School Employee Insurance Plan and Design Committee

Interim Report to the Minnesota Legislature

Experience of School District Plans and Actuarial Observations

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Prepared by:

Earl L. Hoffman, F.S.A.

Reden & Anders, Ltd.

An ingenix Company

Consultants & Actuaries

60 South Sixth Street, Suite 3430
Minneapolis, MN 55402
(612) 339-7933 phone
(612) 349-3788 fax
www.reden-anders.com

Reden & Anders, Ltd.

An ingenix Company

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I. Introduction

OVERVIEW

The health plans offered by the 344 school districts in Minnesota are numerous and very diverse. Almost all districts offer more than one plan, and there are probably well over 100 unique benefit designs offered. For the period of Reden & Anders' (R&A) historical experience study (7/1/01 to 6/30/02), the districts paid over $491 million in claims for over 200,000 members. Of these members, approximately 97,500 were active employees or early (under age 65) retirees, 97,500 were dependents under age 65, and 8,000 were members (normal retirees and their Medicare-eligible dependents) age 65 or over. We estimate these claims have grown to over $550 million for the 7/1/02 to 6/30/03 year just completed.

THE CONSULTING ENGAGEMENT

R&A was retained in January 2003 by the School Employee Insurance Plan Study and Design Committee (the Committee) to provide actuarial and consulting services that will enable the Committee to complete its legislative mandate to study the feasibility and desirability of a school employee health insurance plan. R&A's role is to:

- Collect and analyze information from health plans currently providing coverage to school employees.
- Prepare a limited set of plan designs and compare to currently available plans.
- Prepare technical studies of the feasibility, desirability, structure, and costs of various risk pool structures.
- Compare the costs, plan design choices, and risk issues to those of plans now used and available to school districts.
- Assist the Committee in making recommendations to the Legislature.

DATA REQUESTS

R&A sent a data survey to all Minnesota school districts. This survey requested carrier name, monthly premium rates, employee contribution levels, and enrollment by plan of benefits. Out of a total of 344 school districts, 260 responded to the survey (see Appendices A and B). We are in the process of reviewing the responses we received, to determine if they are representative of all of the districts. If so, we will use these responses and extrapolate their information to all of the districts.

Introduction (cont'd)

R&A also sent a larger data request to carriers that cover or service school districts. The carrier data request was much more extensive than the school district request. It asked for detailed, claim-by-claim data from six of the largest carriers and summary level claims information from five other carriers that cover single school districts. It also asked for premium, member, employee, retention (administrative and other expense), and stop loss information. All but two carriers, which cover only two districts, provided an adequate response. However, the carriers used different file organization, data naming conventions, group and plan structure, and plan design information. In addition, with the data privacy requirements of the federal HIPAA going into effect on 4/14/03, carriers had understandable concerns regarding compliance with this Act and, consequently, imposed varying restrictions on the level of detail they would provide for this study.

R&A studied the claims and premiums incurred in the period 7/1/01 to 6/30/02 and paid through 1/31/03. These twelve months that we chose for the study period represent the most recently completed plan year for the large majority of districts.

INTERIM STUDY TOPICS

For this interim report, R&A focuses on the following aspects of school employee health plans. For each, we present a graph or table, present our observations, and discuss some implications the findings may have on the final study.

1. What is the covered population? What is its distribution by age, region, group size, and carrier?

2. What was the cost of these plans in the 7/1/01 to 6/30/02 study period? What proportions of claims were paid by employees and retirees?

3. How do the cost and utilization levels of this population compare to an average commercially insured population with a similar age and geographical distribution? What are some possible cost drivers?

4. If current plans are left unchanged, what do we project costs to be in the period 7/1/04 to 6/30/05? How would this projected cost change under different plan designs?

5. What funding mechanisms are now being used? What are administrative, commission, tax, and other expenses did these plans incur? What are the stop loss costs?

II. Glossary of Key Terms and Abbreviations

Allowed Cost: The total cost of health services received by plan members *after* provider discount, other contracted reimbursement and coordination of benefits are applied, but *before* member cost sharing is deducted.

Carriers: Any entity that insures or provides or administers coverage to members for health care. Carriers include insurance companies, HMOs, Blue Cross Blue Shield (BCBS); third party administrators.

Cost Sharing: The portion of each claim that members must pay out of pocket, based on plan design. Cost sharing does not include paycheck deductions for the employee's share of plan cost. Cost sharing is also referred to as out-of-pocket (OOP) expense.

HIPAA: The Federal Health Insurance Portability and Accountability Act. Among its requirements, HIPAA also mandates that carriers and other users of health plan data maintain strict confidentiality standards.

HRA: Health Reimbursement Arrangements. An employer-funded plan that reimburses employees for medical care expenses and allows unused amounts to be carried forward. An HRA can be funded by a VEBA (Voluntary Employee Benefit Association) and can be used alongside an employer-funded flexible spending account.

Member: Anyone who receives coverage from one of the districts' health plans. These include employees, retirees, COBRA individuals, and dependents.

Minnesota Service Cooperatives: These eight regional cooperatives provide health benefits and services to school districts and other public and non-profit entities. BCBS provides the benefits through a partially self-funded, minimum premium arrangement.

Out-of-Pocket (OOP): This is the portion of medical and drug allowed cost that members pay themselves. Examples of OOP expenses are office visit and drug copayments, deductibles, and coinsurance. OOP does not include employee and retiree contributions to plan premiums that are deducted from salary or pension.

PEIP: Public Employee Insurance Program. PEIP is run through the Minnesota Department of Employee Relations and is administered by Marsh-Seabury. HealthPartners, MMSI/Mayo, and Preferred One provide benefits on a self-funded basis to PEIP.

PMPM: Per Member Per Month. This is the common way in which health plans develop, compare, and track a plan's costs over time.

Retention: Expenses charged by a carrier to administer a health plan. Retention also includes premium and HMO tax, Minnesota Comprehensive Health Association (MCHA) assessments, commission, broker fees, Medicaid surcharge, and the carrier's profit or contribution to the carrier's reserves.

Glossary of Key Terms and Abbreviations (cont'd)

Retirees – Early: Retirees under age 65 and therefore not eligible for Medicare.

Retirees – Normal: Retirees age 65 and over who are eligible for Medicare.

Risk Pool: In the context of this project, a risk pool is an aggregation of school districts that could potentially agree to provide a standard set of benefit plan, jointly purchase or administer health coverage and related services for their members, and share overall gains and losses among themselves.

Stop Loss: Insurance to a self-funded plan or risk pool that covers claims in excess of an "attachment point" in a given plan year. In specific stop loss, the attachment point is an amount of claims per individual per year—typically $50,000 or more. In aggregate stop loss, the attachment point is expressed a total amount of claims in the year for the entire group.

Subscriber: The person who is or was an employee, through whom family members receive coverage. Subscribers include active employees, COBRA-eligible individuals, and retirees.

TPA: Third Party Administer. A TPA administers health plans for self-funded groups.

Trend: The combination of inflation - the increase in the costs per service - and the increase in utilization - the number of services and mix of services used by members.

III. School Plan Demographics and Related Features

OBSERVATIONS

Nearly half of all covered members are "subscribers"—employees and retirees—under age 65 (see Figure 1). A slightly higher number are dependents. Only 3% of members are retirees age 65 and over—the population for which Medicare is the primary payer and the school plan is secondary. This low percentage is somewhat surprising but possible, considering:

- Most districts require retirees to pay the full premium for coverage.
- Many districts have the same premiums for active employees and for all retirees, even those eligible for Medicare. Therefore, Medicare-eligible retirees may find it less expensive to purchase individual coverage or to get coverage from spouses.

There are approximately the same number of subscribers (employees and retirees) under 65 as there are dependents under 65. This one to one ratio is lower than we see in a typical commercial insured population. Based on a sample of responses from larger districts around the state, the percentage of subscribers electing family coverage is approximately 43%. In a typical commercial population, this percentage would be 51%.

We have been told by Committee members that retiree coverage is a significant part of most districts' costs. Because most carriers did not consistently identify covered subscribers as active employees or retirees, we are unable to look at the retired population as a whole. We assumed that all members age 65 or over are retired, and, for the study, combined early retirees with active employees.

The early retiree issue is important—districts must cover these retirees by law, and some pay the same premium share as they do for active employees. Unlike Medicare-eligible retirees, alternative individual coverage for this population is expensive and hard to get. Based on a sample of larger districts that did indicate their retirees, we estimate that 15% of all subscribers under age 65, and 40% of subscribers 55-64, are retirees. We will use this sample to compare retiree to active employee claims at later stages of this study.

The covered school district health plan population under 65 is significantly older than the average commercially insured population (Figure 2). Over 21% of the school plan members are 50-59; versus only 11% in the average commercial population. This is due to the fact that all districts must by law provide coverage to early retirees, whereas relatively few non-government groups do. The school groups also have a higher proportion of female members (Figure 3).

School Plan Demographics and Related Features (cont'd)

We divided the state into 6 geographical regions, using the boundaries of the Department of Health's Regional Coordinating Boards (Figure 4a). Nearly 52% of the members are in the Twin Cities metropolitan area. The next two largest regions, Central and Southwest, have only 15% and 11% of members, respectively (Figure 4b). The split of claim dollars by region (Figure 4c) resembles the member split. However, please note that part of these regional differences in net claims could be due to plan design differences by region.

Over 27% of the groups in our data have 50 or less covered employees and retirees, and 86% have less than 500 (Figure 5a). However, the smallest group size category has only 3% of covered employees and retirees, and even all of the groups with less than 500 employees have only 39% covered employees and retirees (Figure 5b). Groups with 500 or more employees make up only 11% of the group count but cover 61% of the employees and retirees. Note that *covered* employees and retirees are not the same, and are sometimes significantly less than, *eligible* employees and retirees. We did not receive consistently reliable data on eligible employees or retirees waiving coverage to be able to subdivide experience by total number of district employees. In addition, the group count included 42 additional non-school district groups. These are some charter schools, special districts, and education-related entities that we could not separate from the school districts in time for this study.

Blue Cross Blue Shield of Minnesota (BCBS) had 54% of the net claims paid for 7/1/01-6/30/02 (Figures 6). BCBS' large share is due to its being the carrier for the Minnesota Service Cooperatives, which cover approximately 250 districts, and also for several large districts outside of the Cooperatives. The next two largest carriers, Medica and HealthPartners, had 22% and 17% of the claims, respectively. HealthPartners, Preferred One, and Mayo/MMSI are also the carriers for the Public Employers Insurance Plan (PEIP), which covers 19 districts. Finally, outside of the Service Cooperatives and PEIP, which are technically self-funded risk pools, there are 14 other districts that are separately self-funded and administered by either the large carriers mentioned above or by other TPAs, such as CBSA and Wausau Benefits.

IMPLICATIONS

The Committee should consider, in its plan designs, wellness programs targeted to the districts' generally older plan membership. In addition, significant financial incentives, such as employer health spending account contributions or lower payroll deductions, may be necessary to encourage this generally older population to take plans with higher cost sharing.

School Plan Demographics and Related Features (cont'd)

The fact that over half of the members are in the Twin Cities area may influence perceptions of cost equity among districts in a single, statewide risk pool. The possible combination of a large number of small districts with few members and a small number of large districts with many members is a critical issue in designing a risk pool, especially if the proposed pool is voluntary—that is, districts can opt in or out. Large districts have fairly credible experience and can more easily shop for coverage, if their claims experience is lower than average. In a voluntary pool, these groups could opt out, leaving the pool with only large groups that have higher than average claims and small groups, whose experience is not credible.

Many of these issues are solved either by having a mandatory pool (districts must join) or by the legislature's creating financial incentives for districts to join the pool. Even in these situations, it is still important to maintain equity among groups, in the sharing of gains and losses. In addition to a single statewide risk pool, the Committee should consider risk sharing arrangements that base at least part of a group's share of pool results on the group's own experience.

There are clearly several coverage sources that districts can now choose from. This is particularly true for the districts in the Twin Cities and those large enough to self-insure. In order to offset the perceived advantages of carrier choice, any possible new risk pool will have to demonstrate advantages, which may include lower administrative cost, lower stop loss expense, a variety of plan choices, more and better plan features, and greater rate stability from year to year through wider risk sharing.

IV. Historical Costs Compared to Benchmarks

OBSERVATIONS

Not counting employee premium contributions deducted from paychecks, members (employees and their dependents) pay out-of-pocket (OOP) approximately 10¢ of every $1 of allowed medical charges, with their health plans paying the remaining 90¢ (Figures 7a and 7b). This benefit level is equivalent to the level we would see in a plan with $10 and $50 office visit and emergency room copayments, $7 and $14 formulary and non-formulary drug copayments, 10% hospital charge coinsurance, and 100% coverage on all else. This level of member cost sharing is less than what we see in typical commercial groups.

For members age 65 and over (Figure 7c), the average level of member cost sharing is higher, at 13%. This is primarily a retired population with Medicare as the primary payer. Prescription drugs are a major, and sometimes the largest, component of plan cost, and they are not covered by Medicare. Cost sharing on these drugs is a usually a higher percentage of allowed cost than the plan's cost sharing on other items, causing the overall member cost share to be higher.

The districts offer a wide variety of plans, from traditional "first dollar" type plans with little hospital and surgical cost sharing and modest cost sharing for other services, to standard HMO designs with $10-15 office visit copayments and little additional in-network non-pharmacy cost sharing, to major medical and PPO plans with deductibles ranging from $100 to $2,000. However, there were relatively few members in the higher deductible plans during the 7/1/01 to 6/30/02 period.

Preliminary data suggest that many school districts contribute the entire single employee/retiree cost of plans with low member cost sharing. Some districts with multiple plans do require employee/retiree contributions for the lowest cost sharing plans, but often these higher employee contributions are less than the increase in value of the benefits of these plans versus other plans.

We next compared the utilization levels and allowed costs (before member cost sharing such as deductibles, copayments, and coinsurance) from the districts during the 7/1/01 to 6/30/02 period to the levels and costs we would expect during the same period from an average commercially insured "benchmark" population, using R&A cost model (Figure 8). We looked only at members under age 65 and adjusted the model costs to reflect school group members' actual age and geographical distributions and average provider discounts around the state. Overall, the costs of school plan members under age 65 were 13% higher than our model costs for this benchmark population. Note that this school population includes a significant number of early retirees, whereas the commercial population would have relatively few early retirees.

The higher PMPM claims of school district members are due to a higher physician utilization rate and to much higher inpatient costs per day and drug costs per prescription than we see in a typical commercial population. Lower school member inpatient and drug utilization offsets some, but not all, of the impact of the higher cost drivers.

Historical Costs Compared to Benchmarks (cont'd)

We will be looking more closely into the factors that influence school group members' utilization levels. To illustrate one such study, Figure 9 shows the top 20 drugs prescribed to district members. These 20 drugs alone account for 22% of all drug costs in the school plans during the study period and 4.5% of *total* plan costs.

IMPLICATIONS

Our starting point in this study is the fact that a large number of employees have chosen plans with low member cost sharing. The Committee will need to consider how to structure new plan designs that will appeal to these employees yet, at the same time, create incentives for them to utilize health services wisely and to engage in wellness activities. In addition, the Committee may want to consider plans with HRAs that can provide a financial incentive for employees to shift to higher cost sharing plans.

Later studies will look further into the reasons why the school population's costs are higher than the commercially insured benchmark population. To the extent we can discover some of these reasons, R&A and the Committee can review wellness activities and education and plan features that target the causes.

For example, the school plan members' average drug cost per population is much higher than our commercial benchmark. This could be due to the fact that the large majority of school plans have either single drug copayments or formulary/non-formulary split copayments. In plans like these, formulary brand drugs cost the member the same as generic drugs. The Committee should consider three or even four tier copayment structures that direct more utilization to generic drugs.

V. Projected Costs Under Current and Alternative Plans

OBSERVATIONS

One of the main legislative charges to the Committee is to "...recommend specifications for a health insurance plans to serve eligible employees..." and to include the projected costs of those plans. To illustrate how this process works, R&A developed three sample plans, called Plans A, B, and C (Figure 10). Please note that the Committee has not decided to recommend these plans; we show them only to illustrate the process of projecting costs and comparing different designs. In addition, the Committee requested that R&A model a plan similar to the Minnesota Advantage Plan available to state employees. This is Plan D (see Appendix for complete plan features).

We next projected the costs of the current mix of plans in the period 7/1/04 to 6/30/05, only for the under age 65 school plan population, using the following annual trend rates, based on R&A's standard assumptions:

TABLE 1
ANNUAL PROJECTED TREND RATES
TRENDING ON ALLOWED COSTS FROM 2001-2002 TO 2004-2005

Service Type	Utilization	Cost	Total
Inpatient	4.0%	7.0%	11.3%
Outpatient	8.6%	9.0%	18.4%
Physician/Other	5.0%	4.0%	9.2%
Rx	6.7%	11.4%	18.9%
Total	5.9%	7.2%	13.6%
Total w/o Rx	5.6%	5.9%	11.8%

We project that *allowed* costs, before member cost sharing, increases by an average of 13.6% per year over the three year projection period. *Net* costs, after cost sharing, will increase by slightly more than this, because deductibles and copayment amounts are fixed and tend to leverage net costs upward.

We project that the cost of the historical mix of plans during the study period, left unchanged, will increase to $298.38 PMPM during 7/1/04-6/30/05. This represents an average increase of 14.1% per year from the 7/1/01-6/30/02 costs (Figures 11a and 11b). We then projected costs in 7/1/04-6/30/05 for each of the four sample plan alternatives. We assumed that the *entire* school employee population would shift to each of these plans.

Projected Costs Under Current and Alternate Plans (cont'd)

Plan A is a high deductible plan, suitable for an HRA arrangement. If all members switched to this plan, we project that the claim cost in 7/1/04-6/30/05 would not change from the 7/1/01-6/30/02 claim cost of the current mix of plans and would be 31% less than the projected 7/1/04-6/30/05 claim cost of the current mix. We estimate that 20% of this reduction comes from lower utilization, and 80% comes from requiring higher member cost sharing. We believe that plans with higher member cost sharing encourage wiser use of health services and provide an incentive for members to adopt healthier lifestyles.

Plans B and C represent benefit levels with lower levels of member cost sharing than Plan A, but higher cost sharing than the average in the current plan mix. A shift of all members to these plans would reduce projected 7/1/04-6/30/05 claim costs by 16% for Plan B and 8% for Plan C. As with Plan A, part of this reduction comes from expected lower utilization and part from requiring higher member cost sharing (see Figure 11b).

Plan D, which is similar to the Minnesota Advantage Plan offered to state employees, has a projected cost that is 1% less than the projected cost of the current mix of plans. To develop the projected cost of Plan D, we assume that there would be a shift of member utilization to lower cost providers, particularly those referred to as Level One, because the plan has lower member cost sharing provisions if members choose Level One providers. In addition, unlike most of the current plans, Plan D provides no benefits for services of non-network providers in Minnesota.

We based our assumptions about utilization and provider charges by level for Plan D on general discussions we had with staff of the Minnesota Department of Employee Relations and with their consultant. The information we received reflects the state employee and retiree population and may not be the same for school employees, who may have different age, gender, and geographical distributions. Nonetheless, we include our model Plan D costs here in order to illustrate how costs can vary by benefit plan. An actual rate calculation for the school employee/retiree population would require more in-depth analysis of allowed provider charges and modeling of utilization by benefit level.

Our assumption that the *entire* school employee population would shift to each of these plans is obviously simplistic, but, given the limitations of our data at this point, at least it allows us to illustrate how plan modeling works. In our later work, we will divide the members by the level of benefits they now have and then model different plan migration patterns, depending on members' current plan choices.

Projected Costs Under Current and Alternate Plans (cont'd)

IMPLICATIONS

With costs projected to increase by 14% or more each year for the next three years, the Committee will consider plan alternatives that allow districts to reduce this expected rise in cost. Increasing member cost sharing is an obvious, but not the only, choice for plan changes. Wellness education, tiered drug copayments, and HRAs that allow members to roll over unused amounts also can play an important role. As we mention above, the challenge is to find new mix of plan designs that are cost effective and yet are still attractive to school plan members, many of whom now choose low cost sharing plans.

VI. Administrative Expenses, Taxes, Other Retention, and Stop Loss

OBSERVATIONS

Expense Items

Carriers include various retention charges in their overall insured premium calculations or fees to administer self-funded plans. The following items are included with retention:

- Administrative expenses to pay claims, handle member relations, perform renewals and other group services, manage provider networks, and provide for corporate overhead.
- Margin for profit or contribution to the health plan's reserves.
- Premium or HMO taxes on insured or HMO premiums.
- Medicaid tax or Medical Assistance surcharge on insured or HMO premiums.
- Minnesota Comprehensive Health Association (MCHA) assessment on insured or HMO premiums.
- Charge to provide individual conversion policies to former group members after their COBRA periods have expired.
- Commissions and fees to brokers.
- Service cooperative expense charges, and expense allocation by the state to PEIP for its administrative cost for PEIP.

For the 7/1/01 to 6/30/02 historical period we studied, these expenses totaled 12.5% of claims (Figure 12). These do not include expenses and commissions built into stop loss premiums. Also, for selected groups where we felt commission may have been under-reported, we increased expenses by 1% to 3% of claims. The highest cost is with the separate insured groups (covered by health plans and insurers but not in PEIP or the service cooperatives). However, these groups' expenses include a significant amount of premium and HMO tax and MCHA and other premium-based assessments.

Excluding premium and HMO taxes and MCHA and other state assessments, which affect the insured groups, the overall expense percentage decreases to 11.0% of claims. The separate insured groups still have a higher expense percentage than the PEIP, service cooperative, and separate self-funded groups have.

Administrative Expenses, Taxes, Other Retention, and Stop Loss (cont'd)

For comparison, the expenses associated with the State Employees Group Insurance Plan (SEGIP; also referred to as the Minnesota Advantage Plan) are slightly less than 10% of claims. The SEGIP expenses would not include taxes and assessments, but we assume other administrative functions would be the same as for the school districts. We should note that SEGIP is a single plan for a single, although very large and diverse, group. SEGIP pays no commissions, whereas there are broker and agent commissions and fees for many school districts. Even excluding commissions, we would expect the SEGIP administrative expense, as a percentage of claims, to be less than that of 344 separate school district groups offering a total of perhaps 100 or more plan variations.

Stop Loss

There are a few separate, independently self-funded groups. These are generally large districts, although some very large districts, like Minneapolis, St. Paul, and Duluth, are insured. The independently self-funded groups purchase specific stop loss coverage for their large individual claims. The specific stop loss attachment points, which are the claims thresholds at which the carrier's liability starts, range from $15,000 to $300,000 per member per year; the average level is roughly $100,000. In addition, the carriers usually provide the groups with aggregate stop loss that covers total group claims for the year that exceed a group-wide claims threshold.

The Association groups—PEIP and service cooperatives—are technically self-funded pools that purchase stop loss coverage. These attachment points range from $50,000 to $250,000.

We have not analyzed the stop loss costs. Furthermore, it is likely that some self-funded groups and some service cooperatives have raised their stop loss attachment points since 2001-02.

In Figure 13, we illustrate a hypothetical risk pool structure in which the pool buys reinsurance at a $500,000 attachment from an insurer and then spreads among its groups the cost of individual claims between $100,000 and $500,000 per year. Although the stop loss premium at $500,000 is considerably less than the premium at $100,000, the lower premium is mostly offset by additional claims that the pool would be liable for. In addition, the pool would have to use some of the premium difference to maintain a significant stabilization reserve, which in the illustrated hypothetical situation we have set at 30% of annual premium. Please note that this is a hypothetical illustration; actual market stop loss costs and stabilization reserve requirements may not be the same as we show in Figure 13.

Administrative Expenses, Taxes, Other Retention, and Stop Loss (cont'd)

IMPLICATIONS

Expense Items

Considering the diversity of school district groups and plans, the overall average expense level of these plans appears to be reasonable. However, there are significant differences in expense levels between groups.

A large pool with a limited number of standardized plan designs and standardized administration may provide some opportunity to reduce the current overall expense level. Any savings would be initially offset, at least in part, by the cost of setting up a new health insurance pool arrangement for the districts. In the next phase of this study, the Committee and R&A will be estimating the administrative cost of any new arrangements, including start-up costs, and comparing this to the current cost.

Stop Loss

As we illustrate in Figure 13, we believe there may be an opportunity for a large school district risk pool to lower overall costs by using an internal pooling arrangement as described above. The Committee and R&A will study this in more detail when we look into risk pool structures and funding arrangements later this year.

VII. Other Issues

EMPLOYEE CONTRIBUTIONS

We have not reviewed all of the responses we received from the school districts. There are 260 of these responses so far, and a significant number contain partial responses and incomplete information. After we have analyzed the carrier data, we will start to summarize and sample the information we received from the districts. Our objective is to use the district responses to estimate what percentage of the premiums, on the average, that employees pay out of their paychecks. This will enable the Committee to estimate the impact of plan offerings on what employees actually have to pay for the plans.

RETIREE COVERAGE

Many of the school district responses did not provide full information about retirees. In addition, the carriers' member data did not have consistent and reliable retiree identifiers. These factors make it impossible to sort accurately the experience by active employees and retirees. We have chosen instead to separate the experience by members under 65 and members 65 and over. Using a sampling of the information from large groups that did report on their retirees, we estimate that 25% of subscribers age 50 to 64 are retirees, and 40% age 55 to 64 are retirees. These are much higher percentages than we see in the average commercial population. Minnesota law requires districts to offer coverage to the early retirees.

Of the subscribers age 65 and over, we estimate that 87% are retired. Districts do not have to offer coverage to this group, and any coverage they do provide coordinates with Medicare.

Our initial analyses will necessarily have to group all members under 65 together, active employees and early retirees. We will consider the significant presence of early retirees in our work and try to make appropriate assumptions and adjustments that reflect their presence in the under 65 population data.

VIII. Next Phases of Study and Conclusion

Now that we have a database and reasonably good picture of the school plan population and the plans now being offered, R&A and the Committee can move into the next phases of the project:

1. **Separate the covered population by their current levels of benefits**. This will allow us to move from the modeling we show here—everyone moving to one plan—to a more realistic situation of members migrating initially to plans similar to what they now have.

2. **Develop different plan designs**. This includes wellness features and medical savings features. How many plans should be offered? Should there be employer contribution requirements and restrictions against paying cash in lieu of benefits? What wellness services can a larger pool make available?

3. **Is a school employee health plan pool feasible and desirable?** The Committee will address the issues of cost, coverage provided, financial feasibility, solvency, and management.

4. **How would the cost of a proposed statewide pool or regional pools compare to current plans' costs?** Would there be savings and, if so, would the savings be large enough to justify setting up a new structure? Would a structure involving the current carriers and intermediaries be workable and cost effective? Are there carriers who can administer and take some of the risk of a proposed pool? The Committee will compare coverage provided by fully insured plans, multiple employer welfare organizations, self-funding, and existing sources.

5. **What would be the administrative expense and stop loss costs under a new pooling structure?** We will measure current costs and compare these to estimated costs under various structures. Since any new structure may have to use provider networks already set up, at least initially, R&A and the Committee will try to get cost estimates to administer a new pool from carriers now in the Minnesota market. For stop loss, we can get estimates from both existing carriers and from insurers that only write this coverage. A large risk pool may be able to purchase stop loss at a very high attachment point--$500,000, for example—then spread the cost of smaller catastrophic claims over its member groups, such that these groups' total stop loss cost could be less than the level they would otherwise pay separately. The Committee will consider the effects of a pool on districts of various sizes, locations, and financial resources and will study the inclusion of non-public schools in a pool.

6. **How should a statewide risk pool or regional pools be structured?** If the Committee finds that a new pooling arrangement would save a significant amount from the current plans, then the next step would be to develop the structure. The first issue is the conditions under which a district can join, remain in, and leave a pool. A purely voluntary pool, in which district can each decide to join or leave, brings numerous issues, such as risk selection, rate setting (use of actual group experience to set its rates), employer contributions, employee participation, and pooling of claims, gains, and losses among member groups.

Next Phases of Study and Conclusion (cont'd)

At the other extreme is a mandatory pool, in which districts are required by law to join. This would obviously eliminate most of the above issues but would still require careful consideration of maintaining equity in how rates are set and how gains and losses are divided.

A middle ground is a voluntary pool where districts can still decide to join or leave but where financial incentives are in place to make the pool an attractive choice. For example, if the legislature provides special funding to districts if they join the pool, then depending on the level of this special funding, some large districts with favorable claims experience may find it financially advantageous to join with other large districts that have high claims experience and with small districts. Incentives such as these preserve the voluntary nature of the pool while providing a stabilizing factor.

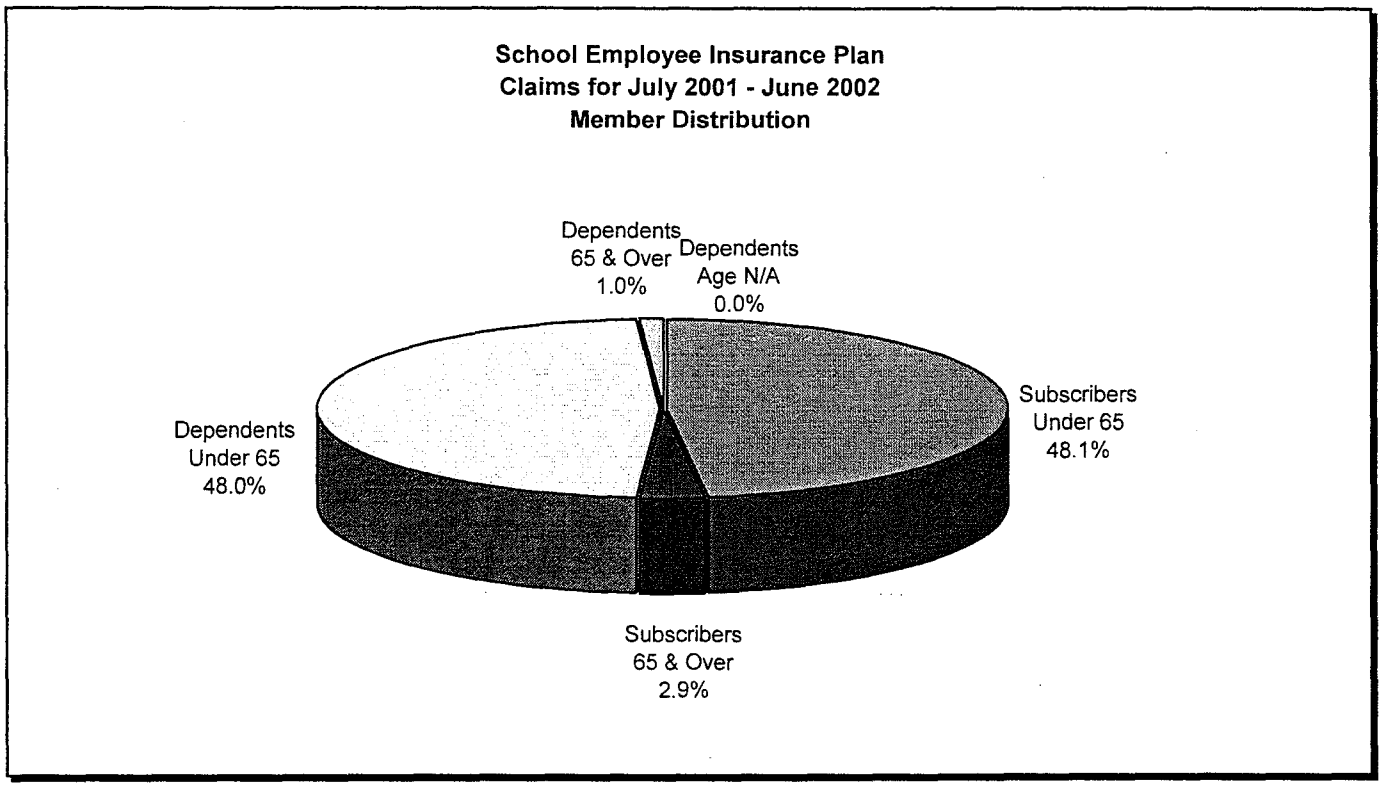
If Committee recommends a new pooling arrangement, R&A and the Committee will develop methods to distribute gains among groups, assess groups for losses, and build up claim and rate stabilization reserves. If the pool is to be voluntary, it will be necessary to develop underwriting rules and requirements for groups to join, remain in, and leave the pool.

CONCLUSION

Although the data-gathering phase has been difficult, and as a result, taken longer than we originally anticipated, we now have a reasonably good picture of the type of plans school districts offer and the characteristics of their insured population. Unlike the state employees' plan, for example, school plans are very diverse—in terms of benefit designs, carriers, employee contribution levels, funding mechanisms, and, of course, the sheer number of independent entities.

Together with the Committee, we look forward to the challenge of studying these plans and their insured population in more detail, to see if new risk pool structures and plan designs are capable of providing savings to the school districts while providing an attractive set of plan designs and an equitable pooling structure.

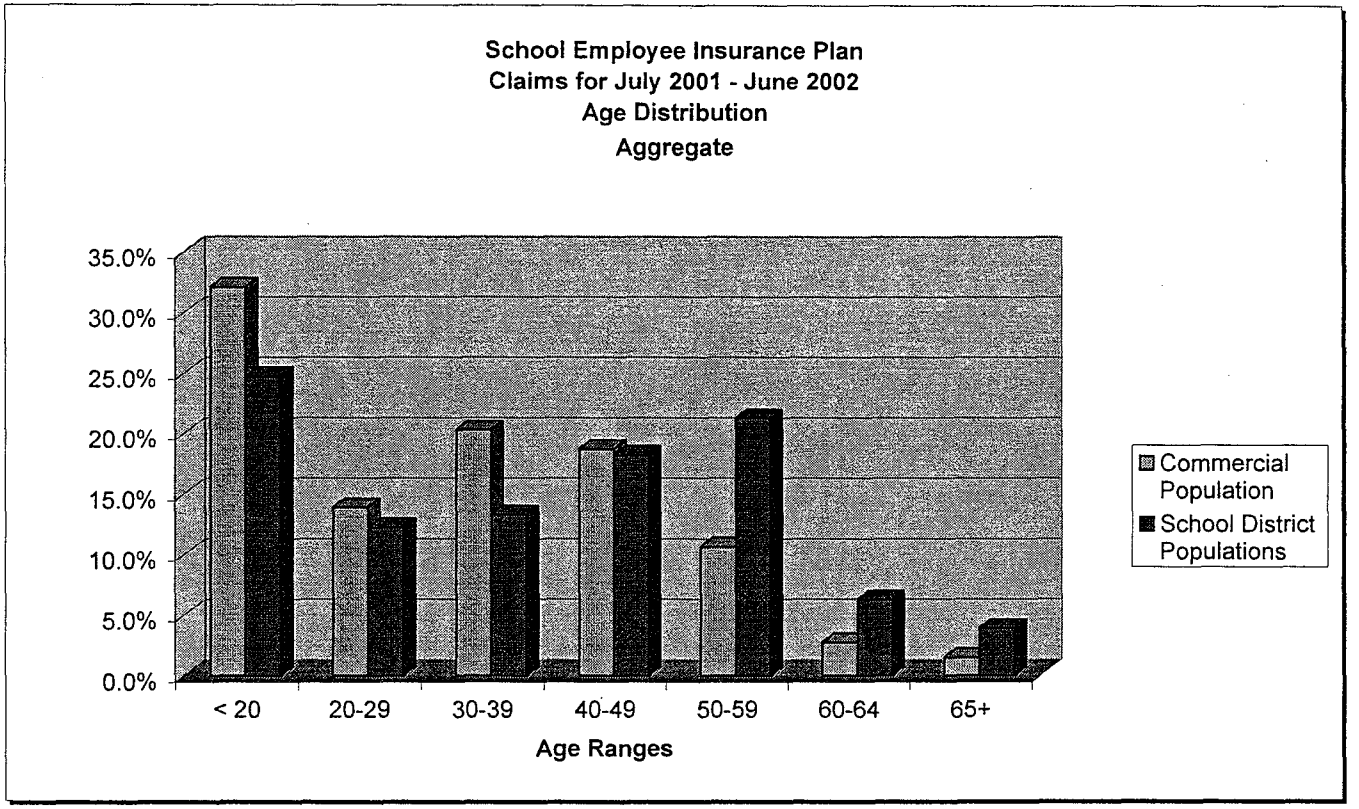
Figure 1



Claims for July 2001 - June 2002	
Member Description	Members
Subscribers Under 65	94,977
Subscribers 65 & Over	5,644
Dependents Under 65	94,618
Dependents 65 & Over	2,009
Dependents Age N/A	6
Total	197,254

Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

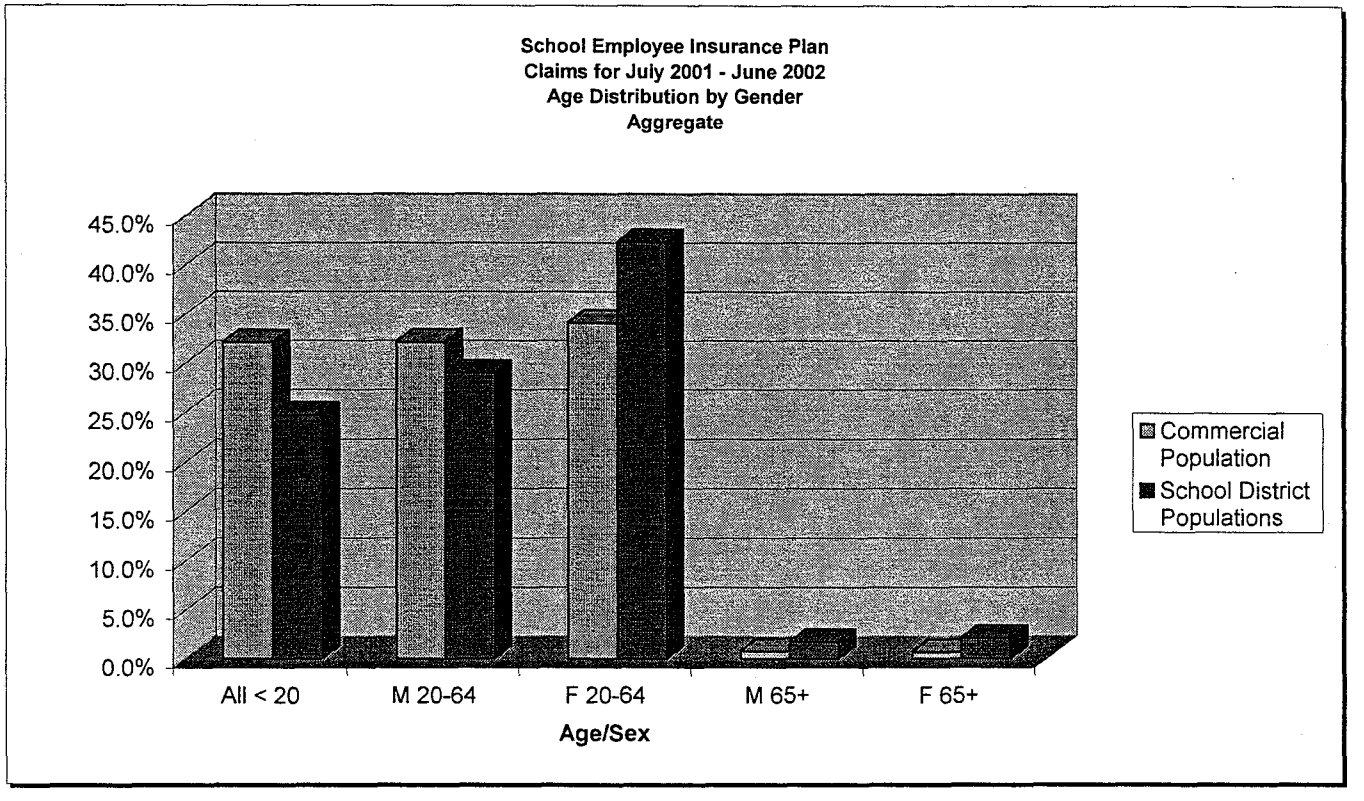
Figure 2



Claims for July 2001 - June 2002		
Age Range	Commercial Population	School District Populations
< 20	32.15%	24.74%
20-29	13.92%	12.24%
30-39	20.28%	13.33%
40-49	18.70%	18.25%
50-59	10.68%	21.26%
60-64	2.76%	6.27%
65+	1.52%	3.90%
Total	100.00%	100.00%

Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

Figure 3



Claims for July 2001 - June 2002		
Age/Sex	Commercial Population	School District Populations
All < 20	32.15%	24.74%
M 20-64	32.21%	28.99%
F 20-64	34.13%	42.36%
M 65+	0.80%	1.77%
F 65+	0.72%	2.14%
Total	100.00%	100.00%

Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

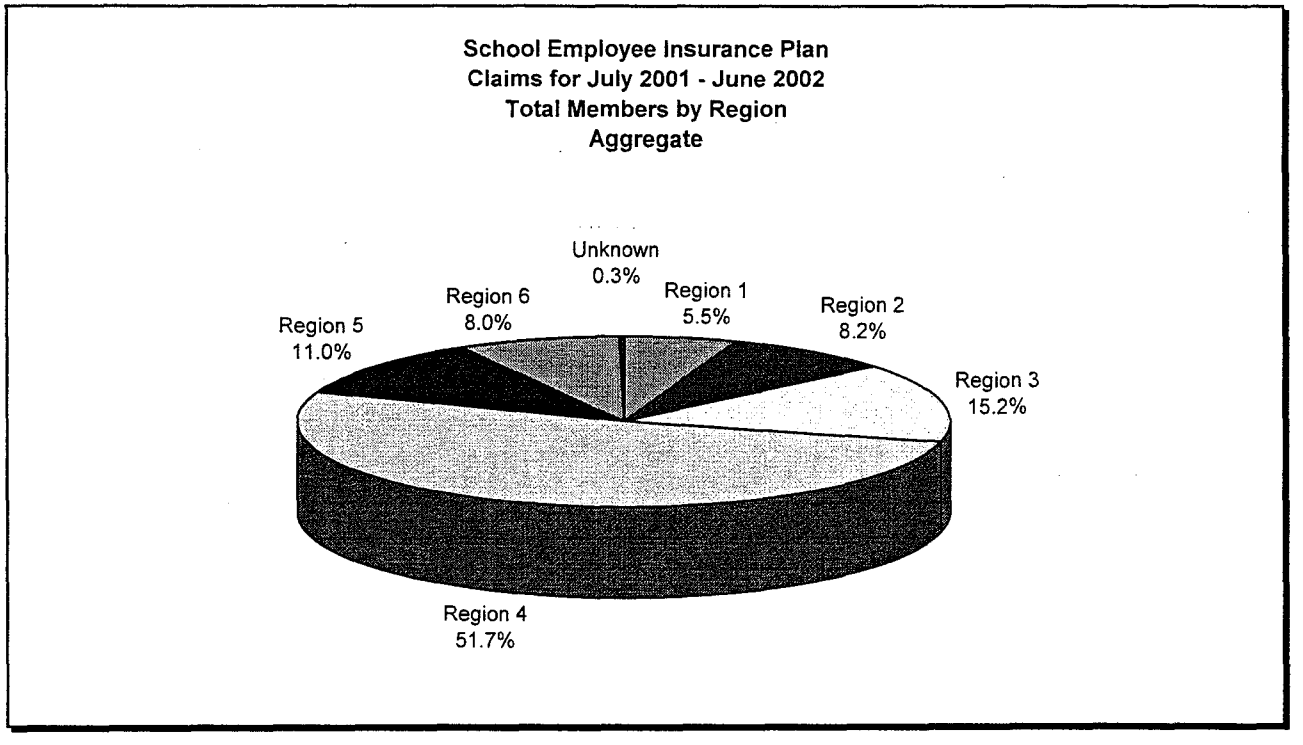
Figure 4a

Preliminary Definitions of School District Regions

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Kittson	Koochiching	Cass	Anoka	Big Stone	Rice
Roseau	Itasca	Crow Wing	Washington	Swift	Goodhue
Lake of the Woods	Aitkin	Otter Tail	Hennepin	Kandiyohi	Wabasha
Marshal	Kanabec	Wadena	Ramsey	Meeker	Steele
Beltrami	St. Louis	Traverse	Carver	Lac Qui Parle	Dodge
Polk	Carlton	Grant	Dakota	Chippewa	Olmsted
Pennington	Pine	Douglas	Scott	Renville	Winona
Red Lake	Lake	Todd		McLeod	Freeborn
Clearwater	Cook	Morrison		Yellow Medicine	Mower
Norman		Mille Lacs		Sibley	Fillmore
Mahnomen		Stevens		Lincoln	Houston
Hubbard		Pope		Lyon	
Clay		Stearns		Redwood	
Becker		Benton		Nicollet	
Wilkin		Sherburne		Le Sueur	
		Isanti		Brown	
		Chisago		Pipestone	
		Wright		Murray	
				Cottonwood	
				Watonwan	
				Blue Earth	
				Waseca	
				Rock	
				Nobles	
				Jackson	
				Martin	
				Faribault	

These regions are the same as the Regional Coordinating Boards.

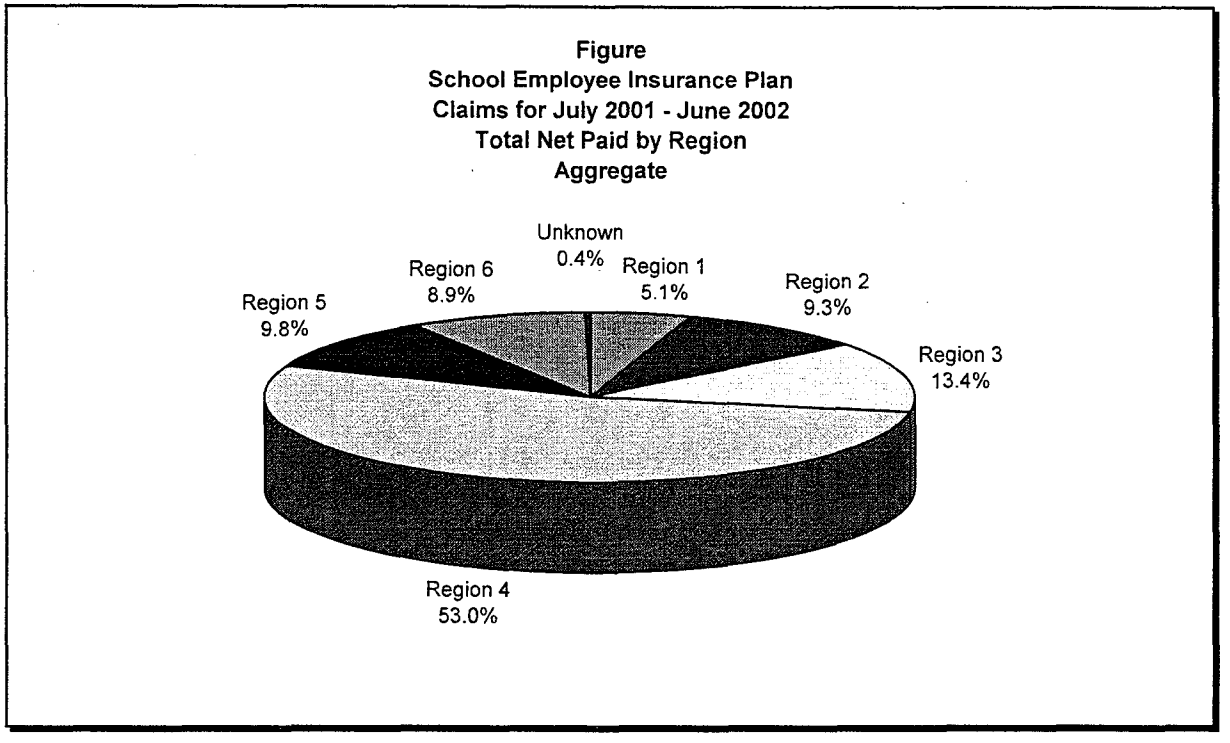
Figure 4b



Claims for July 2001 - June 2002		
Region	%	Members
Region 1	5.5%	11,240
Region 2	8.2%	16,703
Region 3	15.2%	30,823
Region 4	51.7%	104,824
Region 5	11.0%	22,308
Region 6	8.0%	16,238
Unknown	0.3%	610
Total	100.0%	202,747

Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

Figure 4c

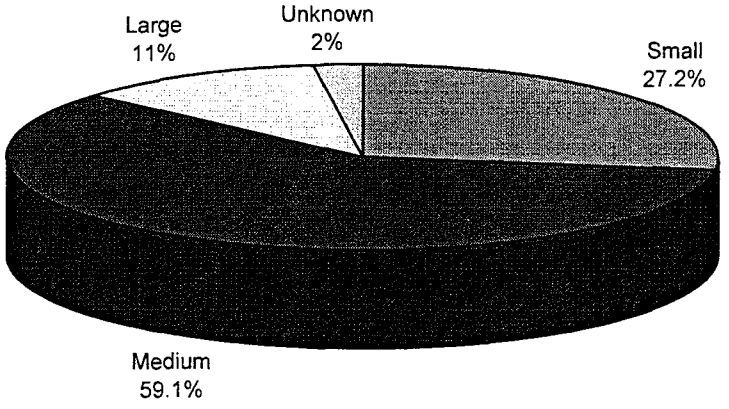


Claims for July 2001 - June 2002		
Region	%	Paid Dollars
Region 1	5.1%	$25,243,690
Region 2	9.3%	45,890,260
Region 3	13.4%	65,757,807
Region 4	53.0%	260,590,536
Region 5	9.8%	48,264,758
Region 6	8.9%	43,858,047
Unknown	0.4%	1,789,319
Total	100.0%	$491,394,418

Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

Figure 5a

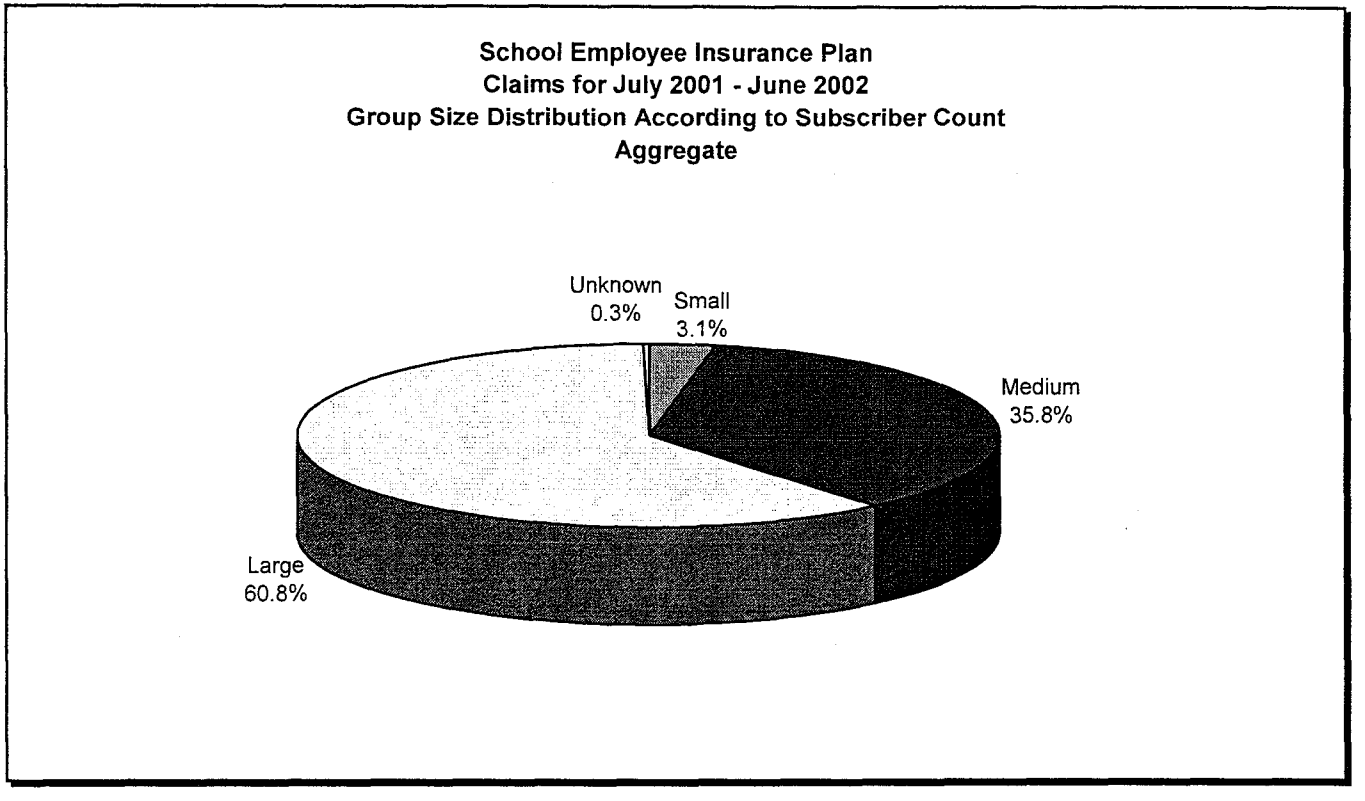
School Employee Insurance Plan
Claims for July 2001 - June 2002
Group Size Distribution According to Group Count
Aggregate



Claims for July 2001 - June 2002		
Size	Criteria	Group Count
Small	(0-50)	105
Medium	(51-499)	228
Large	(>=500)	44
Unknown		9
Total		386

Note: The above counts include some charter schools, special districts, and non-ISD education related entities.

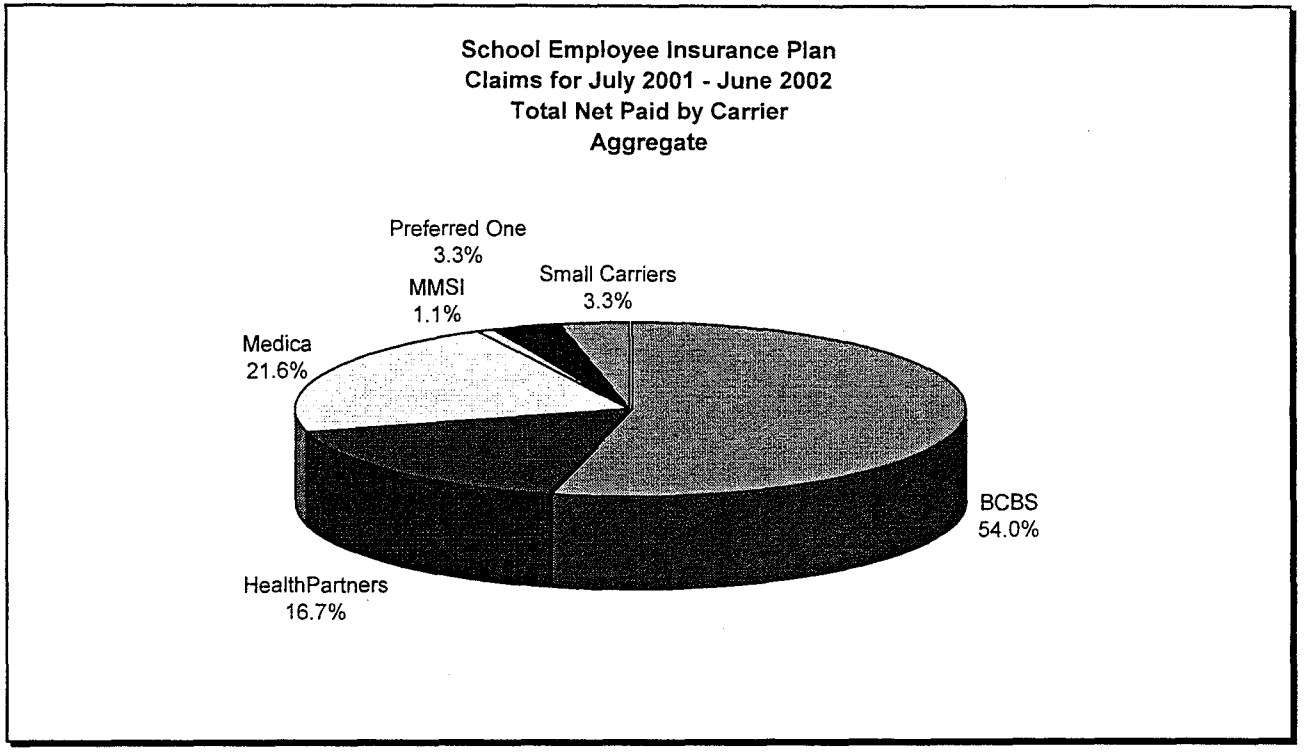
Figure 5b



Claims for July 2001 - June 2002		
Size	Criteria	Subscribers
Small	(0-50)	3,191
Medium	(51-499)	37,069
Large	(>=500)	62,944
Unknown		357
Total		103,561

Note: The above counts include some charter schools, special districts, and non-ISD education related entities.

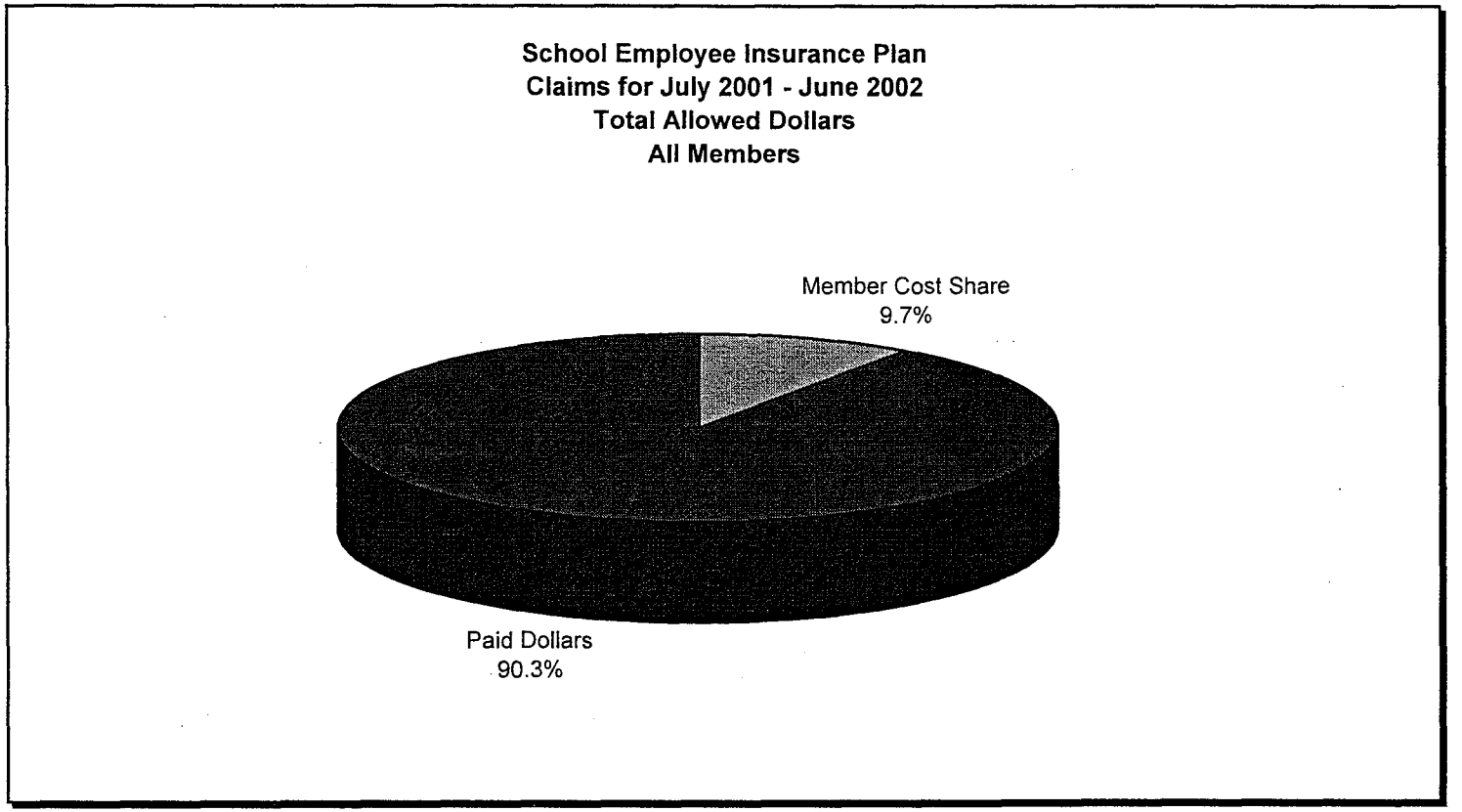
Figure 6



Claims for July 2001 - June 2002	
Carrier	Paid Dollars
BCBS	$265,454,121
HealthPartners	82,266,187
Medica	106,384,377
MMSI	5,191,364
Preferred One	16,062,581
Small Carriers (Est.)	16,035,789
Total	$491,394,418

Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

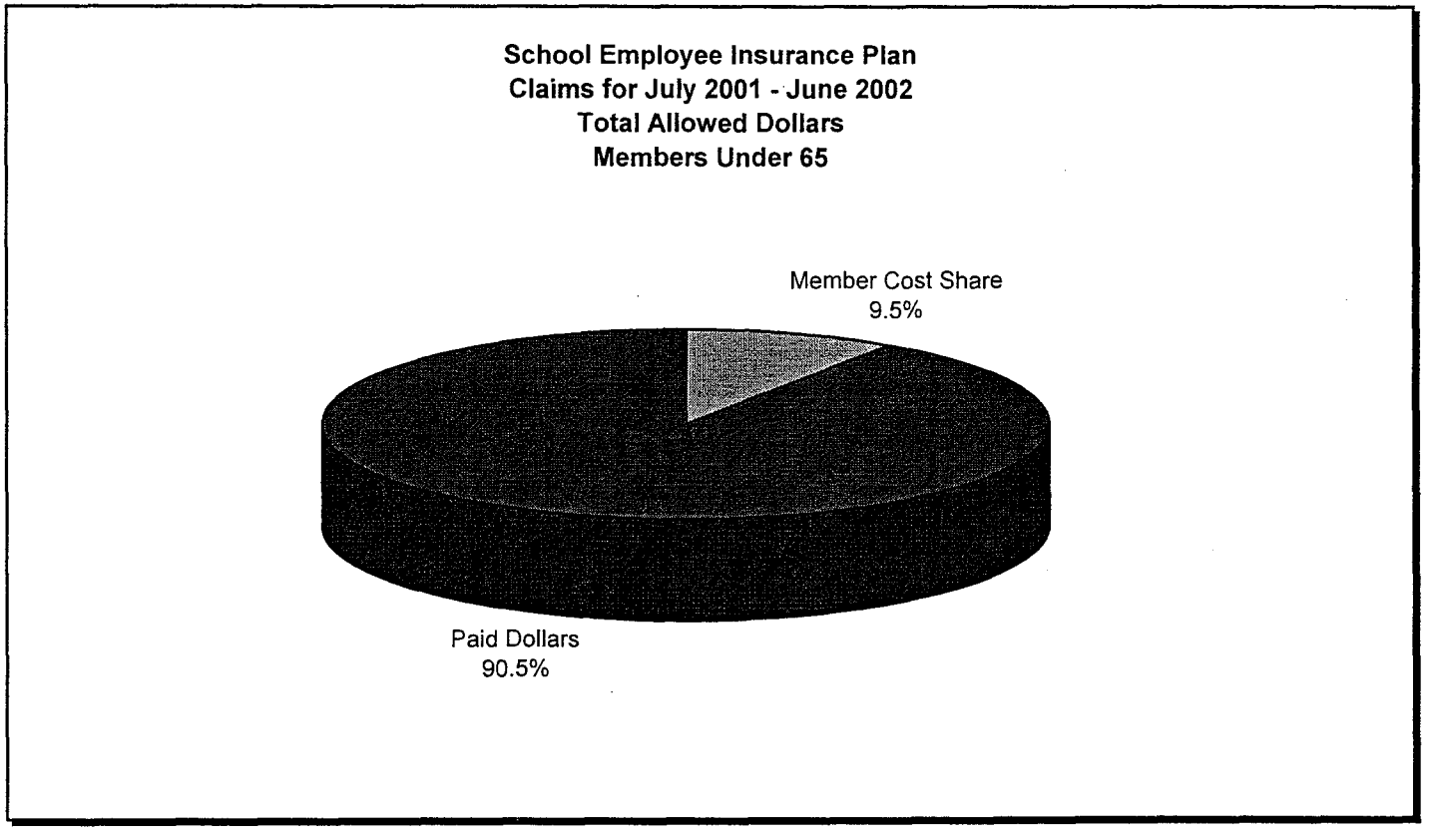
Figure 7a



Claims for July 2001 - June 2002	
	Dollars
Member Cost Share	$51,063,163
Paid Dollars	$475,223,054
Allowed Dollars	$526,286,217

Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

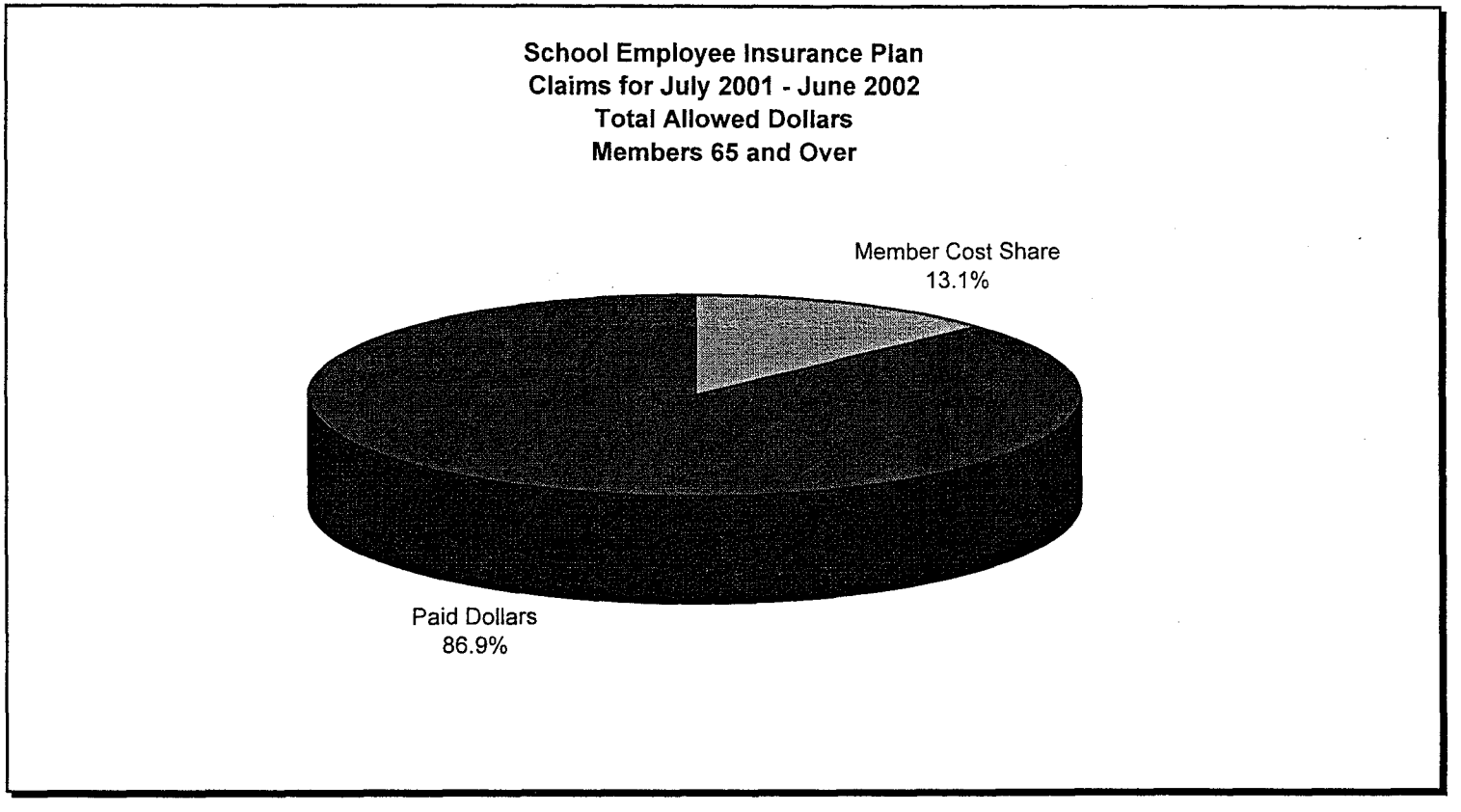
Figure 7b



Claims for July 2001 - June 2002	
	Dollars
Member Cost Share	$46,722,972
Paid Dollars	$446,550,371
Allowed Dollars	$493,273,344

Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

Figure 7c



Claims for July 2001 - June 2002	
	Dollars
Member Cost Share	$4,329,320
Paid Dollars	$28,625,677
Allowed Dollars	$32,954,997

Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

Figure 8

School Employee Insurance Plan
Cost Comparison to Average Commercial Population
July 2001 - June 2002

	ISD Population < 65			Expected for Commercial Plan			% Difference	
Service Category	Completed Util/1000	Allowed/ Service	Allowed PMPM	Completed Util/1000	Allowed/ Service	Allowed PMPM	Completed Util/1000	Allowed PMPM
Inpatient	267	$1,876	$41.73	295	$1,564	$38.42	-9.6%	8.6%
Outpatient	758		$35.60	782		$31.85	-3.0%	11.8%
Hospital			$77.33			$70.26		10.1%
Physician	15,748		$90.42	12,675		$75.64	24.2%	19.5%
Pharmacy	9,020	$64.50	$48.48	12,060	$45.42	$45.65	-25.2%	6.2%
Total			$216.23			$191.55		12.9%

Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

Figure 9

School Employee Insurance Plan
Claims for July 2001 - June 2002
Top 20 Prescriptions

NDC	Brand Name	Strength	# Prescriptions	Net Paid
00071015523	LIPITOR	10MG	32,495	$2,474,110
00046087506	PREMPRO	0.625-2.5	23,506	1,035,387
00069306075	ZITHROMAX	250MG	16,683	514,796
00186074231	CLARITIN	10MG	15,765	1,261,745
00085045803	NASONEX	50MCG	15,662	757,463
00071015623	PREMARIN	0.625MG	14,893	366,912
00046086791	LIPITOR	20MG	14,589	1,747,981
00062190315	ZOLOFT	100MG	13,228	1,005,904
00025152531	PRINIVIL	10MG	12,778	458,259
00173045301	ALLEGRA	180MG	12,430	791,907
00069551066	PAXIL	20MG	12,118	1,068,613
00777310502	ALBUTEROL	90MCG	10,755	113,793
00003010960	PREVACID	30MG	10,691	1,480,720
00006011068	ORTHO TRI-CYCLEN	7 DAYS X 3	10,507	648,310
00029321120	VIOXX	25MG	10,276	868,088
00006010658	PRILOSEC	20MG	10,154	1,684,822
59930156001	PRINIVIL	20MG	9,786	385,281
00049491066	WELLBUTRIN SR	150MG	9,176	819,842
00456402001	ZYRTEC	10MG	9,153	532,009
00173013555	ACIPHEX	20MG	8,790	1,165,934
Top 20 Total			273,435	$19,181,877
% of Rx Total			20.6%	22.1%
Pharmacy Total			1,328,471	$86,660,409

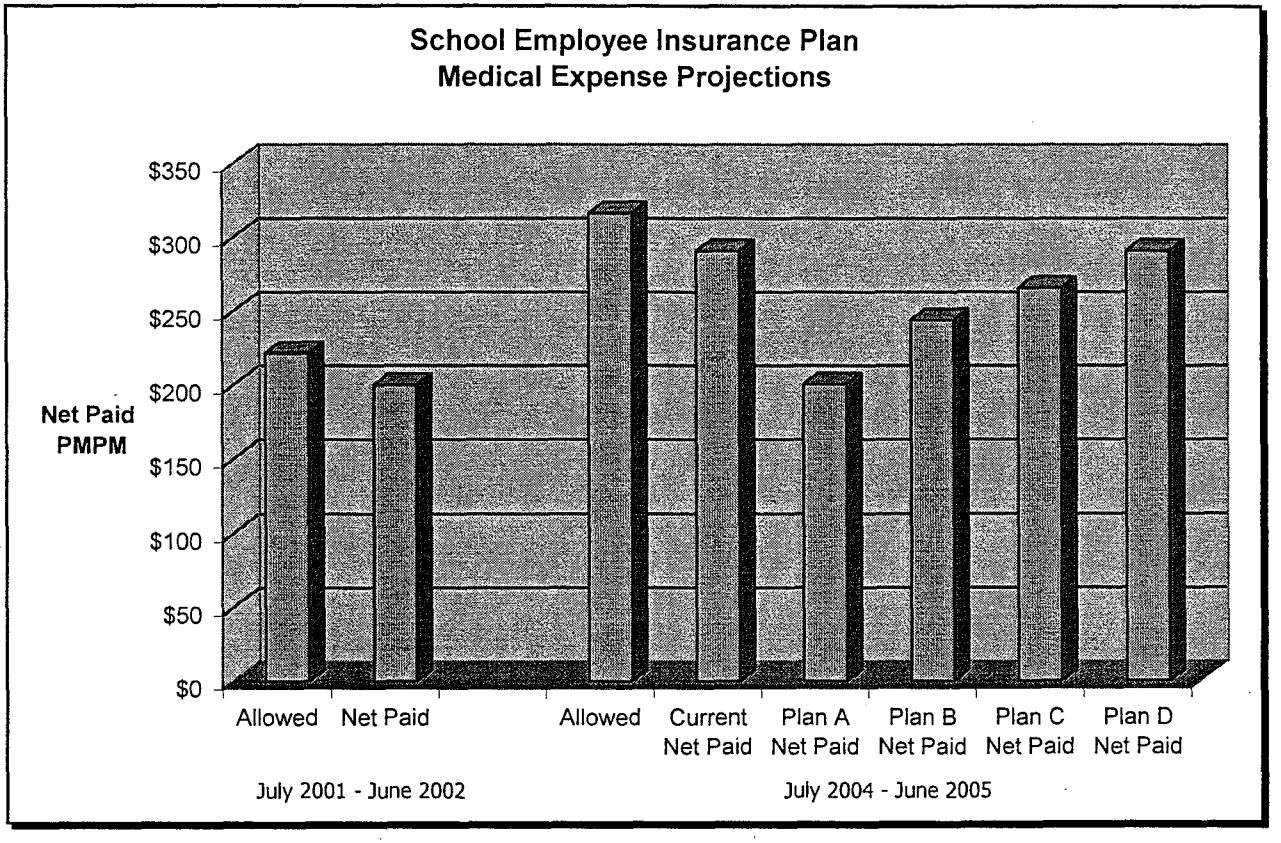
Note: BCBS drug claims that are paid under the Major Medical Plan provision are not included above.

Figure 10

Preliminary New Plan Designs

		Plan A		Plan B		Plan C		Plan D: MN Advantage*		
		In-network	OON	In-network	OON	In-network	OON	Level 1	Level 2	Level 3
Office Visit Copayment		as other services		$20	N/A	$15	N/A	$5	$10	$20
Rx Copayments	Generic	as other services		$12	$12	$10	$10	$12	$12	$12
	Brand-Formulary	as other services		$20	$20	$15	$15	$12	$12	$12
	Brand-Non-Form.	as other services		$50	$50	$25	$25	$25	$25	$25
Deductible		$1,250	$2,500	$500	$1,000	$250	$500	$100	$150	$300
Coinsurance		15%	35%	10%	30%	10%	30%	0%	5%	10%
Out of Pocket Limit (OOPL)		$2,500	$5,000	$2,000	$4,000	$1,250	$2,500	$800	$800	$800
Emergency Room Copayment		as other services		$100	as other	$75	as other	$50	as other	as other
								* See schedule in appendix for services where deductible and coinsurance apply. Rx has only 2 tiers (formulary/non-formulary) & separate $300 OOPL.		

Figure 11a



Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

Figure 11b

School Employee Insurance Plan
Medical Expense Projections

	July 2001 - June 2002		July 2004 - June 2005									
	Current Plans		Current Plans		Plan A		Plan B		Plan C		Plan D	
Service Category	Allowed PMPM	Paid PMPM	Allowed PMPM	Paid PMPM	Paid PMPM	Percent Change	Paid PMPM	Percent Change	Paid PMPM	Percent Change	Paid PMPM	Percent Change
Inpatient	$41.73	$41.06	$57.50	$57.71	$36.31	-37.1%	$44.56	-22.8%	$49.11	-14.9%	$56.30	-2.4%
Outpatient	35.60	33.27	59.06	56.30	$37.29	-33.8%	46.49	-17.4%	50.84	-9.7%	52.94	-6.0%
Total Hospital	77.33	74.33	116.56	114.02	73.60	-35.4%	91.05	-20.1%	99.96	-12.3%	109.25	-4.2%
Physician	90.42	80.72	117.57	107.05	74.24	-30.7%	91.27	-14.7%	99.87	-6.7%	109.21	2.0%
Pharmacy	48.48	40.69	81.55	69.82	51.49	-26.3%	61.90	-11.4%	68.02	-2.6%	69.04	-1.1%
Total	$216.23	$195.74	$315.69	$290.89	$199.33	-31.5%	$244.22	-16.0%	$267.85	-7.9%	$287.49	-1.2%
Total change due to increased member cost sharing						-25.2%		-12.8%		-6.3%		
Total change due to change in member utilization patterns						-6.3%		-3.2%		-1.6%		-1.2%

Note: Totals between exhibits may not be the same due to some carriers and some small service lines not being included in all exhibits.

Figure 12

Administrative & Other Expense

Type of Group	Expense as % Claims	
	All [1]	Exclude Tax [2]
Insured [3]	17.19%	13.16%
PEIP *	11.16%	11.16%
Service Coop. **	10.20%	10.20%
Self-Funded [4]	8.34%	8.34%
Total	12.51%	11.05%

1. All expenses include administrative charges, commissions and broker fees where reported, premium taxes, MCHA assessment, Medicaid and HMO taxes, and other fees and expenses. Because broker and consultant fees may be understanding in the data, we raised the stated retentions by 1-3% on selected groups to approximate the impact of possibly missing commission and broker fees. **Expenses above do not include expense or commission built into stop loss premiums.**

2. Taxes include premium, HMO, and Medicaid tax and MCHA assessment. Unless the carrier provided exact information on these items, we assumed they total 3.2% of insured groups' premiums

3. Separately insured groups outside of PEIP and service cooperatives.

4. Includes only the larger, independently self-funded groups, not those in PEIP or the service cooperatives.

*** Note on PEIP group expense:**
Using 2002-03 administrative expense levels and assuming that premiums and claims increased 14.0%, then a comparable 2002-03 expense level is 10.66%

**** Note on Service Cooperative group expense:**
Using 2002-03 administrative expense and commission levels and assuming that premiums and claims increased 14.0%, then a comparable 2002-03 expense level is 9.24%.

Figure 13

Example of Pool Assumption of Stop Loss Risk Scenario

Assumed current average attachment point	$100,000
Estimated current stop loss cost as % of pool claims	8.7%
Assumed risk pool reinsurance attachment point	$500,000
Estimated current stop loss cost as % of pool claims	0.8%
Difference as % of pool claims	7.9%
Assumed stop loss carrier target loss ratio	65%
Stop loss carrier profit or required surplus contibution as a % of total pool claims.	2.8%
Assumed margin pool needs to fund stabilization reserve	10.4%
Stabilization reserve funding as % of pool claims	0.8%
Possible net savings to risk pool as % of pool claims	**1.9%**

Note: This is an example of the type of internal large claim risk spreading that a risk pool could perform. The percentages above are only for illustration of the reinsurance process and, in an actual operation, may vary from the above based on the charges by a reinsurer, the year of operation, and the large claims experienced by the risk pool.

Appendix A

Reden & Anders, Ltd.

An ingenix Company

Consultants & Actuaries
222 South 9th Street, Suite 1500 • Minneapolis MN 55402
Tel (612) 339-7933 • Fax (612) 349-3788 • www.reden-anders.com

MEMORANDUM

Date: February 21, 2003

To: Minnesota School District Superintendents

From: Earl Hoffman, Reden & Anders, Ltd.

RE: SCHOOL EMPLOYEE INSURANCE PLAN STUDY – DATA REQUEST

The 2002 Minnesota Legislature, through Senate File 1755, established a School Employee Insurance Plan Study and Design Committee (the Committee) to work with the Minnesota Department of Commerce (DOC) to gather information about existing health insurance coverage of school district employees in Minnesota and to make recommendations for the design of a school employee health insurance plan. To provide actuarial assistance, the Committee and the DOC have engaged Reden & Anders, Ltd. (R&A) to carry out the following projects outlined in the statute:

- Collect information from carriers, administrators, and school districts about the health plans currently providing coverage to school employees and retirees.
- Analyze this information and report on the current status of health insurance and other coverage available to school employees, including the cost of the coverage, the types of plans, the demographics of the employees and dependents covered, and the level of employer-employee cost sharing.
- Assist the Committee and the DOC to study the feasibility and desirability of a school employee health insurance plan for all eligible employees, retirees and employers.

Please see the accompanying letter from Minnesota Commerce Commissioner James C. Bernstein that discusses the statutory charge to the Committee and the nature of this project. In order to provide the necessary analysis and assistance for this project, R&A is requesting that your district provide information on all of the health plans it provides to its employees and retirees. We are requesting data on the 24 months from July 2000 through June 2002.

The data we are requesting are shown on the Group and Plan Data Request Excel spreadsheet that accompanies this email. We ask that your response be electronic, as entries on this spreadsheet, with a separate spreadsheet for each plan and year. If your district uses multiple health plans, insurers, or self-funded plans, please treat each as a separate plan. The completed spreadsheets can be combined into a single Excel workbook and then emailed back to me.

If your plan years do not start on July 1, you may have to provide information for three plan years, in order to cover the entire 7/1/00 to 6/30/02 period. For example, if your district offers two plans with a plan anniversary on September 1, you would provide data on six spreadsheets, one for each of the two plans and for plan years starting 9/1/99, 9/1/00, and 9/1/01.

We would appreciate your letting us know as soon as possible who your health plan carrier(s) or administrator(s) is(are), even if you have not completed the full data request. If your district contracts with a pharmacy benefit manager (PBM), outside of your HMO, health insurer, or medical third party administrator, please include these pharmacy costs in your response and let us know the name of your PBM.

The footnotes to some of the sections describe the requested information in more detail. Of particular note is the section on employee and retiree counts and premiums by rating tier. We ask that you specify whether the rating tier is single employee (or retiree) or employee (or retiree) plus dependents. If the latter, please describe the tier (e.g., employee plus spouse, employee plus children, employee plus one dependent, etc.). Some districts may differentiate premiums or employer contributions by occupation or other employment class; the data request spreadsheet has cells where you can describe these different subgroups, if applicable. If you have different subgroups that get a full or partial employer contribution (e.g., full time versus part time employees), you can also describe these as well.

Note that we are sending to health plans, insurers, service cooperatives, and third party administrators a companion data request for information regarding detailed claim, premium, expense, and member count by month information. For this reason, it is important that the group and plan numbers or codes that you show are the numbers or codes that your carrier or administrator uses to bill and report plan information to you.

In order for the Committee to complete its legislative mandated duties on time, we request that you send this data to R&A by **March 28, 2003**. Please e-mail the completed spreadsheets to me (see my e-mail address below). Also, please let me know, by e-mail, the contact person at your district who will be responsible for completing this data request. If your staff has any questions concerning this data request, please do not hesitate to call us. If our data request poses particular problems, we would be happy to explore alternatives with your staff. We can be reached by phone at (612) 339-7933 or by e-mail:

Project Leader:
Earl Hoffman, Senior Consultant: earl.hoffman@reden-anders.com

Data Specialists:
Tim Feeser, Principal: tim.feeser@reden-anders.com
Barbara Johnson, Senior Consultant: barbara.johnson@reden-anders.com
Jon Brunsberg, Principal: jon.brunsberg@reden-anders.com

We appreciate your help with this important project and thank you in advance for the requested data.

Sincerely,

Earl L. Hoffman, F.S.A.
Senior Consultant

ELH:mje

/Enclosure

Appendix A

Group and Plan Data Request

For Each Group, Plan, and Plan Year Combination--To be completed by school districts separately for each plan year spanning 7/1/00 - 6/30/01 and 7/1/01 - 6/30/02

School District Name	
Group Number	As assigned by the carrier or administrator
Group Zip Code	
Group County	
HMO/Insurer/Administrator Name	
Coverage/Benefit Plan Code	As assigned by the carrier or administrator
Funding Type for Plan	I=Fully insured; H=HMO; S=Self-funded; C=Service or Other Cooperative; M=Minimum premium; W=MEWA

Complete the information below for the current plan year and for the previous plan year.

Do you work with a separate pharmacy benefit manager (PBM) to handle the prescription drug portion of your plan? Y or N

This is a PBM not affiliated with or billing and reporting jointly with your health plan, health insurer, or medical plan third party administrator.

If yes, what is the PBM you use?

Plan Year **Start Date:** **End Date:** Please complete a separate spreadsheet for each plan and each plan year.

Stop Loss Coverage Level (if self-funded plan) Specific attachment point Aggregate attachment point (% of expected claims)

Name of stop; loss insurer

Reden & Anders, Ltd.

Employee and Retiree Census by Rating Tier and Monthly Premium Rates in Last Month of the Plan Year
Please complete a separate worksheet for each plan (e.g., $100 deductible and $500 deductible) and each plan year.

	Coverage Tier Definition Codes					
Coverage Tier #	Definition of Coverage Tier [1]	Definition of Occupational Group [2]	Full or Partial Employer Contribution [3]	Employee or Retiree Count	Total Monthly Premium [4]	Employee or Retiree Monthly Contribution
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
Employees opting out of coverage [5]						

Footnote 1: For single employee or retiree coverage or particular family coverage tier. Please input the exact description of the coverage tier. For example, Single Employee, Employee Plus Spouse, Employee Plus Children, Employee Plus Family, Employee Plus One Dependent, etc. Please show normal (Medicare eligible) and early (non-Medicare eligible) retirees separately.

Footnote 2: Input particular professional or occupational group that the count, monthly premium, and employee or retiree contribution apply to. For example, Teachers, Principals, Administrators, other bargaining units. If the same premiums and employee contribution rates apply to all occupational groups, leave this blank. If one set of premiums and employee contribution rates applies to a particular occupational group or groups, and another set to all other employees, input "all other," or just leave blank for all other employees.

Footnote 3: Based on whether the district's contribution rate is the normal, full contribution or a reduced contribution. For examples, most districts pay a reduced contribution for part-time employees. If premiums and employer contributions are the same for all employees, then this field can be left blank.

Footnote 4: This is the monthly premium rate per employee in that tier, if the plan is insured or HMO. If the plan is self-funded, it's the total equivalent plan cost, which is the expected claims, loaded for expenses and stop loss premium. If the plan is a cafeteria plan, use the equivalent amount available to purchase coverage.

Footnote 5: Enter the monthly amount that an employee waiving coverage receives from the district in the column "Full or Partial Employer Contribution."

Reden & Anders, Ltd.

An ingenix Company

Consultants & Actuaries
222 South 9th Street, Suite 1500 • Minneapolis MN 55402
Tel (612) 339-7933 • Fax (612) 349-3788 • www.reden-anders.com

February 3, 2003

«MrMs» «FirstName» «LastName»
«Title»
«Company»
«Address1»
«Address2»
«City», «State» «PostalCode»

RE: SCHOOL EMPLOYEE INSURANCE PLAN STUDY – DATA REQUEST TO CARRIERS

Dear «MrMs» «LastName»:

The 2002 Minnesota Legislature, through Senate File 1755, established a School Employee Insurance Plan Study and Design Committee (the Committee) to work with the Minnesota Department of Commerce (DOC) to gather information about existing health insurance coverage of school district employees in Minnesota and to make recommendations for the design of a school employee health insurance plan. To provide actuarial assistance, the Committee and the DOC have engaged Reden & Anders, Ltd. (R&A) to carry out the following projects outlined in the statute:

- Collect information from carriers, administrators, and school districts about the health plans currently providing coverage to school employees.

- Analyze this information and report on the current status of health insurance and other coverage available to school employees, including the cost of the coverage, the types of plans, the demographics of the employees and dependents covered, and the level of employer-employee cost sharing.

- Assist the Committee and the DOC to study the feasibility and desirability of a school employee health insurance plan for all eligible employees and employers.

Please see the enclosed letter from Commerce Commissioner James C. Bernstein that discusses the statutory charge to the Committee and the nature of this project. In order to provide the necessary analysis and assistance for this project, R&A is requesting that carriers provide data on claims from all of its Minnesota school district groups. The request includes groups covered under your health plan or insurance company and self-funded groups for which your company is the third party administrator. We are asking for data on claims incurred from July 1, 2000 through June 30, 2002 and paid through January 31, 2003. The data is listed in the enclosed Encounter Data Request, Exhibit A. These are

detailed data items from each encounter with a provider that was submitted to your plan, whether or not a claim payment resulted. Exhibit B describes the database file format and electronic media preference we request from all carriers and administrators.

In order to preserve the confidentiality of each member's health information, we request that you scramble the claim ID number and the member number in a way that produces a unique scrambled number for each member, so that we can still aggregate the allowed charges and net paid amounts over the two study years to the individual members incurring the charges.

Please note that we are **not** asking for billed charge amounts, only your allowed amounts and paid benefits. Therefore, we will not be able to determine your provider discounts. Please include prescription drug claims handled by your own pharmacy benefit manager (PBM), any PBM you contract with, and any PBM you partner with. If pharmacy claim data from an outside PBM is not available, please call or email us to discuss how we might obtain this information.

We are sending to the school districts a companion data request for information regarding member demographics, premium levels, and employer contributions. For this reason, it is important that the group and plan numbers or codes in the encounter data that you submit match the numbers or codes you use to bill and report plan information to your groups. **We would appreciate your sending us a list of your Minnesota school district groups as soon as possible, even if the detailed claim data is not ready.**

In order for the Committee to complete its legislative mandated duties on time, we ask that you send this data to R&A by **February 28, 2003**. If your staff has any questions concerning this data request, please do not hesitate to call us. Please confirm, by email, if you are the person to whom we should direct questions about the data. If you are not the person, please let me know who we should contact with questions about the data. If our data format poses particular problems, we would be happy to explore alternatives with your staff. We can be reached by phone at (612) 339-7933 or by e-mail:

Project Leader:
Earl Hoffman, Senior Consultant: earl.hoffman@reden-anders.com

Encounter Data Specialists:
Tim Feeser, Principal: timothy.feeser@reden-anders.com
Jon Brunsberg, Principal: jon.brunsberg@reden-anders.com

We appreciate your help with this important project and thank you in advance for the requested data.

Sincerely,

Earl L. Hoffman, F.S.A.
Senior Consultant

ELH:mje
/Enclosure

Exhibit A
Encounter Data Request

The following are the data elements common to all claim types:

Administrative Fields:
- Claim ID Number
- Claim Type (IP, OP, Prof, Drug, Other)
- Date Received
- Date Paid
- In-network (I) or Out-of-network (O)
- Capitated Service Indicator (if applicable)

Demographic Data:
- Member Number
- Member Suffix/Identifier (Employee, Spouse, child1, child2, etc)
- Member Birth Date
- Member Sex
- Member Zip Code
- Coverage/Benefit Plan Code that explains benefit package provided (if Medicaid data, include eligibility category)

Group Data (These should match the numbers or codes used in reports and billings to groups.)
- Group Number
- Coverage/Benefit Plan Code (unique code within group that links to particular benefit package)

The following are the data elements common to Hospital Inpatient & Outpatient Facility claims only:

Provider Fields:
- Facility Number
- Type of Bill (3 digit code defining type of facility (hospital, SNF, etc), bill classification, and bill frequency)

Claim Fields:
- Type of Admission
- Place of Service (I/P, O/P, Freestanding surgicenter, etc.)
- Diagnosis Codes (primary and all secondary ICD9 codes)
- Procedure Codes (primary and all secondary ICD9 codes)
- Date of Admission (start of care date for outpatient)
- Date of Discharge (end of care date for outpatient)
- Allowed Charges
- Deductible Amount
- Coinsurance Amount
- Copay Amount
- COB Amount
- Paid Amount
- Withhold Amount

The following are the data elements specific to Inpatient Facility claims only:

Claim Fields:
- Source of Admission
- Length of Stay
- ICU/CCU/PICU Days
- Discharge Disposition (to home or self care, to SNF, etc)
- DRG (note in documentation what type of coding system was used)

The following are the data elements specific to Outpatient Facility claims only:

Claim Fields:
- Revenue Code
- CPT Code
- CPT Modifier
- Service Date
- Total Units of Service
- Units of Service Indicator
- Total Charges by Revenue Code

The following are the data elements specific to Professional claims only:

Provider Fields:
- Provider of Service Specialty

Claim Fields:
- Diagnosis Codes (primary and all secondary ICD9 codes)
- Place of Service (office, home, etc)
- Beginning Date of Service
- Ending Date of Service
- Allowed Charges
- Deductible Amount
- Coinsurance Amount
- Copay Amount
- COB Amount
- Paid Amount
- Withhold Amount
- CPT Code
- CPT Modifier
- Total Units of Service
- Units of Service Indicator

The following are the data elements specific to Pharmacy claims only:

Claim Fields:

- NDC Number
- Therapeutic Class
- Formulary Indicator
- Mail Order Indicator
- Brand or Generic Indicator
- Prescription Fill Date
- Prescription Supply Days
- Prescription Quantity
- Units of Measure Indicator
- Billed Charges by Pharmacy
- Average Wholesale Price of Prescription
- Ingredient Cost
- Dispensing Fee
- Sales Tax
- Deductible Amount
- Copay Amount
- COB Amount

The following are the data elements relating to the Membership File:
For all members in-force any time during the period for which claims data is requested

- Payer Type (commercial, Medicare, Medicaid, etc)
- Member Number
- Member Suffix/Identifier (Employee, Spouse, Child1, Child2, etc)
- Member Birth Date
- Member Sex
- Member Zip Code
- Group Number
- Coverage/Benefit Plan Code (links to particular benefit package provided)
- Employment Status (Active-Full Time, Active-Part Time, Early Retired, Medicare-eligible Retired)
- Subscriber Coverage Tier (i.e., single employee, employee plus spouse, employee plus family, etc.)
- Coverage Eligibility Date
- Coverage Termination Date

Exhibit B
Data Request

Database File Format and Electronic Media Preference

Preferred method:

- Database File Format (in order of preference): Foxpro 2.6 (dbf), Access Database (mdb) if file is less than 200 megabytes, fixed width text file, comma delimited text file
- Media (in order of preference): Jaz/Zip disk, CD ROM, zipped floppy diskettes

Alternate method:

- Database File Format (in order of preference): fixed width text file, comma delimited text file
- Media: 9-Track standard length tape (6250 BPI or 1600 BPI, with block size < 32,000)

Text files specifications:

- ASCII (preferred) or EBCDIC
- All fields have been "unpacked", "unsigned", and any Binary data has been converted to standard numeric format (a "signed" field means the last character in a numeric field represents a specific digit as well as designates the number as positive or negative)
- For each type of file include a file layout, complete with descriptors, location, and width of each field. Also it should be clear on the file layout if the raw data of a field must be factored to obtained the actual amount (i.e. 9506 divided by 100 = $95.06 actual amount)
- Include any tables (electronic or hardcopy) that explain codes used in the files

Control Totals:

- For each file, please include control totals (i.e. number of records, bottomline total for all numeric fields, etc.)
- If readily accessible, the first couple of records of a file and/or any summary reports pertaining to a file would be helpful in tying out a transmitted file

Note: If all of the formats described above are extremely difficult to achieve, please contact us to arrange for an alternate method for transmitting the data.

Reden & Anders, Ltd.

An Ingenix Company

Consultants & Actuaries
222 South 9th Street, Suite 1500 • Minneapolis MN 55402
Tel (612) 339-7933 • Fax (612) 349-3788 • www.reden-anders.com

MEMORANDUM

Date: March 3, 2003

To: Health Plans, Health Insurers, or Third Party Administrators of Minnesota School Districts

From: Earl Hoffman, Reden & Anders, Ltd.

RE: SCHOOL EMPLOYEE INSURANCE PLAN STUDY – GROUP AND PLAN DATA REQUEST

This is a second data request related to the School Employee Insurance Plan Study. It is in addition to the encounter-level data request that we sent to you earlier this month. In this second request, we are seeking premiums, enrollment, and administrative expense and other retention charges for your Minnesota public school district groups on a group-wide, plan-wide, and plan-year basis, as compared to the claim level detail of the first request.

You'll recall that the 2002 Minnesota Legislature established a School Employee Insurance Plan Study and Design Committee (the Committee) to work with the Minnesota Department of Commerce (DOC) to gather information about existing health insurance coverage of school district employees in Minnesota and to make recommendations for the design of a school employee health insurance plan. To provide actuarial assistance, the Committee and the DOC engaged Reden & Anders, Ltd. (R&A) to assist them with this project.

Initially, we sent a group and plan data request similar to this one to the school districts. However, we found that most districts do not have the information readily available or the staff expertise to supply this data. In fact, several districts have already forwarded the request to their carriers. The Committee felt that the carriers would be a much better source of this information than the school districts.

The data we request are shown on the Group and Plan Data Request Excel spreadsheet that accompanies this e-mail. We prefer your response to be electronic entries on the enclosed Excel spreadsheet, but we are also willing to work with your staff to develop an alternative electronic (preferably spreadsheet) response format that fits more closely with any standard reporting package you now have or with your company's current reporting capabilities.

We would appreciate a separate response for each group (school district), plan within the district, and plan year. If a group's plan year starts on July 1, as most of them do, we would like separate reporting (spreadsheets) for each of the two years starting 7/1/00 and 7/1/01. If a group's plan year does not start on July 1, we request information across three plan years, in order to cover the entire 7/1/00 to 6/30/02 period. For example, if a district you cover offers two plans with a plan anniversary on September 1, you would provide data on six spreadsheets, one for each of the two plans and for all or parts of the plan years starting 9/1/99, 9/1/00, and 9/1/01. If possible, please combine all spreadsheets for a single group (district) into one Excel workbook.

Although some sections in the data request are self-explanatory, the footnotes to many of the sections describe particular requested information in more detail. Of particular note is the section on employee and retiree counts and premiums by rating tier. We ask that you specify whether the rating tier is single employee (or retiree) or employee (or retiree) plus dependents. If the latter, please describe the tier (e.g., employee plus spouse, employee plus children, employee plus one dependent, etc.). Some districts have different premiums by occupation or bargaining unit; the data request spreadsheet has cells in which you can describe these different subgroups, if they are relevant to the group's premium or premium equivalent rates.

Note that we are sending to the school districts a companion data request for information regarding employee contribution levels and number of employees in their plans and opting out of their plans.

In order for the Committee to complete its legislative mandated duties on time, we request that you send this data to R&A by **March 25, 2003**. As we mention above, if this data request poses particular problems, we are happy to explore with your staff alternative ways to get this information. For example, you may have standard spreadsheet reports that capture almost all of the requested information and that may be suitable for this project. We are available to review this request with you in more detail, compare it to the output of reporting packages you now have, and work with you to come up with alternative ways to get the data. In order to do this, however, we need your feedback and comments as soon as possible regarding this request, so that you will be able to provide the data by March 25.

Please let me know, by e-mail, the contact person at your district who will be responsible for completing this data request. If you find that the enclosed spreadsheet will work for your company as a way to respond to this data request, then we would appreciate your e-mailing the completed spreadsheets to me (see my e-mail address below).

If your staff has any questions concerning this data request, please do not hesitate to call us. We can be reached by phone at (612) 339-7933 or by e-mail:

Project Leader:
Earl Hoffman, Senior Consultant: earl.hoffman@reden-anders.com

Data Specialists:
Tim Feeser, Principal: tim.feeser@reden-anders.com
Barbara Johnson, Senior Consultant: barbara.johnson@reden-anders.com
Jon Brunsberg, Principal: jon.brunsberg@reden-anders.com

¤ ¤ ¤ ¤ ¤ ¤

We appreciate your help with this important project and thank you in advance for the requested data.

Sincerely,

Earl L. Hoffman, F.S.A.
Senior Consultant

ELH:mje

/Enclosure

Appendix A

Group and Plan Data Request

For Each Group, Plan, and Plan Year Combination--To be completed by health plans, insurers, cooperatives, or TPAs separately for each plan year spanning 7/1/00 - 6/30/01 and 7/1/01 - 6/30/02

Group Name
Independent School District #
Group Number
Group Zip Code
Group County
HMO/Insurer/Administrator Name
Coverage/Benefit Plan Code
Funding Type for Plan I=Fully insured; H=HMO (not self-funded); S=Self-funded; C=Service or Other Cooperative; M=Minimum premium; W=MEWA

Complete the information below for the current plan year and for the previous plan year.

Does the group have a separate pharmacy benefit manager (PBM) to handle the prescription drug portion of your plan? Y or N
This is a PBM whose premium or self-funded plan cost data you will not be reporting below or in the detailed encounter level data.
If yes, what is the PBM?

Plan Year **Start Date:** **End Date:** Please complete a separate spreadsheet for each plan and each plan year.

Coverage/Benefit Plan Description	Active Employee Benefit Level		Early Retiree Benefit Level		Medicare-Eligible Retiree Benefit Level	
Note: "HMO-Like" and "Insurer-Like" are general descriptions, not mutually exclusive. Single plans will often have benefit features in both categories.	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
HMO-Like Benefit Features						
Office visit copayment: Primary care						
Office visit copayment: Specialist						
Emergency room copayment						
Outpatient facility copayment						
Inpatient hospital copayments						
Per stay						
Other (please specify)						
Rx copayment: Generic formulary						
Generic non-formulary						
Brand formulary						
Brand non-formulary						
Insurer-Like Benefit Features						
Deductible						
Benefit percentage after deductible						
Out of pocket limit (OOPL) for medical						
OOPL for Rx						

E.g.: If the plan is 80/20, enter 80%
If there is no OOPL, enter 100000
If there is no OOPL, enter 100000; if Rx is included with medical OOPL, enter 0.

Is Rx covered under the plan deductible & benefit %? (Y or N)
If N, then input the Rx copayments in the "Rx copayment" section above.

Monthly Information

	Total Monthly Premium (if insured or HMO)				Total Monthly Stop Loss Premium (if self-funded)					Member Counts					
					Specific				Aggregate						
Month	Active Employees	Early [1] Retirees	Normal [2] Retirees	Total	Active Employees	Early [1] Retirees	Normal [2] Retirees	Total	Total Group	Full Time Employees	Part Time Employees	Early [1] Retirees	Normal [2] Retirees	Spouses [3]	Children [3]
Month 1				$0				$0							
Month 2				$0				$0							
Month 3				$0				$0							
Month 4				$0				$0							
Month 5				$0				$0							
Month 6				$0				$0							
Month 7				$0				$0							
Month 8				$0				$0							
Month 9				$0				$0							
Month 10				$0				$0							
Month 11				$0				$0							
Month 12				$0				$0							

Footnote 1: Early retirees are not eligible for Medicare Footnote 2: Normal retirees are eligible for Medicare
Footnote 3: If you do not know how many children are covered, please provide the number of employees who cover their children in this column, and indicate that this is what you are providing.

Stop Loss Coverage Level (if self-funded plan)

Specific attachment point _____ Aggregate attachment point (% of expected claims) _____
Name of stop loss insurer, if other than reporting carrier _____

Retention Charges

Respond below based on how these expenses are charged or allocated

	Percentage of		Dollars Per Contract		
	Premium	Claims	Employee	Family	Composite
Administration					
PPO Fees					
Commission					
Premium Tax					
MCHA Assessment					
Other					

Reden & Anders, Ltd.

Employee and Retiree Census by Rating Tier and Monthly Premium Rates in Last Month of the Plan Year

	Coverage Tier Definition Codes			
Coverage Tier #	Definition of Coverage Tier [4]	Definition of Occupational Group [5]	Employee or Retiree Count	Total Monthly Premium [6]
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				

Footnote 4: For single employee coverage or particular family coverage tier. Please input the exact description of the coverage tier. For example, Single Employee, Employee Plus Spouse, Employee Plus Children, Employee Plus Family, Employee Plus One Dependent, etc. Please show early (non-Medicare eligible) and normal (Medicare eligible) retirees separately. If early retirees have the same plans and rates as active employees, they can be included with actives.

Footnote 5: Input particular professional or occupational group that the count, monthly premium, and employee contribution apply to. For example, Teachers, Principals, Administrators, other bargaining units. If the same premiums and employee contribution rates apply to all occupational groups, leave this blank. If one set of premiums applies to a particular occupational group or groups, and another set to all other employees, input "all other," or just leave blank for all other employees.

Footnote 6: This is the monthly premium rate per employee in that tier, if the plan is insured or HMO. If the plan is self-funded, it's the total equivalent plan cost, which is the expected claims, loaded for expenses and stop loss premium.

MINNESOTA DEPARTMENT OF COMMERCE

85 7th Place East, Suite 500
St. Paul, Minnesota 55101-2198
651.296.4026 FAX 651.297.1959 TTY 651.297.3067

January 2, 2003

RE: School Employee Insurance Plan Study and Design Committee Update

Dear Superintendent:

The 2002 Legislators, through Senate File 1755, Chapter 378, Minn. Stat. § 62A.661 established a Committee with assistance from the Minnesota Department of Commerce to gather information and make recommendations for the design of a school employee health insurance plan.

The 14 member Committee (see enclosed) representing both employees and employers has selected a contractor (Reden & Anders) to collect and analyze information from health plans currently providing health coverage to schools and school districts throughout Minnesota. This non-identifiable aggregate data will be used to make recommendations to the Committee for various health insurance plans. The Committee will then evaluation these health plans and recommend to the 2004 Legislators which plan or plans should be implemented in Minnesota.

This study must address the issues of cost, coverage, financial feasibility, solvency and management. All health plans must incorporate as key components consumer education, wellness programs and measures encouraging the wise use of health care coverage with the goal of premium reductions and cost containment.

If you or any of your staff have any further questions about this study, please contact the Department of Commerce liaison with the Committee, John Gross. He can be reached at 651-297-2319 or 1-800-657-3602.

Very truly yours,

JAMES C. BERNSTEIN
COMMISSIONER

JCB/JEG/sm

Appendix B

School District That Responded to Data Request

(260 School Districts Responded as of June 20, 2003)

ISD #	District Name	ISD #	District Name
2396	ACGC	2397	LeSueur-Henderson
2854	Ada-Borup	0857	Lewiston-Altura
0511	Adrian	0465	Litchfield
0001-01	Aitkin	0362	Littlefork-Big Falls
0745	Albany	0238	Mabel-Canton
0241	Albert Lea	0837	Madelia
0242	Alden-Conger	0832	Mahtomedi
0206	Alexandria	0077	Mankato
0876	Annandale	0413	Marshall
0011	Anoka-Hennepin	0441	Marshall County Central
0261	Ashby	2448	Martin County West
0492	Austin	2887	McLeod West
0676	Badger	0740	Melrose
0162	Bagley	0821	Menahga
0146	Barnesville	2711	Mesabi East
0542	Battle Lake	0912	Milaca
0726	Becker	0001-03	Minneapolis
2364	Belgrade-Brooten-Elrosa	0276	Minnetonka
0716	Belle Plaine	2149	Minnewaska
0031	Bemidji	0152	Moorhead
0777	Benson	0097	Moose Lake
0786	Bertha-Hewitt	0332	Mora
0756	Blooming Prairie	0769	Morris
0271	Bloomington	0712	Mountain Iron-Buhl
2860	Blue Earth Area	0173	Mountain Lake
0181	Brainerd	2169	Murray County Central
0207	Brandon	0308	Nevis
0846	Breckenridge	0721	New Prague
0513	Brewster	0088	New Ulm
0286	Brooklyn Center	0553	New York Mills
0787	Browerville	0507	Nicollet
0801	Browns Valley	2215	Norman County East
0877	Buffalo	2527	Norman County West

Appendix B

School District That Responded to Data Request

(260 School Districts Responded as of June 20, 2003)

ISD #	District Name	ISD #	District Name
0191	Burnsville-Eagan-Savage	0138	North Branch
0836	Butterfield-Odin	0659	Northfield
0531	Byron	0118	Northland Community Schools
0299	Caledonia	2168	NRHEG
0911	Cambridge-Isanti	0333	Ogilvie
0891	Canby	0627	Oklee
0252	Cannon Falls	0480	Onamia
0093	Carlton	0278	Orono
0115	Cass Lake-Bena	0062	Ortonville
0012	Centennial	0213	Osakis
0108	Central Schools	0279	Osseo Area
0112	Chaska	0761	Owatonna
2144	Chisago Lakes Area Schools	0309	Park Rapids
0695	Chisholm	0547	Parkers Prairie
0771	Chokio-Alberta	0741	Paynesville
0227	Chosen Valley	0548	Pelican Rapids
2311	Clearbrook-Gonvick	0549	Perham-Dent
0391	Cleveland	0484	Pierz
0592	Climax-Shelly	0116	Pillager
0094	Cloquet	0578	Pine City
0013	Columbia Heights	0255	Pine Island
0081	Comfrey	2174	Pine River-Backus
0166	Cook County	0810	Plainview
0095	Cromwell-Wright	0628	Plummer
0593	Crookston	0477	Princeton
0182	Crosby-Ironton	0719	Prior Lake-Savage Area Schools
0611	Cyrus Math Science & Technol. Sch.	0704	Proctor
0378	Dawson-Boyd	0630	Red Lake
0879	Delano	0038	Red Lake Falls
0022	Detroit Lakes	2884	Red Rock Central
2164	Dilworth-Glyndon-Felton	0256	Red Wing
0533	Dover-Eyota	2897	Redwood Area
0709	Duluth	2890	Renville County West

Appendix B

School District That Responded to Data Request

(260 School Districts Responded as of June 20, 2003)

ISD #	District Name	ISD #	District Name
2759	Eagle Valley	0280	Richfield
2580	East Central Schools	0281	Robbinsdale
0595	East Grand Forks	0535	Rochester
0272	Eden Prairie	0750	Rocori
0581	Edgerton	0682	Roseau
0273	Edina	0196	Rosemount-Apple Valley-Eagan
0728	Elk River	0623	Roseville Area
0099	Esko	0850	Rothsay
0208	Evansville	0516	Round Lake
2752	Fairmont Area Schools	0485	Royalton
0192	Farmington	0139	Rush City
0544	Fergus Falls	0239	Rushford-Peterson
2198	Fillmore Central	0743	Sauk Centre
0698	Floodwood	0047	Sauk Rapids-Rice
0051	Foley	0820	Sebeka
0831	Forest Lake	0720	Shakopee
0601	Fosston	0084	Sleepy Eye
0023	Frazee-Vergas	0363	South Koochiching-Rainy River
0014	Fridley	0006	South St. Paul
2859	Glencoe-Silver Lake	0833	South Washington County
0253	Goodhue	0500	Southland
0561	Goodridge	0297	Spring Grove
2536	Granada-Huntley-East Chain	0016	Spring Lake Park
0318	Grand Rapids	0085	Springfield
2683	Greenbush- Middle River	0282	St. Anthony-New Brighton
0316	Greenway	0742	St. Cloud
0447	Grygla	0015	St. Francis
0768	Hancock	0840	St. James
0200	Hastings	0625	St. Paul
0150	Hawley	0508	St. Peter
0203	Hayfield	2170	Staples-Motley
0545	Henning	2856	Stephen-Argyle Central
0264	Herman-Norcross	0486	Swanville

Appendix B

School District That Responded to Data Request

(260 School Districts Responded as of June 20, 2003)

ISD #	District Name	ISD #	District Name
0700	Hermantown	0564	Thief River Falls
0701	Hibbing	2358	Tri-County
2165	Hinckley-Finlayson	2125	Triton
0738	Holdingford	0458	Truman
0270	Hopkins	0914	Ulen-Hitterdal
0294	Houston	0550	Underwood
2687	Howard Lake-Waverly-Winsted	2134	United South Central
0916	Intermediate #916	0706	Virginia
0287	Intermediate District #287	0811	Wabasha-Kellogg
0917	Intermediate District #917	0640	Wabasso
0361	International Falls	0110	Waconia
0199	Inver Grove Heights	2155	Wadena-Deer Creek
0473	Isle	0113	Walker-Hackensack-Akeley
0403	Ivanhoe	2176	Warren-Alvarado-Oslo
0204	Kasson-Mantorville	0690	Warroad
0036	Kelliher	0829	Waseca
0775	Kerkhoven-Murdock-Sunburg	0111	Watertown-Mayer
0739	Kimball	2143	Waterville-Elysian-Morristown
2137	Kingsland	0435	Waubun-Ogema-White Earth
2171	Kittson Central	0284	Wayzata
2853	Lac qui Parle Valley	2342	West Central Area
0300	LaCrescent-Hokah	0197	West St. Paul
0813	Lake City	2898	Westbrook-Walnut Grove
0390	Lake of the Woods	0803	Wheaton
2889	Lake Park-Audubon	0347	Willmar
0194	Lakeville	0577	Willow River
0381	Lake Superior	0177	Windom Area
0356	Lancaster	2609	Win-E-Mac
0229	Lanesboro	0100	Wrenshall
0306	Laporte	2190	Yellow Medicine East
0392	LeCenter	2805	Zumbrota-Mazeppa

Appendix C

School Districts That Did Not Respond to Data Request

(84 School Districts Have Not Responded as of June 20, 2003)

ISD #	District Name	ISD #	District Name
0411	Balaton	0497	Lyle
0091	Barnum	0415	Lynd
0371	Bellingham	2180	MACCRAY
0727	Big Lake	0432	Mahnomen
0032	Blackduck	0881	Maple Lake
2534	BOLD	2135	Maple River
0314	Braham	0004	McGregor
2159	Buffalo Lake-Hector	0763	Medford
0852	Campbell-Tintah	0635	Milroy
2754	Cedar Mountain	0414	Minneota
2888	Clinton-Graceville-Beardsley	0129	Montevideo
0466	Dassel-Cokato	0394	Montgomery-Lonsdale
0317	Deer River	0882	Monticello
0463	Eden Valley-Watkins	0621	Mounds View
0806	Elgin-Millville	0319	Nashwauk-Keewatin
0514	Ellsworth	0707	Nett Lake
0696	Ely	0345	New London-Spicer
2154	Eveleth-Gilbert	0622	North St. Paul-Maplewood-Oakdale
0656	Faribault	0186	Pequot Lakes
0599	Fertile-Beltrami	0025	Pine Point
0600	Fisher	2689	Pipestone Area Schools
0505	Fulda	0195	Randolph
2365	GFW	0883	Rockford
2886	Glenville-Emmons	0418	RTR-Russell
0495	Grand Meadow	0584	RTR-Ruthton
0402	Hendricks	0409	RTR-Tyler
0330	Heron Lake-Okabena	0748	Sartell-St. Stephen
0002	Hill City	2310	Sibley East
0671	Hills-Beaver Creek	0858	St. Charles
0423	Hutchinson	0075	St. Clair
2895	Jackson County Central Schools	2142	St. Louis County
2835	Janesville-Waldorf-Pemberton	0283	St. Louis Park
0717	Jordan	0885	St. Michael-Albertville
2172	Kenyon-Wanamingo	0534	Stewartville
0404	Lake Benton	0834	Stillwater
2071	Lake Crystal Wellcome Memorial	0417	Tracy
2167	Lakeview Schools	0487	Upsala
0499	LeRoy-Ostrander	0818	Verndale
0424	Lester Prairie	0277	Westonka
0482	Little Falls	0624	White Bear Lake
2753	Long Prairie-Grey Eagle	0861	Winona
2184	Luverne	0518	Worthington

Appendix D

Data Reliance, Data & Study Limitations, and Key Assumptions

Data Reliance

We relied on the following information in our preparation of this report:

From the carriers of the school health plans:

1. Detailed claim data at the level of each service rendered. We requested this from the six Minnesota-based carriers that paid 93% of the claims during the 7/1/01 to 6/30/02 study period.

2. Detailed membership files, showing effective and, where applicable, termination dates of coverage, group and plan or subgroup of member, employee, dependent, and, sometimes, retiree status, and some indication of age or date of birth, consistent with each carrier's interpretation of HIPAA data privacy requirements. We requested this from the six Minnesota-based carriers that paid 93% of the claims during the 7/1/01 to 6/30/02 study period.

3. Summary claim data at the group and plan level. We requested this from seven carriers, and received information from five of them.

4. Premium, retention (administrative expense, taxes, commissions, and fees), and stop loss expense and levels at the group and plan level. We requested this from all of the carriers.

5. Plan benefit relativity factors that express the value of one plan's benefits versus those of other plans. We received these from BlueCross BlueShield of Minnesota, HealthPartners, and Medica. We tested these carrier factors against R&A cost model PMPM net claims for a representative sample of plans and adjusted the carrier factors where necessary.

6. Descriptions of benefit plans.

7. From the administrator of the PEIP plans, descriptions of and premiums for the standard plans, along with retention charges and stop loss premiums.

We performed basic checks of data reasonableness and discussed possible data issues with the carriers supplying data. In several cases, carriers re-ran their data submission, or provided additional data, in response to these discussions.

From school districts (260 out of 344 responded):

1. The carrier's name and the type of funding (insured, self-funded, service cooperative, etc.)

2. Monthly premium rates as of the last months of their policy years that ended in 2001 and 2002, for single employees and employees with family coverage.

3. The number of employees and retirees with single and family coverage in those months, and the employee and retiree contribution rates.

4. The number of employees who did not take coverage, and the cash payments to those employees in lieu of coverage. Few districts provided this information.

Data and Study Limitations

1. Not every carrier identified retirees in their membership files. In addition, for at least one of the carriers that did identify retirees, this identification was voluntary on the part of their groups. Therefore, for this carrier, the retiree identifier was not a reliable field on which to base our analyses. To estimate the number of early retirees, we will look at districts which have 500 or more covered subscribers and which provided their carriers with a retiree identifier; we will then extrapolate the results to all districts.

2. We did not receive detailed claim and membership data from six TPAs and carriers that each covers one district. Three of these districts are small, but the other three—Austin, Red Wing, and Rochester—are significant in size. After discussing with several of these carriers the problems and expense of special reporting and database creation for just one group, we agreed, for most of these carriers, to allow them to report claims and members at a summary group and plan level. The data on these carriers' groups was therefore not included in most of our exhibits and graphs.

3. One carrier did not report employees and dependents separately, for individuals with family coverage. We used standard R&A demographic assumptions to estimate the number of employees and dependents covered by this carrier.

4. We are still in the process of compiling several parts of the data, including:

    - For insured groups, premiums paid during the 7/1/01 to 6/30/02 period.
    - Overall retention level as a percentage of claims
    - Stop loss premiums
    - Indicators measuring relative benefit levels
    - Employee/retiree contribution levels

Key Assumptions

1. Trend: See Table 1 in the text. This represents R&A's best estimate of the annual rate of increase in allowed costs, before member cost sharing, over the three year period from 1/1/02 (the middle of the historical study period) to 1/1/05 (the middle of the projection period).

2. Retirees: As we mention above, we cannot reliably split the retirees from the active employees. We assumed that all "subscribers" (employees and retirees) age 65 and over are retired.

3. Allowed cost: We calculated this as the net benefit payment plus amounts that the member paid out of pocket, such as deductibles, copayments, and coinsurance. Therefore, allowed cost does not include amounts that the plans did not have to pay because of coordination of benefits (COB). For members under 65, COB is typically a small percentage of overall charges, generally under 5%. However, for retirees 65 or older, for whom Medicare is the primary payer, COB is typically about 60% of overall charges. We believe that charges net of Medicare payments is the proper base for allowed charges of the Medicare-eligible members.

4. Cost projections to 7/1/04-6/30/05 year: These reflect not only the trend on allowed costs, but also leveraging of fixed dollar copayments and deductibles. To represent the current mix of plans in these projections, we developed a model plan that produced the same level of 7/1/01-6/30/02 member cost sharing as the current mix of plans. This model plan has $10 office visit, $50 emergency room, and $7 formulary/$14 non-formulary drug copayments and 10% coinsurance on hospital expense.

5. Group size: We based our definitions on the number of *covered* subscribers – employees and retirees. Although our data request to the districts asked for the number of employees waiving coverage, most districts did not provide this information. Therefore, we cannot develop the total number of *eligible* employees in the districts.

Appendix E

Minnesota Advantage Health Plan 2003 Benefits Schedule

2003 Benefit Provision	Cost Level 1 You pay	Cost Level 2 You pay	Cost Level 3 You pay
A. Preventive Care Services • *Routine medical exams, cancer screening* • *Child health preventive services, routine immunizations* • *Prenatal and postnatal care and exams* • *Adult immunizations* • *Routine eye and hearing exams*	Nothing	Nothing	Nothing
B. Other Services covered at 100% • *Lab, pathology and x-ray* • *Allergy shots* • *Blood pressure checks*	Nothing	Nothing	Nothing
C. Office Visits for Illness/Injury • *Outpatient visits in a physician's office* • *Chiropractic services* • *Outpatient mental health and chemical dependency*	$5 copay per visit	$10 copay per visit	$20 copay per visit
D. Outpatient Physical, Occupational or Speech Therapy	$5 copay per visit	$10 copay per visit	$20 copay per visit
E. Emergency/Urgent care (in service area) • *Urgent care facility* • *Emergency care received in a hospital emergency room*	$5 copay per visit $50 copay	$10 copay per visit $50 copay	$20 copay per visit $50 copay
F. Inpatient Hospital Copay	Nothing	$200 copay per admission	$400 copay per admission
G. Outpatient Surgery Copay	Nothing	$75 copay per visit	$150 copay per visit
H. Hospice and Skilled Nursing Facility	Nothing	Nothing	Nothing
I. Prosthetics, Durable Medical Equipment, Diabetic Supplies	20% coinsurance	20% coinsurance	20% coinsurance
J. Expenses Subject to Annual Deductible and Coinsurance: expenses not covered in A-I above, including but not limited to *Ambulance* *Home Health Care* *Outpatient Hospital Services (non-surgical services)* • *Radiation/chemotherapy* • *Dialysis* • *Day treatment for mental health and chemical dependency* • *Enhanced radiology services, including CT scans, MRIs*	Nothing after $100 annual deductible per person, $200 annual deductible per family	5% coinsurance after $150 annual deductible per person, $300 annual deductible per family	10% coinsurance after $300 annual deductible per person, $600 annual deductible per family
K. Prescription Drugs • *34 day supply including insulin; 3-cycle supply of oral contraceptives* • *For brand name drugs when a generic is available you pay the copay plus the cost difference*	$12 formulary $25 non-formulary	$12 formulary $25 non-formulary	$12 formulary $25 non-formulary
L. Maximum Out-of-Pocket Expense for Prescription Drugs (excludes PKU, infertility, growth hormones)	$300 per person $600 per family	$300 per person $600 per family	$300 per person $600 per family
M. Maximum Out-of-Pocket Expense (excluding prescription drugs)	$800 per person $1,600 per family	$800 per person $1,600 per family	$800 per person $1,600 per family

Emergency care or urgent care at a hospital emergency room or urgent care center out of the plan's service area or out of network: 80% of the first $2,000 of eligible charges, then 100% per calendar year.

Out-of-Network coverage for early retirees permanently living out of the service area: There is a $350 single or $700 family deductible and 70% coinsurance to the same out-of-pocket maximums above. Prescription drugs are covered as in the table above.

A standard set of benefits is offered in all SEGIP Advantage Plans. There are still some differences from plan to plan in the way that benefits are administered, and in the referral patterns of primary care clinics.