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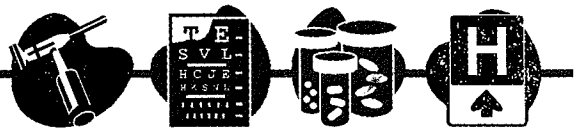
Minnesota State Employees Group Insurance Program (SEGIP)

Biennial Report

1999-2002



DOER Department of Employee Relations

Executive Summary

As required by Minnesota statute,[1] this report concerns the performance of the employee benefits program[2] administered by the Department of Employee Relations. Also included is a required study of local and statewide market trends regarding provider concentration, costs, and other factors as they relate to the state's health benefits purchasing strategy, and a report on the number, type, and disposition of complaints relating to the department's insurance programs. This report covers two biennia, 1999/2000 and 2001/2002, with data from 1998 included for comparison.[3] Unless otherwise noted, the source for all data is the Department of Employee Relations. Questions and comments should be directed to Paul H. Strebe at paul.strebe@state.mn.us

About SEGIP

The State Employee Group Insurance Program (SEGIP)[4] provides insurance benefits[5] to current and former employees and their dependents in the executive, legislative, and judicial branches of Minnesota state government, the Minnesota State Colleges and Universities,[6] and various quasi-state agencies (Figure 1). SEGIP contracts with vendors to provide health, dental, life, disability and long-term care coverage, and pre-tax savings plans to about 118,000 persons, 59% of whom are dependents. The program is funded by a combination of premiums charged to employees and participating agencies, and an administrative fee charged to agencies.

SEGIP's cost containment efforts

SEGIP used many of the approaches used by other employers to control costs, but has also sought to move beyond these strategies by first evaluating the systemic problems and then putting together strategies, including shifting more costs to members, self-insuring, reintroducing competition, managing demand, encouraging quality, focusing on total cost, managing pharmacy, encouraging self-service, contracting for accountability, and keeping administrative costs low. Currently, SEGIP is moving forward with various initiatives to help contain health care costs, including evaluating and, if needed, modifying the Advantage plan,[7] studying consumer-driven plans,[8] obtaining more qualitative information from health plans, targeting high cost conditions,[9] and evaluating prescription drug purchasing strategies and copayment structures.[10]

How SEGIP compares

SEGIP is the largest employer-sponsored, self-insured program in the state, with an older, unionized membership that is geographically dispersed. However, when compared to employers with similar characteristics, SEGIP compares favorably in many ways, including the portion of compensation spent on coverage, recent premium increases, and cost of administration.

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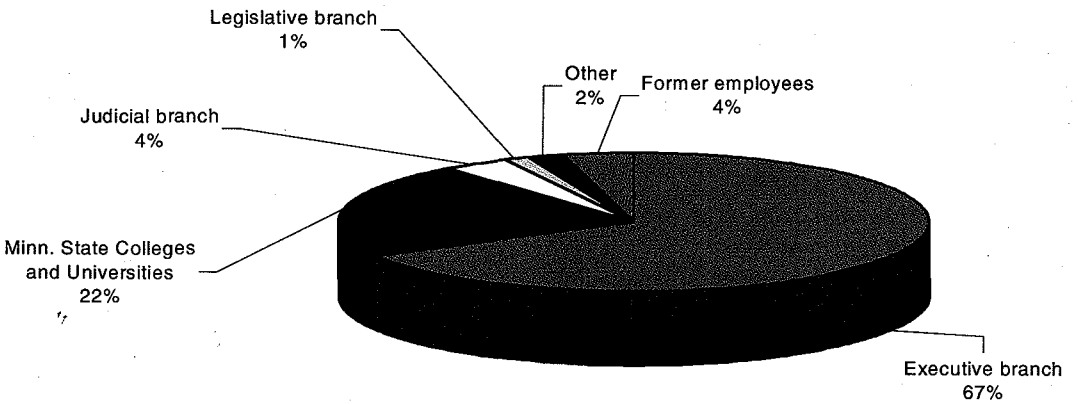
I. Background on SEGIP

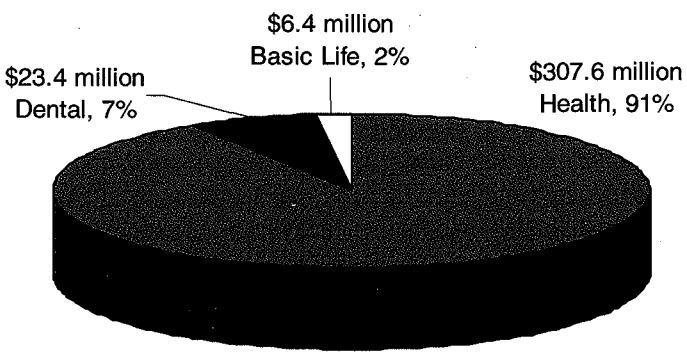
The State Employee Group Insurance Program (SEGIP)[11] provides insurance benefits[12] to current and former employees and their dependents in the executive, legislative, and judicial branches of Minnesota state government, the Minnesota State Colleges and Universities,[13] and various quasi-state agencies (see Figure 1). SEGIP contracts with vendors to provide health, dental, life, disability and long-term care coverage, and pre-tax savings plans to about 118,000 persons, 59% of whom are dependents. The program is funded by a combination of premiums charged to employees and participating agencies, and an administrative fee charged to agencies.

Figure 1/ SEGIP enrollment, 2002



The majority (91.1%) of SEGIP's benefit costs are attributable to health insurance (see Figure 2). The program contributes toward the cost of all employees' health, dental and basic life coverage, [14] while the remaining coverages are optional and paid for entirely by enrollees. In 2002 it cost the state about $316 million to administer and provide health insurance benefits to about 118,000 members. This represented about 2.3% of the $14 billion spent in Minnesota during 2002,[15] while nationally, 7.9% of all spending in state budgets is on employee benefits.[16]

Figure 2/ SEGIP expenditures, 2002



Approximately 90% of all state employees belong to unions, and Minnesota law[17] requires that state employee health benefits are negotiated between the executive branch and the bargaining units. Although each of the state's 17 bargaining units negotiates a different contract with the state, insurance benefits are generally the same and are extended to the 10% of employees who are not represented by unions.

When the state first began offering "medical insurance" in 1945 (see Sidebar 1), the cost of health care was relatively low, so coverage was optional and paid entirely by enrollees. Since then, health coverage has evolved into an integral part of employee compensation, comprising about 6% of employees' total compensation nationally.[18]

The Department of Employee Relations (DOER)[19] has been responsible for administering SEGIP since 1973. The department negotiates and oversees agreements with vendors and unions, enrolls employees, collects premiums, and resolves coverage and claims disputes. To help with these activities, the department employs about 40 full-time staff and contracts with a private consulting firm for assistance.

Since 1973, state employees have been able to unionize and collectively bargain benefits and since 1986, DOER and the state's unions have worked together on the Joint Labor Management Committee on Health Plans (JLMC).

In 2002, DOER merged its insurance and labor relations divisions into one unit, the Labor Relations and Total Compensation Division, in recognition that employee remuneration is not just based on salary, but the total sum of all benefits, tangible and intangible. This division manages the costs of all labor contracts and attempts to maximize the value to employees while minimizing the cost to taxpayers.

Sidebar 1: A brief history of SEGIP

1945
State began to offer optional, member-paid "medical insurance" during World War II as a way to recruit and retain workers. Board consisting of elected officials and agency commissioners oversees program.

1957
State begins to offer coverage through one of the country's first health maintenance organizations, Group Health.

1966
State begins to contribute toward the cost of employee coverage.

1967
University of Minnesota employees join SEGIP.

1973
Public Employees Labor Relations Act is passed, allowing employees to unionize and to bargain benefits. State begins to contribute toward the cost of dependent coverage.

1986
State self-insures one of its plans

2000
State self-insures all of its plans.

2001
University of Minnesota leaves SEGIP

II. Trends in Minnesota's health care market

Minnesota's health care market has significantly influenced SEGIP's purchasing strategy over the half decade that it has been providing health coverage to state employees and their families. As a large, public purchaser, these trends have sometimes affected SEGIP differently than some private employers.

In recent years, per capita spending on health in Minnesota has been less than the U.S. average ($3528 versus $4,309 in 1999) and has represented a smaller share of the state's economy (9.7% versus 12.7%) than nationally.[20] Moreover, Minnesota remains insulated from some trends caused by for-profit HMOs and hospitals.[21] Nevertheless, the cost of health care has increased greatly for all employers in Minnesota in the last decade.

Cost is the result of price (how much things cost) times the volume (how many times things are paid for), plus administration.[22] The price of health care services has been driven by consolidation of providers, the economy and inflation, labor costs, prescription drugs, medical technology, and world events. The volume of services has been driven by an aging and less healthy population, patients who are demanding more care, care that is less managed, and improvements and innovations in medical technology.[23]

1. Price of health care services increasing

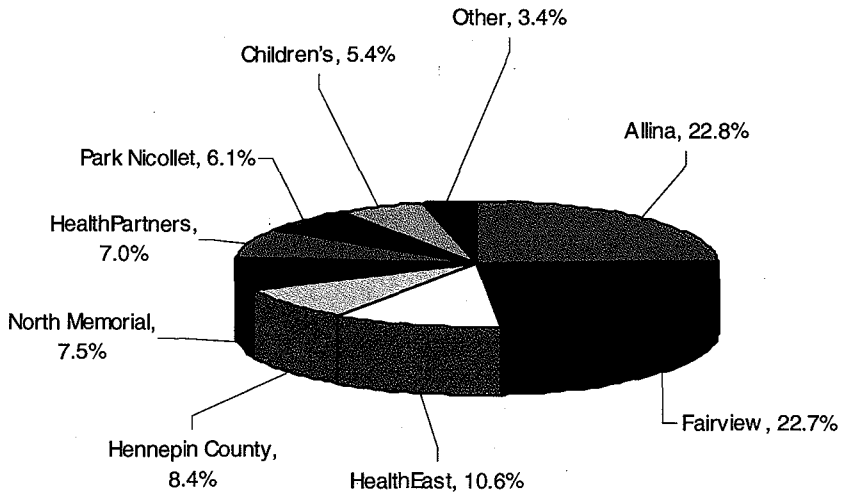
A. Providers continuing to consolidate

While sometimes difficult to measure, it's generally agreed that consolidation among health care providers has occurred in Minnesota, especially in key medical specialties, thereby increasing costs to purchasers. This varies by locality, and a distinction should be made between the Twin Cities metropolitan area and the non-metropolitan area.[24]

In 1999, Minnesota spent less than the national average on hospital (29.2% versus 33.4%).[25] However, in the metropolitan area, two hospital systems controlled half of the market in 2000 (see Figure 3), and the share of total dollars spent on hospital increased from 28% to 29.2% between 1994 and 1999, mostly due to increases in outpatient costs.[26] Consolidation among clinics is more difficult to measure. In 1999, Minnesota spent less on physician services (22.2% versus 23%) than was spent nationally, but the portion of dollars spent increased from 21% in 1994 to 22.2% in 1999.[27]

The reasons for consolidation among health care providers can be at least partly blamed on employers' individual actions. That is, during times of low unemployment, employers have bowed to member wishes and retreated from tightly controlled managed care. Plans and providers have responded with geographically-broader provider networks and fewer products, since employers have seen little difference among them. Perceiving their increased bargaining position, providers have then consolidated to create submarket monopolies.[28] The overall result has been less competition in the market place.

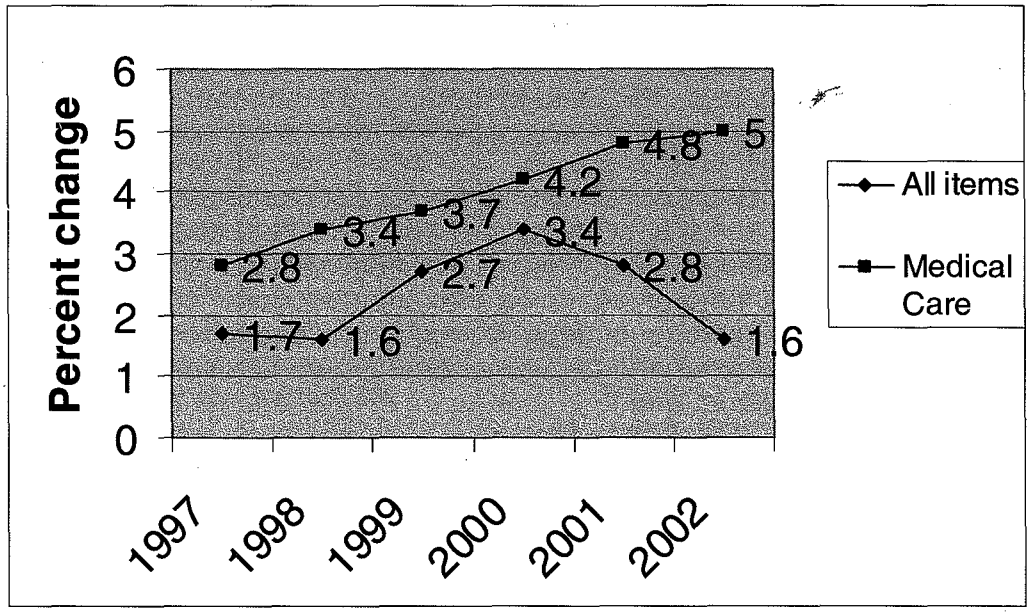
Figure 3/ Twin Cities hospital market share, 2000



B. Higher inflation in medical services and lackluster economy

Inflation in medical care has continued to outpace the underlying inflation rate (see Figure 4). This has been somewhat compounded in the last year by the recessionary environment and the impact of the 2001 terrorist events.[29]

Figure 4/ Change in CPI for all items and medical care, 1997-2002



Source: U.S. Bureau of Labor Statistics

C. Labor market for health services remains tight

Minnesota is experiencing a labor shortage in the health care industry and has the highest number of job vacancies. As shortages occur, demand outstrips supply and wages are bid up. Compensation in the health care industry is also growing at a faster rate than in the private sector.[30]

D. New drugs

Prescription drugs are the fastest growing segment of health care expenditures. In 1999, drugs accounted for 10.5% of all spending on health care in Minnesota compared to 8% nationally.[31]

E. New technology

Innovations in medical technology have increased the cost of care, particularly in the area of catastrophic care and transplants, and may be a larger cost driver than aging.[32]

2. Volume and type of health care services increasing

A. Population aging

The median age for all Minnesotans was 35.4 in 2000. This was higher than the national average of 35.3, and grew more rapidly over the past decade than it did nationally— from 32.4 years to 35.4 years.[33] While persons tend to utilize somewhat more health care services as they age, aging may not be as strong a factor in increasing health care costs as once thought.[34]

B. Population less healthy

In addition to growing older, Minnesota's population appears to be less healthy. While rates for some unhealthy behaviors such as smoking have decreased,[35] other health factors such as obesity have increased.[36]

C. Patients demanding more care

In addition to needing more health care as they age, the dominant generation of baby boomers may also be seeking more treatment than the previous generation because of a heightened awareness and concern for health, and less stigma for treatment of certain conditions, such as mental illness.

D. Care is less managed

Nationally, number of persons in health maintenance organizations decreased from 31% to 23% between 1996 and 2001, with persons shifting primarily to preferred provider and point of service plans.[37] This relaxation of restrictions is likely the result of employers responding to members' complaints. This includes fewer gatekeepers and more direct access to specialties, more provider choices through larger networks and out of network access, and less utilization review.[38]

E. More technology used

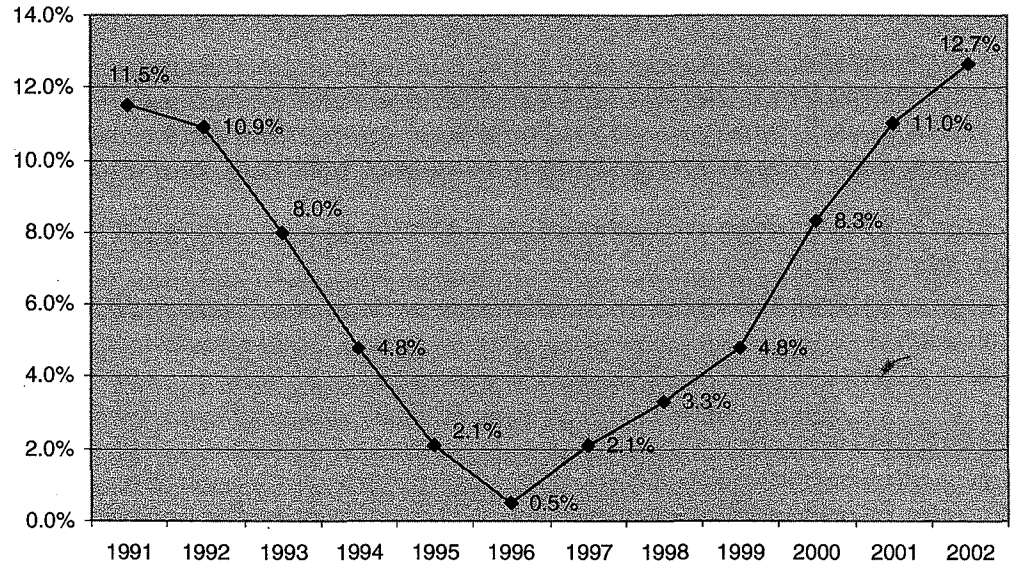
In addition to adding to the cost of care, advances in medical technology have increased the number of procedures completed and has changed the type of care that is administered.[39]

3. Underwriting cycle may have peaked

Through the late 1990s and early 2000s, most employers have experienced rapid premium and cost growth (see Figure 5), but there is evidence that these trends may start to moderate somewhat beginning in 2003, as the cycle that drives premiums begins to shift downward. However, this change will have limited impact on employers that are self-insured and those with high underlying cost drivers, such as older and less healthy populations.[40]

Premiums don't measure the actual cost of employee health care—they only measure the cost of offering coverage. They may not be a good indicator of actual health care costs in any given year because insurers set their premiums using historical and projected claims data. This results in what's called an "underwriting cycle" or "premium cycle," where insurers keep premiums low following years of lower than expected costs to gain or keep market share, followed by years in which premiums exceed actual costs to make up for past losses.[41]

Figure 5/ Increases in total cost of employment-based health insurance nationally, 1991-2002



Source: Kaiser/HRET, 2002

III. SEGIP's cost containment efforts

In recent years, most employers have pursued a handful of strategies to contain health care costs, all with varying somewhat limited success.[42] These include:

- Shifting a greater share of costs to members through increased copays, etc., in hopes of reducing utilization.
- Switching insurers more often in search of better deals.
- Self-insuring to retain profits that would otherwise go to the insurer.
- Managing pharmacy expenses more closely via more limited benefit structures, doing more utilization review, and encouraging use of generics and mail order.
- Maintaining status quo by doing nothing out of hopelessness and/or resignation

SEGIP has taken action in many of these areas, but also sought to be innovative over the years (see Sidebar 2) and move beyond these strategies by first evaluating the systemic problems—what's wrong with the health care market and delivery system—and putting together strategies to address problems. In analyzing these problems, SEGIP has recognized that there are some factors it can control and others that it can't. But as Minnesota's largest employer, the state is better situated than most to create positive change.

1. Shifting more costs to members

Requiring members to agree to more cost sharing is often difficult in a unionized environment, but SEGIP was successful in doing so in 2002, when it implemented a new health plan, Minnesota Advantage. In addition, SEGIP has continued to discuss using other contribution strategies with bargaining units.

Sidebar 2: SEGIP cost containment milestones

1957
SEGIP begins to promote use of managed care by offering coverage through one of the first health maintenance organizations.

1986
To explore various approaches to health care cost containment outside the formal collective bargaining environment, SEGIP creates the Joint Labor Management Committee on Health Plans.

1987
SEGIP begins to only contribute toward the lowest-cost plan in employees' county to promote competition among health plans and to encourage employees to be more cost-conscious.

1990
SEGIP phases out last of its indemnity plans so that all SEGIP members are enrolled in managed care plans.

1991
SEGIP begins to survey members to assess satisfaction and quality,

1995
SEGIP joins a coalition of employers, the Buyers' Health Care Action Group (BHCAG), to explore strategies to contain health care costs.

1998
SEGIP begins thorough study of better models for purchasing health care benefits.

2000
SEGIP fully self-insures all health costs. SEGIP begins to build data warehouse to compile information so that health care costs across all provider groups can be analyzed.

2002
SEGIP implements Minnesota Advantage health care plan which uses risk adjustment to pass more of cost of care to members while retaining choice and access.

While a complete assessment of the cost changes between 2001 and 2002 is difficult to complete, Figure 6 shows some changes that occurred for copayment.

Figure 6/ Changes in SEGIP health copayments between 2001 and 2002

	2001 Primary Network	2002 Advantage
Office copay	$0	$5-$20
Urgent care copay	$0	$5-$20
Outpatient emergency copay	$30	$50
Outpatient surgery copay	$0	$0-$150
Inpatient hospital copay	$0	$0-$400
Formulary drug copay	$10	$12
Non-formulary drug copay	$21	$25

2. Self-insuring

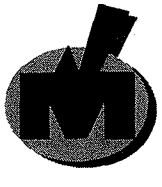
SEGIP self-insured its first health plan in 1986 and self-insured all of its plans beginning in 2000. This has been fairly common among other state employee benefit plans, with 68% of states self-insuring at least one of their plans, and 26% self-insuring all of their plans in 2002.[43]

Nationally, employers have moved away from self-insurance, partly due to the increased cost of reinsurance, which shields employers from catastrophic loses. And, while most private self-insured employers are exempted under federal law[44] from all state mandates regarding benefits, state law[45] requires that SEGIP comply with the same state regulations that fully-insured plans must comply with. Nevertheless, SEGIP has self-insured because it allows the program to more easily adapt to market changes, provides improved program monitoring and management capabilities, and enhanced data for decision making.

3. Reintroducing competition

In addition to the above strategies, DOER has pursued approaches that attempt to address the root causes of increasing health care costs, such as lack of competition due to provider consolidation. This includes creating and transitioning to a new health plan and continuing to study emerging defined contribution models.

A. Changed to Minnesota Advantage



In 2002, SEGIP took a bold step and changed from the "managed competition" model it had been using since 1987 in which the state had contributed towards the lowest cost carrier in the employee's county, to one in which providers were assigned to tiers and members were charged more for using providers that were less efficient.

The change to the new approach, Minnesota Advantage, was the result of SEGIP recognizing that the health care market had evolved to the point where competition among health plans had become limited and financial accountability of the plans had diminished. Advantage shifted the focus from the health plan level to the care system level and empowered members to affect competition.

To design Advantage, SEGIP used a new methodology, risk adjustment, to examine how the costs for treating the same type of patient vary across individual groups of providers. Advantage classified providers into three cost tiers, thereby identifying their performance, making them more accountable, and encouraging them to compete against each other.

The state contributes to the low cost tier so that everyone has similar access. To encourage employees to select low-cost providers and to decrease unnecessary utilization, SEGIP significantly expanded requirements for co-pays, deductibles, and co-insurance. Therefore, Advantage passes more of the cost of care on to members who choose providers at the higher cost tiers, but it offers choice and puts medical decisions closer to the physician/patient level.

If the state continued with its previous plan, costs for the state would have been much higher in 2002 and beyond. SEGIP estimates that Advantage will reduce anticipated total health care costs by $25 million over the next two years—about 3% of total expenditures. The state could spend about $10 million less over the two years, while employees could spend about $1 million less in 2002 and $14 million less in 2003.

B. Studying "consumer driven" plans

In view of increasing health care premiums, there has been a great deal of discussion about defined contribution health care plans, known also as "consumer-driven health plans." In its 2002 assessment of SEGIP,[46] the Office of the Legislative Auditor suggested that the program investigate these types of plans. One approach combines a high-deductive health care plan with a health care reimbursement account. The intent of these plans is to provide members with more choice, flexibility and control.

4. Managing demand

Another way to reduce health care costs is to reduce members' demand for care without reducing members' health or quality of care. This includes programs focused on managing expensive diseases and educating members so they can take better care of themselves.

A. Targeting high cost conditions

One of the flaws of the current health care system is that it tends to only identify and treat conditions after they worsen or injury has occurred. Also, a relatively small number of chronic conditions account for a large share of health care costs. If addressed early, many of these conditions can be prevented or their expense can at least be limited.

In response to this problem, SEGIP under took an effort in 2002 to better coordinate efforts with its health plans to target particularly expensive diseases and manage them better so as to limit costs in the future. This involves identifying persons with certain conditions, such as diabetes, and following them to ensure that they comply with medications and are provided with the proper resources to manage their diseases. This approach is still relatively new among employers, with slightly less than half of all large (10,000+ employees) reporting that they were exploring this, according to a recent survey.[47]

In 2003, SEGIP is targeting four categories of health conditions: psychosocial, asthma, diabetes and congestive heart failure. For psychosocial conditions, SEGIP is working with its health plans to assess its mental health services and benefits, and will make any changes necessary to ensure that care is provided in the most integrated and cost-effective manner.

For asthma, diabetes and congestive heart failure, SEGIP's benefits consultant, Deloitte and Touche, has projected that targeting just three of these four categories of conditions could save SEGIP a total of $3.5 million[48] (see Figure 7).

Figure 7/ SEGIP targeted conditions, 2002

Condition	Assumptions	Savings per member per year	Savings total
Diabetes	5% reduction in costs due to reduced hospital admissions, emergency room and office visits.	$400	$1.5 million
Congestive heart failure	17% reduction in costs due to reduced hospital admissions and inpatient stays.	$2,300	$1 million
Asthma	5% reduction in costs due to reduced inpatient admissions and emergency room visits.	$230	$1 million

Source: Deloitte and Touche, 2002

B. Encouraging self-care and behavior change

SEGIP has worked alone and in tandem with its health plans to provide information to help members take care of themselves and to change behaviors that affect their health. SEGIP recently developed a summary of health improvement resources that are offered through the plans,[49] a compendium of websites that provide reliable health information,[50] monthly health tips[51] and a collection of interactive calculators and quizzes that educate members about health issues[52]. In addition to a conventional yearly health fair, SEGIP also maintains a website with a "virtual health fair"[53] and a calendar of national health events[54] so that members can access health-related information all year long. In 2003, SEGIP will be working with its plans to develop online Health Risk Assessment (HRA) tools, with implementation in 2004.

5. Encouraging quality

In a commitment to promote quality health care and benefits for its members, SEGIP has conducted and participated in various surveys for over a decade. As data, technology, and the knowledge of best practices has evolved, so has the program's approach.

A. Surveying members

Initially, SEGIP concentrated on assessing members' satisfaction with their plans with the belief that employees would use this information to make wiser choices. Although it was considered innovative and was the most cost-effective quality assessment tool known at the time, it was not always clear what impact this information had, and there was some concern that the survey was rating members' satisfaction with the customer service of their health plan and not the quality of care. As a result, SEGIP changed to a survey of care systems for 1999 and 2001.[55]

In 2002, SEGIP reassessed its approach to measuring and promoting quality health care. It stopped participating in surveys of its whole population and began exploring a new approach which focuses on surveying only members with chronic illnesses, as these are the persons who have the most experience with the system and incur the most costs. SEGIP also plans to coordinate its efforts with national surveys[56] so that the program can better compare itself to others.

B. Gathering and analyzing comparable data

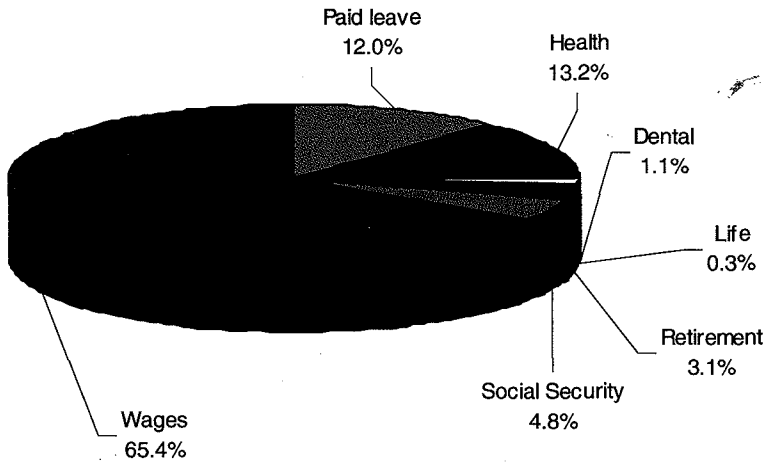
This change was made possible not only through improved knowledge in this area, but also through greater access to SEGIP member data through the program's data warehouse that was implemented in 2000. This has enabled SEGIP to obtain and analyze data that is similar for all of its health plans. This was the first of its kind in Minnesota, and was later copied by the Minnesota Buyers' Health Care Action Group.[57] Prior to this, SEGIP got information from its health plans in different formats, making it difficult to compare information so that the program could improve its quality of care, etc.

In 2003, SEGIP also plans to obtain additional data from its warehouse using selected HEDIS (Health Plan Employer Data and Information Set)[58] measures in order to further measure the quality of care being provided by SEGIP health plans.

6. Focusing on total cost

Traditionally, employers have accounted for the cost of health insurance separate from the more indirect costs of poor health, including absenteeism, disability, injury, turn over, and productivity. But all of these costs are related, and in many instances, these indirect costs exceed the direct costs of health care (see Figure 8).[59]

Figure 8/ Break down of SEGIP total compensation, 2002



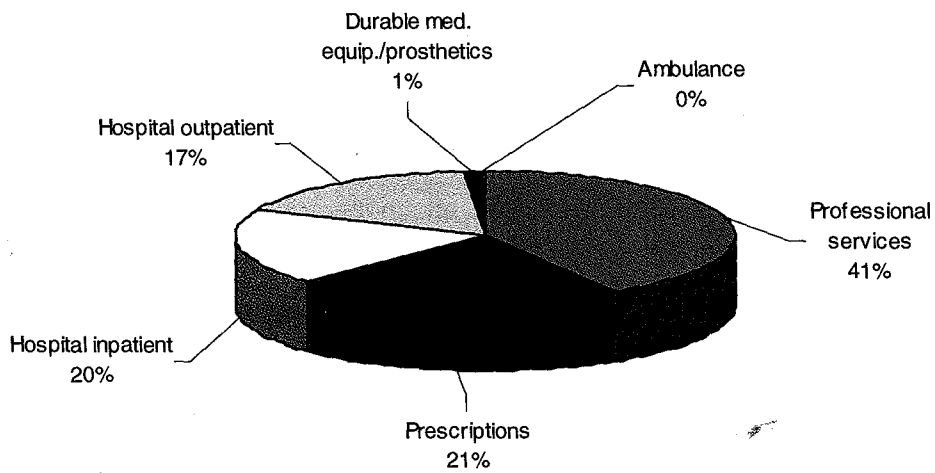
In 2002, SEGIP took a new approach and began to assess total costs related to employee health. In recognizing these interrelationships, SEGIP has worked to establish strategies that attempt to reduce not only health insurance and workers' compensation costs, but also state employee absenteeism and other factors that impact productivity and administrative costs within state government. This new approach has included an organizational change, in which previously separate work units related to safety and industrial hygiene, employee assistance, and health promotion work together, as well as a focus on quantifiable results.

Part of this new approach has included an internal assessment of SEGIP's behavioral health services in late 2002 and early 2003 to develop and implement strategies that reduce the costs for members with behavioral health problems. This project includes an analysis of the gaps between the behavior health services provided by the state and SEGIP's health plans, an evaluation of the state's current model for purchasing behavioral health services, and a collaborative effort with the health plans to develop risk management strategies for controlling behavioral health conditions.

7. Managing pharmacy

Drugs are the most rapidly growing component of Minnesota health plan costs, but professional services contribute most to overall growth.[60] For SEGIP, drugs accounted for 20.8% of expenditures in 2002 and are projected to be 21.1% in 2003. Meanwhile, professional services account for about 41% of costs (see Figure 9). But the cost trend (10.2%) and utilization (10.6%) for drugs was the highest of all expenditures in 2002.

Figure 9/ SEGIP expenditures, 2002



While escalating drug costs are a problem, care should be taken not to concentrate too much on this area at the expense of others, such as medical technology. Increasing drug costs may, in fact, be the fulfillment of managed care's original promise, which was to manage disease through early intervention with medication and, spending on drugs has likely reduced costs in other areas.[61] Therefore, care must be taken not to increase out of pocket costs too much, or employers may sabotage their efforts to further manage chronic conditions.

Some of the strategies to decrease drug expenditures that SEGIP has been using or studying include shifting a greater chare of drug expenses to members, encouraging use of mail order drugs, changing to a single pharmacy benefit manager.

A. Shifting greater share of costs to members

Under SEGIP's new health plan, Minnesota Advantage, members have been required to pay higher drug copayments. Copayments for formulary drugs increased from $10 in 2001 to $12 to 2002, while copayments for nonformulary drugs increased from $21 to $25.

B. Encouraging use of mail order

SEGIP's utilization of mail order has been somewhat below industry standards, so the program has tried to increase this by having plans send information to members, publishing information on the state's web newsletter, and planning other communication efforts for the future.

C. Studying new ways to administer benefits

Since the summer of 2002, SEGIP has been conducting an internal study to determine if members and taxpayers would be better served by changing the arrangement the program has between its plans and their pharmacy benefit managers (PBMs). This study began with a literature review, and retreat for SEGIP managers, interviews with current vendors, and an analysis of the results.

A number of new approaches are possible and each has various trade-offs. Existing health plans are in many cases fairly integrated with their pharmacy benefit managers, so any change may cause disruptions in service. Most of the approaches would likely result in some cost savings, but this may be offset by additional health plan administrative burden and expenses for SEGIP to oversee a new contract with a single PBM.

D. Studying new benefit designs

As recommended by the Office of the Legislative Auditor, SEGIP is studying possible changes to its prescription drug co-pay structure to determine if other approaches would be more cost-effective.[62] However, state law somewhat limits the program's ability to change from a two-tier to a three-tier benefit design, and since benefits are collectively bargained, the program can not make any changes unilaterally.

8. Encouraging self-service

In recent years, advances in technology have enabled SEGIP to change the way it interacts with its members and state agencies. This includes a movement towards enabling members to better serve themselves through the internet, thereby providing administrative efficiencies and improving service.

A. Redesigned open enrollment process

Like many employers, SEGIP used to conduct its yearly benefit enrollment on paper and tended to act as an intermediary between its benefit plans. The program contracted with an outside vendor to design extensive enrollment materials, and required health plans to send each member copies of plan materials. This approach was not only costly, but resulted in somewhat uneven customer service, since SEGIP relied on personnel in agencies throughout state government to administer benefits, and their knowledge varied.

Beginning in 1997, SEGIP began to redesign its entire enrollment process. That year, the program began requiring members to complete their yearly benefit enrollment either through the internet or interactive telephone. The program also took the design of enrollment material in house, and began to dramatically reduce the volume of paper sent to members by shifting this information to its website. In 2003, SEGIP plans to phase out telephone enrollment and continue to improve the resources on its webpage. This change has not only increased the efficiencies in administration, but also provided members with faster, fairer service and better protection of employee information.

B. Upgrading computer system

SEGIP has also been working since 2001 to plan and install a new internet-based software package to administer employee benefits. The software, which is used by many large employers, will automate many processes and allow SEGIP to move toward a centralized administration of benefits. When it is first implemented in the spring of 2003, the software will allow new employees to enroll in benefits and current employees to make some changes in their coverage. In addition, the department expects to phase in further enhancements over time. This change will not only save the state money in the long run, but will provide members with better customer service, and ensure that SEGIP complies with various laws concerning employee benefits.

9. Contracting for accountability

One strategy that SEGIP has used to contain program costs is to include provisions in its contracts that provide vendors with financial incentives to meet specific goals. These include penalties and bonuses for fully-insured products and services, and also risk-sharing arrangements for products which the state self-insures. These incentives have also resulted in contracts with more specific language concerning vendor duties, expectations and deliverables.

A. Health and dental

Current SEGIP health and dental plan contracts include incentives and penalties in areas such as claims cost (e.g. number of prescriptions given), health outcomes (e.g. number of breast cancer screenings), and customer service (e.g. membership cards mailed out on time). Beginning in 2003, SEGIP health plan contracts also include extensive provisions for health risk management, in which the health plans are required to develop, maintain, and refine programs concerning health risk management, disease management, health promotion, health education, self-care, and other efforts toward reducing health care costs, improving the health of, and educating members to be informed consumers of health care. All programs are to be data-driven and have a positive return on investment in the first year. All programs have risk-sharing arrangements and performance guarantees.

B. Actuarial services and pre-tax administration

In 2002, SEGIP also put its contracts for actuarial services and pre-tax benefit administration out for bid. The resulting contract for actuarial services included more specific duties and deliverables than the previous one, and the contract for pre-tax benefit administration now includes performance penalties.

10. Keeping administrative costs low

SEGIP has continued to make efforts to keep its administrative expenses low. Toward that end, the program recently integrated several work units to make better use of existing resources and to eliminate six positions at a savings of $310,000, reduced its use of consultants for a savings of approximately $100,000, changed from a biennial satisfaction survey to a less costly assessment tool for a savings of approximately $203,000.

Summary of cost control methods

Figure 10 shows various health cost-control methods that were suggested in 2002 by the Office of the Legislative Auditor,[63] and the status of each method in SEGIP.

Figure 10/ Methods to control health costs

Health cost-control method.	Use in SEGIP?
Self-insure to eliminate some of the carrier charges associated with fully-insured plan.	Yes. Insured one plan in 1986 and all three by 2000.
Offer managed care plans, such as HMOs or PPOs, that include management tools for controlling costs.	Yes. Began using one of the country's first HMOs in 1957.
Provide employees with a choice among several plans and set the employer contribution based on the lowest cost plan (managed competition model).	Yes. Used managed competition model from 1987 to 2001, but switched to risk adjusted model in 2002 because approach no longer effective.
Require co-pays, deductibles, and co-insurance.	Yes. Have required copays for prescription drugs and copays for office visits since 2002. Have required deductibles and co-insurance.
Require prescription drug co-pays.	Yes.
Establish higher co-pays for brand name drugs with generic drug substitutes.	Yes.
Establish different categories for prescription drug co-pays and implement prescription drug co-insurance.	Yes. Have had different categories of drug copays. Have considered requiring drug co-insurance.
Establish a separate contract for prescription drug benefits.	Considering. See above.
Offer a high deductive health insurance plan and a personal health care savings account.	Considering. See above.

IV. How SEGIP's Advantage compares

Various measures can be used to compare SEGIP's health plan, Minnesota Advantage, with other employer-sponsored plans, but consideration must sometimes be given for SEGIP's somewhat unique position of being the state's largest employer-sponsored, self-insured program, with an older, unionized membership that is spread throughout the state. However, when examined next to employers with similar characteristics, SEGIP compares favorably in many ways.

1. Coverage is collectively bargained

In general, larger employers tend to offer somewhat more generous benefits than smaller ones,[64] and this is particularly true of public sector employers who have traditionally used benefits rather than wages to attract and retain employees. This is also partly due to Minnesota law,[65] which requires that public employers, including state government, meet and negotiate with its public employee unions on the terms and conditions of employment, including health insurance benefits. These items typically include provider networks, scope of coverage, and employee share of premiums.

SEGIP members may enjoy a slight advantage over employees in other sectors concerning health benefits, but this may be balanced out by lower compensation in other areas, such as wages. About nine percent of employees in the private-sector belong to unions, whereas 37.5 percent of employees in the public sector are represented.[66] Among the eleven Midwestern states of North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Wisconsin, Illinois, Michigan and Indiana, only six besides Minnesota allow collective bargaining of state employee benefits. Of those six, only one besides Minnesota permits strikes.[67]

The state and unions negotiate benefits as part of a total compensation package that includes salaries and other benefits. When more money is negotiated for salaries, less is available for benefits, and vice versa. If contract negotiations or state agency practices result in compensation packages that are greater than legislative appropriations, then state agencies are generally expected to make up the shortfall by adjusting their budgets.

So, while collective bargaining may sometimes create a richer benefit set than found with non-unionized employers, the method by which benefits are negotiated may have a moderating effect on overall compensation. In effect, when employees and their unions choose to keep benefits high, they may be agreeing to trade away other compensation, such as salaries.

2. Membership is older and less healthy than average

SEGIP members, as a whole, are older than typical Minnesota workers. In 2000, the average age of the Minnesota state government workforce was 46,[68] while the average age of the working age population (ages 20-60 years old) was 35 for both Minnesota and the U.S.[69] This aging has occurred fairly rapidly. In 1984, the median age for state employees was 38. By 1994, it was 42, and by 2000 it was 46.[70] Currently, seventy percent of SEGIP employee members are over age 40.[71]

SEGIP's older population plays a role in the program's increasing costs, although a recent study shows that aging is not a major cost driver. Between ages 18 and 64, annual per capita health spending increases by about $74 on average for each additional year in age. After age 50, spending starts rising more rapidly—about $152 for each additional year in age between 50 and 64, the study found.[72] Using these numbers, it appears that SEGIP is spending on average about $814 (about 12%) more per member per year than an average Minnesota employer with an average employee age of 35.

Evidence also suggests that, partly as a result of being older, SEGIP's membership may be sicker. Between 2000 and 2001, the number of SEGIP members who were identified as being in high cost disease states increased 14%, from 36,000 to 41,000.[73]

3. Membership is diverse and geographically dispersed

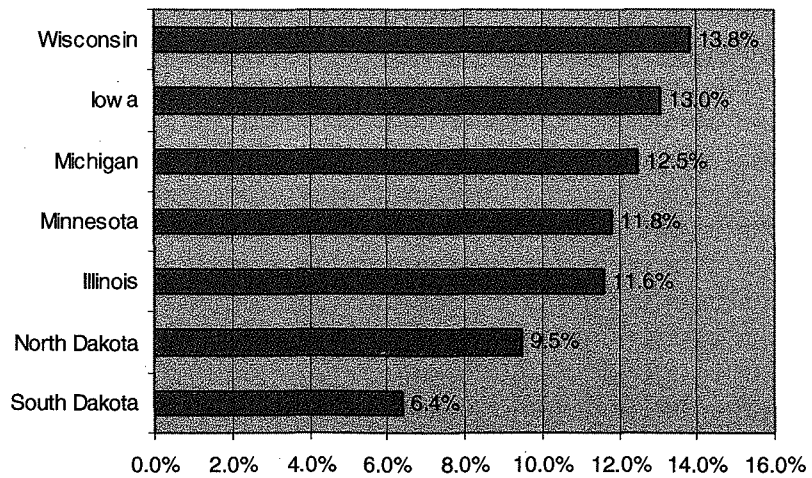
SEGIP provides coverage to perhaps the most diverse work force in the state. Its members are employed in a wide range of jobs in 39 different career categories, including administrative assistant, agronomist, management analyst, maintenance worker, x-ray technician and zookeeper. With these occupations comes a wide range of attitudes and income, so providing a single set of health benefits is challenging.

Compared to other Minnesota employers, SEGIP's members are also widely dispersed around the state and this creates unique access issues that other employers do not have. Half of all state employees live and work outside the Twin Cities metropolitan region and they live and work in every county in Minnesota. With 118,000 members, SEGIP is serviced by over 50 different provider groups. In comparison, the Buyers' Health Care Action Group has 140,000 members in the Twin Cities (10 percent of local market) with its membership concentrated in 28 care systems.[74]

4. Portion of compensation spent on coverage is average

Compared to other state employee benefit programs in the Midwest, SEGIP is average when examining the percentage of health insurance that comprises total employee compensation. The average for state employee programs in Wisconsin, Iowa, Michigan, Illinois, North Dakota, and South Dakota is 11.3%, while SEGIP was 11.8%[75] (see Figure 11).

Figure 11/ SEGIP health coverage as portion of total compensation, 2002

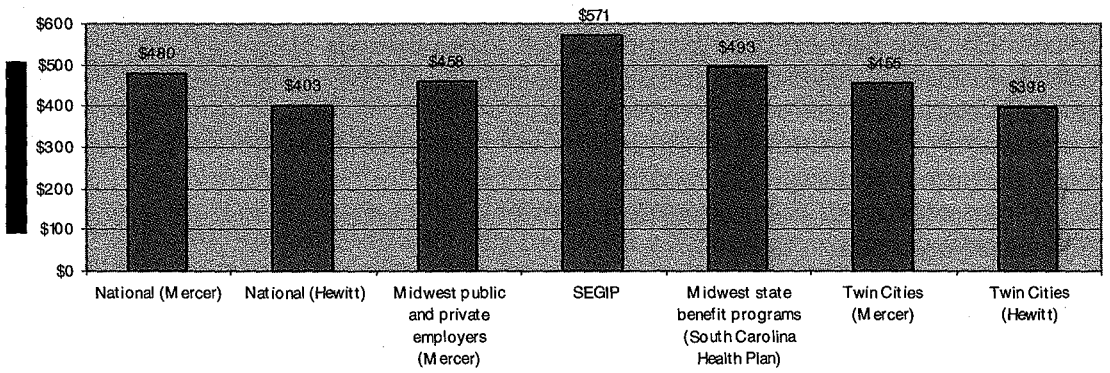


Nationally, the portion of total compensation that is spent by employers in all sectors declined during the 1990s, but it is beginning to rise again.[76] In 2002, the average was 6.6% for all sectors, 6.1% for private industry, and 8.9% for state and local governments.[77] State employee benefit programs in the Midwest have tended to spend a higher percentage than those nationally. While the national average for state employee benefit programs is 9.6%, the average for programs in the Midwest is 11.3%.[78]

5. Cost of coverage is higher than average

The average cost per SEGIP member in 2002 was high compared to various benchmarks for public and private industry, but when compared to perhaps the most appropriate measure, an index of Midwestern state benefit programs, SEGIP's average cost was 15.8% higher in 2002 (see Figure 12).

Figure 12/ Total cost of coverage per member per month, 2002



6. Recent premium increases are about average

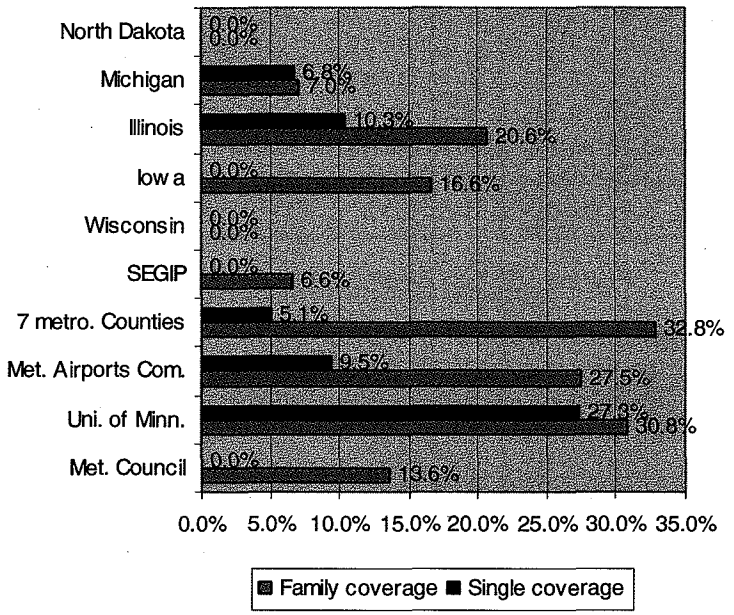
According to the 2002 study conducted by the Minnesota Office of the Legislative Auditor, premium increases for SEGIP have generally been consistent with national and state trends.[79] In recent years, state and local governments nationwide have had the highest increases in premiums of any industry.[80] However, SEGIP's 2003 premium increase of 16.3% for health coverage appears to be only slightly above predictions of 14.4% to 15.4% nationally from various benefits consulting groups.[81] Moreover, recent premium increases in the Midwest may be one slightly higher than national figures, with one firm showing an average of 15.8% for employers in the Midwest.[82]

7. Employee contributions lower than average

Compared to typical public and private sector health plans, SEGIP provides a higher level of subsidy, with a full subsidy for single coverage and an above average subsidy for family coverage.[83] But, public employee contributions for coverage have tended to be lower than for private employees,[84] and state employees in the Midwest pay a smaller share of premiums than their public and private sector colleagues in other regions.[85]

The average employee contribution for single coverage nationally ranged from 13.8%[86] to 18.7%[87] in 2002. For SEGIP, single coverage was fully subsidized, whereas a recent survey showed that this was true of only 8% of private sector companies.[88] However, like Minnesota, three of five (60%) Midwestern states (North Dakota, Michigan, Illinois, Iowa, and Wisconsin) pay the full cost of single coverage for their state employees.[89] The average employee contribution nationally for family coverage ranged from 26.8%[90] to 27.7%[91] for 2002. SEGIP members pay 6.6% (see Figure 13).

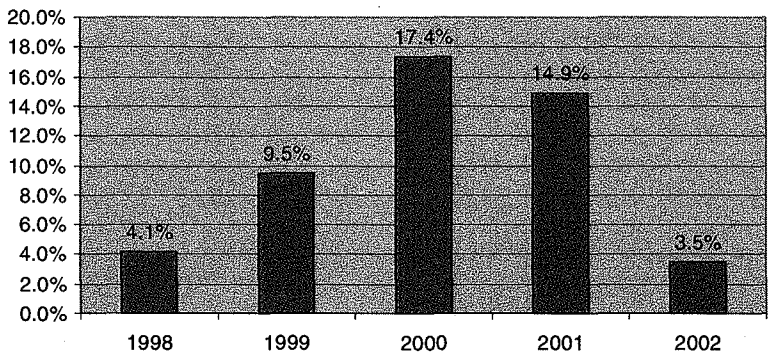
Figure 13/ Employee Contribution to Coverage, 2002



8. Cost per member rising slower than in past

Between 1997 and 2002, the real cost per SEGIP member rose each year (see Figure 14), with the highest increase occurring in 2000 (17.4%). Since then, the rate of increase (above inflation for medical services) has slowed markedly, with 2002 showing just a 3.5% gain. This may indicate the impact of SEGIP's new approach to health coverage purchasing using Advantage.

Figure 14/ SEGIP per member cost increase (adjusted for inflation)

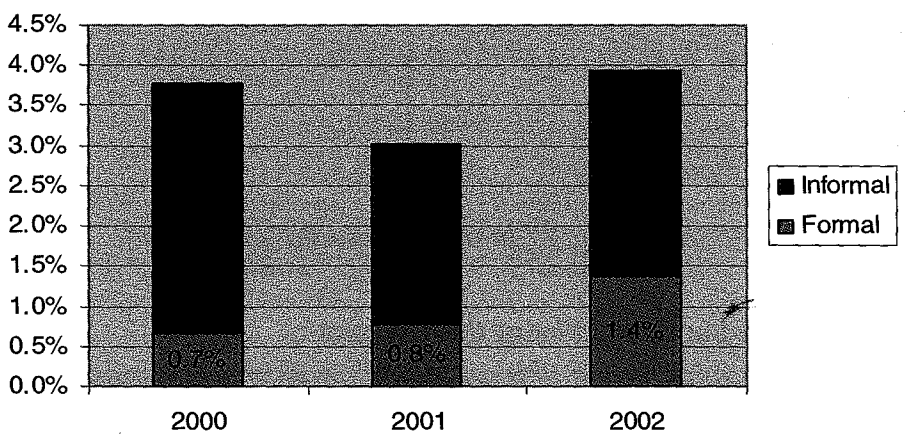


9. Number of complaints remains low

As required by statute,[92] SEGIP is to report the number, type, and disposition of complaints relating to the insurance programs. The health plans that SEGIP contracts with have tracked complaints for some time, but beginning in 2000, SEGIP obtained a software package to also track inquiries and complaints made to the department. Contracts with health plans contain incentive/penalty provisions for various cost management and operation performance measures. Within the operational performance measures, plans are measured on the average speed that customer service calls are answered and the rate at which calls are lost. Each area has a performance "target corridor" and plans are paid incentives if they exceed it and they pay penalties if they do not.

The number of complaints to SEGIP is quite low compared to the number of enrollees. In 2002, the overall number of complaints regarding SEGIP's programs was up –3.93% of enrollment compared to 3% in 2001—but was only slightly higher than the 2000 number of 3.78%[93] (see Figure 15). This increase is likely due to the introduction of the Advantage plan. The largest area of increase came in formal complaints,[94] which are appeals. They increased from 0.77% in 2001 to 1.37% in 2002.

Figure 15/ SEGIP complaints, 2000-2002



The number of informal complaints also increased, but only slightly in 2002—from 2.24% to 2.56%. The majority of the informal complaints came in the areas of networks/clinics, claims, and benefits. The largest increase in 2002 came in the areas of networks/clinics, as might be expected under the new Advantage plan, as some enrollees were required to pay more out-of-pocket for their provider, or change providers. The second largest increase of informal complaints was in enrollment, which might also be expected under a plan that was somewhat different to enroll in than SEGIP's previous arrangement (tiers versus health plan).

Figure 16/ Informal SEGIP complaints, 2000-2002, as a percentage of enrollment

Informal complaints	2000	2001	2002
Network/Clinics	0.58%	0.54%	0.73%
Claim	0.89%	0.58%	0.61%
Benefit	0.37%	0.38%	0.45%
Enrollment	0.23%	0.09%	0.19%
Administration	0.16%	0.31%	0.18%
Referral	0.26%	0.12%	0.17%
Prescriptions	0.28%	0.13%	0.14%
Open Enrollment	0.04%	0.01%	0.04%
Eligibility	0.07%	0.03%	0.03%
Rates	0.10%	0.01%	0.02%
Billing	0.05%	0.02%	0.01%
Medicare	0.05%	0.00%	0.00%
Retirement	0.02%	0.00%	0.00%

10. Cost of administration remains lower than average

Besides holding down claims costs, SEGIP has tried to do an effective job administering the program. The overall cost of administering SEGIP in 2002 was approximately 8% of total premium costs, which is well below the industry standard of 10-15%.[95]

[redacted]

V. What's on the Horizon?

SEGIP is currently moving forward with various initiatives to help contain health care costs, including evaluating and, if needed, modifying the Advantage plan,[96] studying consumer-driven plans,[97] obtaining more qualitative information from health plans and targeting high cost conditions,[98] and evaluating prescription drug purchasing strategies and copayment structures.[99] The success of these initiatives will be partly affected by trends for the program's population and within the health care market. The following are potential short-term outcomes.

1. Premium increases likely to continue in double digits

Local experts have suggested that the premium cycle may have peaked in Minnesota and that premium increases may moderate for some employers.[100] However, this may have a limited affect on self-insured programs like SEGIP, and the underlying trend of higher utilization in the program's membership is likely to more than offset this. National surveys are suggesting that employer-sponsored programs can expect continued double-digit increases in the near future,[101] and there is good evidence to suggest that SEGIP will follow this trend.

2. Prescription drug spending may moderate somewhat

Nationally, drug spending has been rising about 15% a year over the last several years,[102] and is forecasted to rise faster than other medical costs over the next decade, but at a slightly lower rate than in recent years.[103] This slow down is expect to be the result of a decrease in the introduction of expensive "blockbuster" drugs, and an increase in three-tier copayment structures.[104] This may have some impact on SEGIP's health costs, particularly if it makes changes to its approach to prescription drug purchasing and its benefit structure.

3. Greater share of costs likely to be shifted to members

Many industry experts have suggested that the trend of members paying a greater share of health costs is likely to continue, with members paying increased contributions, copays, deductibles, and coinsurance.[105] This is partly the result of the slowing economy, in which employers feel less inclined to pay these increases themselves in order to attract and retain employees. Although SEGIP benefits are collectively bargained, employees and their unions may be more inclined to accept higher out-of-pocket costs in return for other compensation.

4. Limited interest in tightly managed care

Up until fairly recently, a tight labor market had resulted in employers loosening restrictions on access to providers, etc., in order to attract and retain employees. This resulted in a focus on customer service rather than quality of care. Large networks and increased provider choice shifted the "quality decision" to the member, so that choice became a proxy for quality.[106] With the economic slow down, some employers may return to more limited networks, but surveys suggest that a full return to tightly managed care is unlikely in the near future.[107]

5. Limited interest in consumer driven options

In the same way that most employers have switched from defined benefit pension plans, to defined contribution 401(k) plans, some employers have been interested in these various approaches because they can save employers a great deal of money.[108] This is evidenced by a recent survey showing that for those employers who offer this coverage, it is the lowest cost plan for 85% of them.[109] However, consumer-driven plans have been slow to gain popularity; only two percent of companies offered them in 2002.[110] But 16% of large (200+ employee) firms said they were likely to introduce a defined contribution plan in the next five years.[111]

Major employers that have implemented these plans may find limited interest among members as long as they continue to offer conventional coverage. The University of Minnesota, for example, implemented a defined contribution plan called Definity in 2002, but only 4.4% of the members selected this option. Nationally, employers who are offering these plans are having about 15% of their members enroll in them.[112] Nevertheless, SEGIP will continue to study this option, as experts predict that interest in this approach will grow.[113]

Conclusion

When first introduced over fifty years ago, health care coverage was an optional, member-paid benefit for most employees, but has since evolved into a critical part of state budgets and employee compensation, as the cost of health care has skyrocketed.

Public purchasers of health care coverage face many challenges.[114] However, with its size and market share, programs such as SEGIP have many unique opportunities to shape the marketplace. With large amounts data and less restrictive privacy regulations, SEGIP is able to conduct and disseminate research that can help improve areas such as quality for both its own population and other employers, thereby reducing the cost of research for all. Indeed, federal and state employee benefit programs have often been the harbinger for the rest of the market.[115]

The cost of health care coverage is likely to continue to increase considerably in the foreseeable future. SEGIP's challenge will be to pursue strategies that not only provide value to taxpayers, but also enable its participating employer units to attract and retain qualified employees by offering coverage that is competitive with other comparable employers.

Notes

1 Minnesota Statutes (2002) §43A.31 subd. 2 http://www.revisor.leg.state.mn.us/stats/43A/31.html

2 http://www.revisor.leg.state.mn.us/stats/43A/22.html http://www.revisor.leg.state.mn.us/stats/43A/30.html

3 Data in this report is presented based a calendar year, as this is how it is reported by the state health plans.

4 http://www.doer.state.mn.us/ei-segip/SEGIP.HTM

5 http://www.revisor.leg.state.mn.us/stats/43A/22.html

6 http://www.mnscu.edu/

7 State Employee Health Insurance, Office of the Legislative Auditor, State of Minnesota, February 2002, p. 51.

8 OLA report, p. 67

9 OLA report, p. 86

10 OLA report, p. 57

11 http://www.doer.state.mn.us/ei-segip/SEGIP.HTM

12 http://www.revisor.leg.state.mn.us/stats/43A/22.html

13 http://www.mnscu.edu/

14 The state also contributes towards manager and faculty disability, but in 2002, the state's share only totaled $424,791. Therefore, this coverage will not be discussed in this report.

15 Number includes second half of FY02 and first half of FY03.

16 Milbank Memorial Fund, 1998-1999 State Health Care Expenditure Report

17 Minnesota Statutes (2000) §179A

18 U.S. Department of Labor, Bureau of Labor Statistics, 2001 data for private industry.

19 http://www.doer.state.mn.us/

20 Minnesota Department of Health and Centers for Medicare and Medicaid Services

21 Allan Baumgarten, Concentration and Competition in Minnesota: Key Market Trends and Issues, May 6, 2002. Allan Baumgarten, Concentration and Competition in Minnesota: Key Market Trends and Issues, May 6, 2002.

22 Scott Leitz and Julie Sonier, Minnesota Department of Health, "An Overview of Health Care Costs in Minnesota", January 11, 2002.

23 Michael Scandrett, Minnesota Council of Health Plans, "Task Force on Health Care Costs and Quality", http://www.health.state.mn.us/divs/hpsc/hep/JTF/costqual.pdf

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28 Jon B. Christianson, University of Minnesota, and Sally Trude, Center for Studying Health System Change, "The Impact of Employer Decisions on Local Health Care Markets", December 10, 2001. http://www.hschange.org/CONTENT/394/Christianson.pdf

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30 Scott Leitz and Julie Sonier, Minnesota Department of Health, "An Overview of Health Care Costs in Minnesota", January 11, 2002.

31 Minnesota Department of Health and Centers for Medicare and Medicaid Services

32 Aging Baby Boomers Play Limited Role in Health Care Cost Trends, Bradley C. Strunk, Paul B. Ginsburg, Center for Studying Health System Change, September 2002, http://www.hschange.org/CONTENT/473//

33 Minnesota State Demographer's office and 2000 U.S. Census.

34 Aging Baby Boomers Play Limited Role in Health Care Cost Trends, Bradley C. Strunk, Paul B. Ginsburg, Center for Studying Health System Change, September 2002, http://www.hschange.org/CONTENT/473//

35 http://www.ama-assn.org/sci-pubs/msjama/articles/vol_286/no_21/jms1205012.htm

36 http://jama.ama-assn.org/issues/v289n1/abs/jbr20304.html

37 "Employer Health Benefits 2001 Annual Survey", Kaiser Family Foundation/Health Research and Education Trust.

38 Scott Leitz and Julie Sonier, Minnesota Department of Health, "An Overview of Health Care Costs in Minnesota", January 11, 2002: http://www.health.state.mn.us/divs/hpsc/hep/JTF/hthcrcst/nn4/hthcrct.htm

39 http://www2.mms.org/pages/102202pr_stateofstate.asp

40 Minnesota Department of Health, Health Economics Program, December 18, 2002

41 State Employee Health Insurance, Office of the Legislative Auditor, State of Minnesota, February 2002: http://www.auditor.leg.state.mn.us/ped/2002/pe0206.htm

42 Michael H. Bailit Presentation, Bailit Health Purchasing, "Containing Costs to Preserve Coverage: Lessons from the Private Sector", July 18, 2002

43 Self-funding Survey, Arizona Health Care Cost Containment System, January 2002, http://www.ahcccs.state.az.us/Studies/HRSAGrant/FinalSelf-funding%20Survey%20Report.pdf

44 Employee Retirement Income Security Act (ERISA) of 1974

45 Minnesota Statutes (200) 43A.23

46 OLA report, p. 53

47 Deloitte and Touche survey, 2001

48 Deloitte and Touche recognizes that some of these savings may have already been achieved through existing programs

49 SEGIP Plans' Health Improvement Resources: http://www.doer.state.mn.us/ei-sehpp/resourcebrochure/index.asp

50 Summary of SEGIP health links: http://www.doer.state.mn.us/ei-sehpp/links2.asp

51 SEGIP monthly health tips: http://www.doer.state.mn.us/ei-sehpp/HP-Tips/list.asp

52 SEGIP health tools: http://www.doer.state.mn.us/ei-sehpp/tools.htm

53 Virtual Health Fair: http://www.doer.state.mn.us/ei-sehpp/circus.asp

54 Calendar of national health events: http://www.nationalwellness.org/freepdf/Health_Observances_Calendar/hoc2003.pdf

55 Results of 2001 SEGIP survey: http://www.doer.state.mn.us/hcsurvey/stwide.htm

56 Foundation for Accountability: http://www.facct.org/facct/site

57 http://www.bhcag.com/

58 http://www.ncqa.org/Programs/HEDIS/

59 "Investing in workplace productivity", Washington Business Group on Health, National Institute of Mental Health, March 1999, http://www.wbgh.com/pdf/attmtb.pdf

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67 2002 Central States Survey

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72 Aging Baby Boomers Play Limited Role in Health Care Cost Trends, Bradley C. Strunk, Paul B. Ginsburg, Center for Studying Health System Change, September 2002, http://www.hschange.org/CONTENT/473//

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80 Kaiser Family Foundation, Employer Health Benefits, 2001

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82 Mercer Consulting, 2002

83 Hay Group Employee Benefit Review, 2002

84 Employer Spending on Health Care: 1987-2000, Employee Benefits Review Institute, http://www.ebri.org/facts/1202fact.htm

85 A composite analysis of South Carolina's State Health Plan standard option rates to state plans across the nation, South Carolina Budget and Control Board, January 2002

86 Kaiser Family Foundation/HRET, 2002

87 Towers Perrin 2003 Health Care Cost Survey

88 Hay Group Employee Benefit Review, 2002

89 Central States Survey

90 Kaiser Family Foundation/HRET, 2002

91 Towers Perrin 2003 Health Care Cost Survey

92 Minnesota Statutes (2002) §43A.31 subd. 2 http://www.revisor.leg.state.mn.us/stats/43A/31.html

93 Data for 4th quarter estimated based on historical data

94 No breakdown by type of formal complaints/appeals is currently available, but SEGIP is working with its health plans to eventually have this detail.

95 Deloitte and Touche, 2002

96 State Employee Health Insurance, Office of the Legislative Auditor, State of Minnesota, February 2002, p. 51

97 OLA Report, p. 67

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99 OLA Report, . 57

100 Department of Health, Health Economics Program, December 2002

101 KFF/HRET survey of Employer-sponsored health benefits, 2002

102 Health Affairs, Jan/Feb 02)

103 Health Affairs, Mar/Apr 02

104 Health Affairs, Sept 02

105 KFF/HRET, 2002

106 Jon B. Christianson, and Sally Trude, Center for Studying Health System Change, "The Impact of Employer Decisions on Local Health Care Markets", December 10, 2001

107 KFF/HRET, 2002

108 Investing in workplace productivity", Washington Business Group on Health, National Institute of Mental Health, March 1999: http://www.wbgh.com/pdf/attmtb.pdf

109 2002 health care survey, Mercer Human Resource Consulting, as cited in "Employers pleased with consumer-driven health results", Benefitnews.com, December 17, 2002

110 2002 health care survey, Mercer Human Resource Consulting, as cited in "Health Care Costs: Workers to hear more of burden", Saint Paul Pioneer Press, December 9, 2002

111 KFF/HRET survey of Employer-sponsored health benefits, 2002

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