Minutes

HEALTH PLAN TASK FORCE

Thursday, November 20, 1997
1:00-3:00
346 Coffman Memorial Union

Present: Richard McGehee (Chair), Amos Deinard, Robert Fahnhorst, Bart Finzell, Richard Purple, Harlan Smith, Robert Sonkowsky, Mary Yamashita

Absent: None

Regrets: Avner Ben-Ner, David Hamilton

Guests: Kathy Burek, Dave Haugen, Budd Johnson

Others: Matt Maciejewski, Julie Swietzer

Website

- The website includes a message board and links to the State , Allina, Blue Cross, and HealthPartners.
- It will be linked to the University Senate home page and a notice will be sent to the University community notifying them of this site.
- Those people wising to submit private messages should send them to the alias that has been set up for the task force because the message board is public
- Modifications will be made to the website if problems occur with the message board being open to the public.
- E-mail messages that have already been submitted to task force members will not be posted on this site, but the people who sent those messages should be alerted of this website.
- It can be arranged for each committee member to be made aware when a new message is posted on the message board, but it is easier to just look there every so often.
- Features for advanced users include the capability of responses being sent directly to the submitter instead of that person having to return to the website for the response.
- There is also another e-mail alias and website that has been set-up for committee members to communicate among themselves.

Research Assistant

- Areas to investigate include: what other major employers of the State offer for health plans, especially those who have small branches in greater Minnesota; and other Big Ten or comparable institutions (including their retirees coverage).
- Information can be found at the Health Economics Program in the State Department of Health since it has a good amount of market level research, Allen Bon-Gartner's Survey of the Twin Cities Market, and the University Employee Relations Department.

- The final report should include: consideration of all four campuses; an Appendix with a chart showing all of the different plans and their premiums, co-insurance, deductibles, coverages, and admissions; and a comparison of the care system models.

Legislative Hearing

A public legislative hearing will be held on Tuesday, November 25, in the Biomedical Building that will focus on the role of the Academic Health Center in a managed care marketplace as well as to deal with particular concerns people may have. Formal presentations will be made by the State and the University.

State Presentation

Representatives

- Kathy Burek, Assistant Commissioner for Employee Insurance with the Minnesota Department of Employee Relations.
- Budd Johnson, Manager of Purchasing for the Insurance Division.
- Dave Haugen, Assessor of the State's purchasing strategy and the long term and Staff of the Joint Labor Management Committee (JLMC).

Overview

The Minnesota Department of Employee Relations is the State's human resource which administers the State's civil service system and negotiates the terms and conditions of employment with the unions representing State employees.

Unions include: ASFME, one for professional employees, one for front-line supervisors, three for faculty of State universities and community and technical colleges, one for State university administrators, one for nurses, one for engineers, and one for law enforcement.

95% of State positions are covered by a bargaining agreement. The other 5% are those who have a management function or their positions are confidential.

Unlike the University, the State health insurance package is negotiated as part of the larger package of terms and conditions of employment, which makes the decision process for insurance much sharper and intense.

As part of the budgeting process, the legislature budgets money to cover benefits and salary increases, but, two years ago, no additional money was recovered and last year there was only two and half percent given to cover both.

The State was very disappointed with Medica dropping one of its plans because they were not made aware of it so there were only two months to determine how to replace that product since plans provide rates in mid-April and a contract has to be in place by June 30. Because of this, rates of other plans went up significantly, including the employer contribution increasing by ten

percent and the weighted average increase advancing to almost twelve percent. The only comfort in all of this is that other large employers in the market place have experienced the same thing. However, this is a classical oligopoly because plans compete by lowering their costs too much and than they have to increase rates to maintain reserve requirements.

Because of all of this, the JLMC is working extensively on alternative health plan options, incorporating what the State should sacrifice for cost containment, price stability, and network access. Criteria will also be established to measure the current system to see how well it measures up against other alternatives.

Health plan alternatives include:

1. Review of the current system of the health plan competition model and find ways to improve it. Suggested changes include adding new plans and/or incorporating a risk adjustment process because some plans have higher per member per month costs since they attract a sicker population.

   Currently, there are five products available to State Employees in the metro area, but each of them are a part of Blue Cross, HealthPartners or Allina. Other carriers include U Care, Preferred One, and Altrue, but the only way these plans could be included is by proving they are cost competitive or can provide a network not provided in another plan.

2. Consideration of the Buyers' Health Care Action Group (BHCAG) model, which incorporates care systems instead of health plans. Care systems are organized primary care doctors who give hospital specialty referrals, which leaves more control over health care delivery and prices to the provider instead of the plan, but there is a fee for service arrangement that is adjusted on a prospective basis determined by the provider meeting their quoted rate proposals. The advantages of a care system model include no worries of doctors moving in and out of plans or plans changing, it is self-insured, and it has a risk adjustment model. However, there are high co-payments because this is a buying process instead of plan process.

   Outstate clinics would not have to contract with a larger hospital in the metro area because this plan is for organized primary caregivers who would have to make arrangements for specialists and hospital care. An ad hoc care system would be developed for those areas not covered or a hybrid would be provided that would offer health plans instead.

   The State could either replicate the BHCAG Model or simply join the existing one. BHCAG would like the State to join because there are some locations around the State where member companies don't have enough employees to make this plan effective. The State would not be buying into the same benefits set, though, because benefits would still have to be bargained with the unions.

   The advantage of BHCAG is that there are a large group of companies that can put together a plan that doesn't involve insurance because each member company assumes

their own risk. Therefore, there are no statutory requirements with the maintenance of reserves since federal legislation claims self-insured companies are exempt from State regulation. However, if the State were to implement this program, it would still maintain the same reserve requirements that would be required if regulated.

3. Offering of only one plan which would allow the employer to rebid their business every three to four years so premiums could stay low. Although this is the easiest option because one health plan is contracted on a full or self-insured basis, the only plan large enough to handle the State is Blue Cross. Also, there is no incentive for the plan to monitor their costs even though this disparity would be eliminated with benefits sets. This option is more realistic for a smaller employer that is concentrated in one geographic area.
4. Investigation of medical savings accounts which would ultimately put more accountability on the consumers for their health care choices. Under this option, the employer buys a high deductible plan and employees put a certain amount of money in a pre-tax account that can be rolled over from year to year or cashed out. However, there is debate that this option would only attract the healthy population, which would drive up the premium. One advantage to this option is that it could be added as a possibility to any of the other options. Currently, there is the ability to offer such a product, but there are no tax advantages so many employers aren't.

Collective Bargaining Process

Beginning in February, a renewal document is sent to each plan that requests justification for their rates by mid-April and network information by mid-March. The plans are reviewed thoroughly by actuaries throughout the following month to make sure the rates are justified. At the bargaining table, the unions (as a group) propose what insurance coverage they would like. The State then shows the new network configurations, recommends who should be the low-cost plan in all 87 counties, and provides the rates. The State negotiates with the plans and the unions at the same time, but the bargaining occurs more on the economic side than on the plan offering. After negotiations, the plans go to a joint subcommittee of the legislature for preliminary approval. The full legislature has to ratify the contracts in the form of a bill, but are not allowed to make any amendments. If anything is sent down, all negotiations are off the table and the State would be in breach of contract with the health plans. The budget constraints must be maintained, otherwise the contracts will not be approved.

State Employees' Group Insurance Program (SEGIP)

The goal of the SEGIP assessment and planing project is to determine:

- How well the current managed competition purchasing strategy is meeting the needs of the SEGIP.
- Whether changes are needed or desired.
- How to reach any goals.

The proposed stages of the SEGIP assessment and planning project stages are:

- Determining the criteria for decisions making.
- Describing and assessing options against criteria.
- Deciding among options based on the criteria.
- Preparing and beginning implementation.
- Completing, evaluating, and continuously improving the implementation process.

The goal of implementing change to the status quo has been set for January 1, 2000 since the State operates on a biennial budget basis and the major contract negotiations work on the same schedule.

The process will begin now and involves preliminary JLMC project discussions and planning, where core values and key goals will be determined. Early winter will bring discussion on how the different options fit with the decision criterion. A final decision on a purchasing plan will be made available by mid-March. A conference scheduled for April 29-30 will then bring together all State agencies, human resources, benefits specialists and unions to review the plan in detail. (The University will have representation at that conference with members from the task force, civil service staff, and administration.) A request for proposals will be organized when the purchasing plan decision is complete in order to find vendors who will provide the desired services and products. The RFP will be sent July 1, 1998 and those responses will be reviewed through next fall. Contract negotiations will begin early 1999 and begin open enrollment the fall of 1999, with implementation of the new plan on January 1, 2000.

Comments or Issues Raised

- Since the State is self-insured there is no way of knowing what will happen for 1999 since options are limited. However, the majority of people enrolled in the State Health Plan could enroll in the Select plan without changing their consumption patterns. This is may be questionable, though, because an influx of people into the State plan could affect the cost of health care.
- Health care is now being considered as a long term investment so open enrollment may not be offered every year. This would provide incentive to providers and plans to invest in preventative care and patient education.
- The constraints for determining the low-cost plan include the HMO plans staying in accordance with state law, the State Health Plan being specified in the union contract, and the DOER proposing those plans that are eligible to be the low-cost plans in each county. The union makes the final determination based on benefits and network options.
- University employees will be included in the process of determining the new health care plan since there has been a big enough change.
- If it is determined that the University needs a different health benefits package than the one decided upon by the executive branch of the State government, the University should consider separating from the State and selecting its own plan.
- Under State statute, the University does not have to participate in the State program.
- There is no way of knowing which option will be chosen. The unions are leaning towards the BHCAG Model, but ultimately it will come down to funding. The State must use licensed carriers, which could be located anywhere in the country, but the State's preference is to stay with a local business for convenience sake. The health plans are not

fond of the BHCAG model, but since there are so many State employees, they must be accommodating.

- Out of state coverage is an issue for both the University and the State (the faculty unions at MnSCU) because of the increasing number of out-of-state coverage responsibilities (ex-spouses). Solutions considered include budget-neutral or rider coverage, but there have been problems with each. Since significant discounts that have been negotiated with local providers out-of-state coverage appears to be much higher. In order to solve the problem, the exact difference in the expenses will have to be determined while focusing on who will pay the difference. If each person is responsible for their own expenses, each person has to pay the extra premium charges as well as the cost differential of the health care expenses.
- Although University faculty are more concerned than other State employees that they have to pay the highest rate to have their primary care come from the University clinics, the State is committed to working with the University to get the those primary care clinics into the lower cost plan.
  Considering risk adjustment when a contract is developed with University providers helps eliminate any disadvantages it has against other health care providers because it allows the University to prove that the population it serves is more at risk. At this point, no additional subsidies will be provided until issues such as this one are resolved.
- Currently, there are 60,000 State employees (14,400 which are University employees) participating in the State plan.
- Provider access of mental health coverage has been met with employee satisfaction because all providers with co-payments were removed from the network when the Parity Act was passed. A guide was also assembled describing how each plan went about making decisions on mental health coverage. One issue that hasn't been resolved has to do with in and out of network services.
- There are advocates at the State level that help resolve any problems between a plan and an employee and the University can utilize this service. Currently, there is a committee at the Health Department addressing the issue of advocacy by determining the vehicles available to employees when a conflict arises. Guidelines will be published to help people find advocates in problem situations.
- The State Health Plan is self-insured by the State, and the University purchases insurance from the State. For those people who go beyond the $2 million cap, they no longer have insurance, but no one has ever hit the cap because people change plans or the limit is increased.
- It is not certain why there are no family plans for spouses who both work for the State. Currently, each spouse has to choose his/her own plan but cannot be a dependent under the other's plan because each will automatically be assigned to a plan if none is chosen. However, there are some premiums for spouses.
- There is no way of controlling what each plan chooses to offer. However, even though there was no way of keeping Medica Premier, the Primary product was expanded to cover the twenty outstate counties that would otherwise be without of a Medica option.
- Medica claims the reason it dropped its Premier plan is that the attracted a higher risk group, and no risk adjustment was possible under the current system. HealthPartners believes Medica does not negotiate good terms with their providers or control utilization, so their costs got too high.

- The plans ultimately decide rates, but the rates must be substantiated, actuaries review each of them for validity, and there is enough documentation available to prove that the rates are accurate. Lately, the price competition among plans have caused them to discount rates, but the State Health Plan cannot be discounted because it is self-insured.

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