geared more towards businesses rather than government groups.
- A bid option should be set up to consider nation-wide coverage. The premium may be to high, but at least the University will know how much that option costs.
- Preferred 1 should be contacted for supplemental options, but they need an insurance vehicle to attach their product to.

Comments and Concerns

- If the University becomes self-insured it will save money, but state laws will not apply so patients may not get the same level of treatment that they are used to. However, ERISA preempts state legislation so the benefit design would still have to meet some guidelines.
- State regulations apply to the BHCAG model because member companies pass insurance or business risk, meaning insurance is provided.
- In the self-insured industry, employers are entitled to compensate employees when there are problems because of the consumer protection stipulations outlined in ERISA.
- Although coverage for AIDS and other new diseases are being limited, they are not the most expensive illnesses to cover. The most expensive health care includes: pre-natal care, premature births, and transplants.
- The mental health care legislation passed in January is aimed at insurers and does not extend to self-insured entities.
- If a health plan were designed for the University, it would be modeled after an existing plan that best meets the needs of the University.
- Provider-sponsored organizations allow providers to directly contract their services with hospitals and clinics and will not effect the University unless UMP becomes a member, which is not very likely.
- It is not certain if more legislative changes addressing mental health care coverage are being proposed.

- There is a minimum standard of mental health care which stipulates that a patient provided with mental health care must get better, not worse.
- Patients have become discouraged with mental health care because the question of necessity has become a barrier.
- A normal grievance process must be regulated.
- The various Blue Cross/Blue Shield companies in different states are only loosely allied and have little in common other than the name.

Mental Health-Presentation by Professor Thomas Mackenzie

- There has been a decrease in public sector funding since regulatory drugs were developed in the 1950's, and state institutions have been closed.
- Urbanization and population density has changed the nature of survival so the gap between the least and most affluent has increased.
- Many mental illnesses are different than other illnesses in that they usually strike when a person is in their teens or twenties and last for thirty to fifty years. This creates a relatively high morbidity rate and a low mortality rate of illnesses.
- Mental illnesses are not recoverable. Instead, they are maintained.
- It is difficult to determine where one aspect begins and another ends in mental illnesses so treatment is difficult to determine in a short time span.
- If a consumer receives services from different entities, the cost burden becomes unrecoverable.
- There are 400 named psychotherapies which becomes problematic for insurers since getting all of the necessary specialists into their networks is costly and probably impossible.
- Cost-effectiveness is an issue because there is no way to determine how many visits will be enough.
- Outcomes are the most important measuring devices, but they are not utilized to determine the level of coverage needed.
- Bureaucratic rationing has allowed managed care companies to pass along discounts to the provider if there are errors on the provider's part which makes it impossible for the provider to offer services because the cost recovery is too low.
- Medication costs are not regulated so they are extremely expensive because of research and development costs. Middle-aged people have the costs covered by their health plans, but older people are not covered under the Medicare B option.
- Since there is so much focus on cost control for employer funded insurance, there is the challenge of determining when potential has been met in serious conditions.
- Insurance is determined by risk rating methods so people in high risk pools pay high premiums.
- It is not clear if the focus of mental health care should be on life problems or illnesses.

Comments and Concerns

- Psychologists create a proliferation of providers.
- Drugs and therapies have created too large of an arena for mental health care.

- Managed care plans would like a closed panel of mental health care providers because they believe providers give too much care, they are only friends to patients, and a cure should be obtainable.
- Many plans do not allow residents to provide services.
- The training mission makes the University inefficient in providing services and the market place does not pay for training.
- It is impossible for faculty members to teach, conduct research, and make money through clinical services.
- Referrals are only given for the more difficult cases.
- The federal government pays resident stipends through Medicare Part B.
- The amount of time a patient sees a provider is a major concern.
- Restrictions on the number of visits has created a greater usage of drugs.
- Current mental health care provided through the State health plan stipulates a patient must go through BHSI. However, the State will not work with BHSI so patients are not getting the coverage they are entitled to.
- None of the surveys conducted by the current health plans question the satisfaction of mental health care.
- Even though there is a regulation that results of a satisfaction survey must be reported yearly to the Health Board, there are many areas to test for satisfaction.
- Surveys on patient satisfaction show that changes have been made, but surveys should not only be about outcome.
- There is no other specialty that publishes books that allow patients to determine their illness before they see a provider.
- Mental health patients are not in the position to determine if the coverage they are receiving is satisfactory.
- The solution to mental health care would be to outline the systematic problems and determine what a better system would be within cost constraints.
- A better system would include eliminating several separate providers and keeping everything internal. The University should also declare that delivering a quality clinical product is as important as teaching and research.

Adjourn

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