Health Plan Task Force Minutes

Tuesday, March 31, 1998
10:00 a.m.-12:00 noon
300 Morrill Hall

Present: Richard McGehee (Chair), Linda Aaker, Avner Ben-Ner, Amos Deinard, Keith Dunder, Robert Fahnhorst, Bart Finzel, Martha Johnson, Matt Maciejewski, Richard Purple, Harlan Smith, Larry Thompson

Absent: David Hamilton

Regrets: Judith Gaston, Priscilla Pope, Robert Sonkowsky

Guests: Scott Giebink, Lisa Jetland

Others: None

[Meeting topics: Discussion with UMP Representatives, SEGIP Purchasing Model Choices]

Minutes

The January 7, 9, 14, and 22 minutes were approved as presented.

Chair's Report

Purchasing Models

The State will decide at its April 15 JLMC meeting which purchasing model will be pursued for the year 2000 so the task force should decide which of these options would best suit University employees by then.

The model choices include the existing managed care option that would contain modifications; the BHCAG model that would be like BHCAG, but the State would not actually be a member of BHCAG; and the single buyer option, but the only companies large enough to provide services would be HealthPartners, Allina, or Blue Cross/Blue Shield.

It appears that the State is most interested BHCAG model and will default to the existing model if that does not work out. The single buyer option is not at all likely.

Actuarial Study

Vice President Bruininks has agreed to finance an outside consultant to do the actuarial study. The two possibilities are Deloitte & Touche or Watson Wyatt. Deloitte and Touche are doing the modeling for the State so they would be familiar with the information.

Comments and Concerns:

- The quality of service provided by Deloitte & Touche depends upon who is assigned to the case.
- Professor Ben-Ner agreed to organize a faculty steering committee, composed of Carlson School of Management faculty members, that would oversee the work done by the consultants.
- Although the School of Public Health faculty would like to provide consultant services, they cannot because they are too busy consulting on other issues, there is a conflict of interest, and there is a perception problem with them being part of the Academic Health Center.
- The University has considerable clout in requesting the services of Deloitte & Touche because the University has contracted their services for the past five years.
- The actuary handling the State's case would be assigned to University and Kathy Burek has welcomed that idea.
- The actuarial study will consist of gathering experience data, which will become available from the State in April, and putting it up against various purchasing models to determine the cost of each of them.
- There may be a conflict of interest if Deloitte & Touche works for the State and University at the same time.
- It is possible for Deloitte & Touche to only gather the data because the State has access to that already anyway, but the modeling can be done by another consulting firm.
- Deloitte & Touche is a professional firm so it would have to agree not to share University modeling information with the State.

Discussion with UMP Representatives--Scott Giebink and Lisa Jetland

Access Issues

The current paradigm utilized by the State to configure health plan designs is based upon a primary "gate-keeper" model where employees designate a primary care provider and are referred to specials and/or are designated to a network where there are defined referral relationships. This model design restricts referrals to UMP, who represent a skill set not replicated in the community and draw a higher risk pool.

Regardless of the model chosen by the State, the task force should consider a referral access relationship to the UMP that is equal and overlays all of the underlying models. Otherwise, UMP will never be part of any referral system because of the risk they carry.

The overall health care system through DOER is underfunded and needs cannot be met with the current budget. Unless the budget is raised, model reconfigurations will only shift the unfunded risk which is disproportionately represented by those with greater health care needs and UMP because they provide for those needs.

Purchasing Models

BHCAG Model

BHCAG is similar to the current State Health Plan Select model because it contracts with systems of care, which are primary care facilities that are fully at risk and have referral systems. UMP can only compete in this model if they attempt to become a care system. However, UMP will not be a primary care system by the year 2000 because it is complicated to organize University groups to develop a care system and the Department of Family Practice is still working with UMP to become integrated. Therefore, the only way to access UMP through BHCAG is by referrals for specialty care, but it must be mandated that UMP is included on all list of referrals and sufficient funding must be provided to proportionately compensate specialty groups.

Single Payer Model

The Single Payer Model is the most advantageous model for UMP to be a part of because the provider will be work with UMP to get proper funding at the legislature since 60,000 employees require an open access system and UMP fairs best when there is an undefined referral system.

Comments and Concerns

- The issues cited as most important in the task force report and are most relevant to UMP include out-of-area coverage, access to University providers, and mental health care.
- Access to University providers is very important to University employees because of convenience and access to specialty care.
- For 1999, negotiations are taking place between UMP and Blue Cross/Blue Shield in order for UMP to become part of the Select option, but it is not certain what is happening for the year 2000.
- If the University separates from the State, the RFP could have a design that would include access to UMP.
- The University is able to develop a special plan with UMP that does not require employees to go through an existing plan to get to them.
- It is difficult to convince the State to choose the single payer model because it would create a demand for access to the most expensive providers in the State which increases costs for everyone.
- UMP is not more expensive, but they meet the needs of those individuals with greater needs. The need will not go away even if there is no access to UMP.
- It has been stated that UMP not only provides services to those most in need, but they also use the health care system to subsidize Medical School education and research.
- There are virtually no medical dollars that go to support education and research anymore, and there is no academic build-in to the fees that are charged by UMP.
- Even though the amount of time 450 physicians in UMP spend in clinical practice only equals the work of 185 full-time employees it does not mean that they are not less efficient. They just are not practicing full-time.

- The University's leverage at the State will be based on access and the only way to get access to specialists throughout the state is to make access equal throughout the state.
- Outstate leverage will be lost if the University separates from the State.
- Mayo has the same problem of access as the University.
- It would be helpful to have information on how many state employees utilize the services of UMP.
- Through the Medica Premier product, there were 3000 members selecting UMP and 7000 accessing UMP through a referral basis. However, when Medica pulled that product, 2000 members were lost.
- The issue does not have to do with how many people have accessed UMP, but how easy it is for University employees to access UMP.
- Other health plans may refuse to refer to UMP if the State refuses to refer to them.
- It is not certain how high quality medical care, teaching, and research will be funded at the University all at the same time.
- The State will not select the single payer model because the options that are likely to come forward will not be acceptable by the employees.
- In the present market there are two options for cost savings: neutralize the risk pool with a single payer model or manage the cost by managing the providers.
- Given the current market, any additional cost savings will only be incremental so the issue does not have to do with cost savings, but with avoiding cost increases because of underfunding.
- An underfunding subsidy will not come from the legislature but from employees' wages.
- The State claims that even though much effort has been given to including UMP in the various health plans at the JLMC meetings, there has not been a positive response from UMP. However, UMP has sent four responses to the JLMC in regards to proposed RFPs.
- The entire Medica structure had 30,000 members when the Premier product was pulled and there were only 3000 Medica Premier members in UMP which only cost Medica $3 million. This shows that UMP did not contribute to the cost excess that forced Medica to pull its Premier product.
- Based on risk adjustments, care provided by UMP is less expensive than care provided by other plans.
- There are claims that UMP is only concerned with filling their clinics and not about providing services to faculty members because the faculty members cannot afford it.
- UMP wanted to be part of the Select product, but Blue Cross/ Blue Shield declined because the Select program is being run as a three-year model and they did not want interrupt the provider network configuration and the analysis of data on the success of the model.
- Despite efforts made by UMP and Mayo, none of the plans will be structured to include either of them as providers.
- Mayo may become part of the referral structure, but only because they are buying family practice clinics that gives them a risk mix.
- UMP is willing to work with BHCAG to make sure the risk adjustment assigned by BHCAG is sufficient for UMP to become a member.
- Forty percent of referrals to UMP are from outstate.
- It helps that Park Nicollet is part of the BHCAG model because it can act as a point of comparison for UMP since it deals more with specialty care.

- Providers work across the systems so the entire region receives the best possible medical care available.
- UMP has held discussions with BHCAG and negotiations run on a two-year cycle so more discussions will take place soon.
- UMP must present to as many constituencies as possible their ability to serve as an integrated system. However, this will not meet access needs or define UMP so UMP has to create the ability to compete in that arena.

Open Discussion

- If there are other groups that the task force should meet with, please let Professor McGehee know.
- The State has considered adding the BHCAG model as an option to the managed care system to test the BHCAG model.
- There is strong interest in pursuing the BHCAG model at the State level, but if it receives a negative reception at the JLMC Conference in April, the managed care model will be used instead.
- The current premiums paid by the State and University are based on the low-cost carrier and if the BHCAG model is chosen it is not certain what the subsidy will be based upon.
- Out-of-area coverage is important to the Labor movement but there has never been a good solution to deal with it.
- Health care coverage for retirees has gotten worse because they can only take the high cost option.
- It is not clear how risk adjustment is different for specialty care than it is for primary care.
- Risk adjustments are made for high risk consumers and the providers that service them.
- The out-of-area coverage issue for college-aged children could be solved if they utilize the medical services provided at their school, but those services are not always that good
- Out-of-area coverage concerns are shared by those individuals who are divorced and are mandated to provide health care coverage for their dependent children who do not live in the area.
- University residents are practicing all over the metropolitan area.
- A mandated referral system will never be developed because it could occur now and it does not.
- The University does not provide unique services because provider competition is present.
- A monopoly would be created if all providers had to refer to UMP.
- Every model can accommodate the needs that the task force has outlined as most important as long as there is some modification to each of them.
- Provider stability is not very good in the single payer model.
- Health plans would have to be eliminated if they carried too high of risk so the risk keeps being shifted.
- The BHCAG model would expand to cover the outstate area if the State takes it as its model.

- Even though dental care coverage is an issue, it is not as immediate as the medical care issue.
- A chart outlining the options and their coverage of the University's most important issues will be analyzed at the next meeting and the group will also rank the University's needs in terms of importance.

Adjourn

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