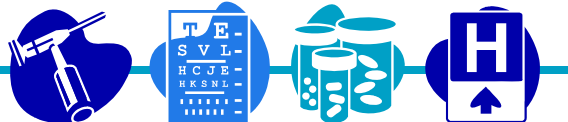




*Minnesota State Employees Group
Insurance Program (SEGIP)*

Biennial Report

2003-04



DOER Department
of Employee
Relations 

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Executive Summary

Minnesota Department of Employee Relations

The Minnesota Department of Employee Relations (DOER), an executive branch, cabinet-level state agency, serves as the human resources management agency for state government. In this capacity, DOER administers compensation and benefits for state employees and other groups under legislative authority provided in Minnesota Statutes 43A. DOER's Employee Insurance Division (EID) oversees the State Employee Group Insurance Program (SEGIP), which offers a variety of insurance benefits for eligible employees of state agencies and quasi-state agencies and organizations.

Reporting requirement

This report has been prepared in accordance with Minnesota Statutes 43A.31, which requires the commissioner of DOER to report each biennium to the Legislative Commission on Employee Relations concerning DOER's administration and operations of insurance benefits. This report covers the 2003-2004 biennium.

In addition, the report also satisfies provisions in M.S. 43A.31 for:

- a study of local and statewide market trends regarding provider concentration, costs, and other factors as they may relate to the state's health benefits purchasing strategy, including consultation with the commissioners of the departments of Commerce and Health;
- reporting the number, type, and disposition of complaints relating to the insurance programs offered by the DOER Commissioner.

State Employee Group Insurance Program (SEGIP)

SEGIP is the single largest employer group purchaser of insurance in Minnesota, covering more than 48,000 employees as well as their dependents – a total of nearly 118,000 covered lives. The program develops and administers coverage for all three branches of state government, including Minnesota State Colleges and Universities (MNSCU), as well as quasi-state agencies, such as the Minnesota Historical Society.

The state's share of premiums for SEGIP insurance-related costs and administration totaled more than \$391 million in 2004. The majority of these costs, more than 93%, were associated with health coverage, with the balance expended for dental and life coverage. Insurance fringe benefits are an important part of total employee compensation, accounting for nearly 14% of state government's \$2.8 billion payroll. These expenditures are also an important part of the state budget and make SEGIP an important, visible presence in the state's health care market.

SEGIP is a leader and innovator in insurance design, purchasing, and administration. It was an early adopter of managed health care, a pioneer in implementing a new model of market discipline in health care known as "managed competition," and one of the first employers to measure and report on the quality of health care it was purchasing. In 2002 it implemented an innovative, new tiered health benefits design known as the Minnesota Advantage Health Care Plan that was unique in the nation. SEGIP continues to innovate and serve as a leader in the development of health plans that help hold down the costs while improving the overall health of its members.

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Important developments and events during this biennium

SEGIP has developed a number of important insurance features and initiatives that have worked towards making the program more efficient and responsive, these include:

New health risk management/disease management initiatives to improve health, contain costs

Approximately 10% of SEGIP members account for 63% of its costs. These costs are concentrated primarily in chronic and complex conditions, often associated with aging, such as diabetes and heart disease. This is especially true for SEGIP because the state workforce is on average older than the workforce generally. In order to contain health care costs and improve health outcomes and quality, it is essential to help reach those with these conditions and to provide them the right care at the right time.

In 2003, DOER successfully launched a major ongoing effort to work with health care providers to help reach those most at risk. This initiative seeks to provide the care that best manages current health conditions while preventing later complications and higher costs. As part of this effort, DOER began to use its health plan and other vendor contracts to bring about greater integration of mental and behavioral health services, including services provided through its Employee Assistance Program (EAP), with physical health care services.

Changes in health and dental benefits

During 2003 and 2004 SEGIP took significant steps to control health care costs and improve health care outcomes and quality. At the same time the state addressed a \$4.5 billion shortfall -- its largest in history. Without control over the increasing cost of employee health care the state would have been forced to make greater cuts in state services, a reduction in the size of the state workforce, employee compensation, or some combination of all of these. Despite protracted and difficult labor negotiations, DOER and the unions representing state employees were able to reach a voluntary settlement of labor contracts that resulted in changes in health and dental benefits that helped offset the need for reductions in other areas. These changes were also designed to help improve the structure and operations of a new tiered health benefit program that had been implemented in 2002, and to continue to provide employees and families with as many options for holding down their share of costs as possible.

Major upgrade of the management information system (MIS) used to administer insurance benefits, and integration with the state's overall human resources and payroll system.

The effective and efficient administration of insurance relies on timely, accurate, reliable, and secure data. In April, 2003 DOER completed a significant upgrade of its management information system (MIS) as it was an outdated legacy system that was inadequate to meet current needs. The replacement was part of a collaborative effort between three state agencies – DOER, Finance, and Administration – to create a comprehensive, seamless statewide MIS solution that integrated the state's human resources, payroll, and insurance functions. The three year project was completed on time and on budget. It included enhanced capabilities for greater employee self-service that allow employees to better, more easily access information, enter updates, and conduct transactions, such as online open enrollment to make annual benefits selections and registrations. SEGIP's \$5.3 million share of the costs was financed through administrative fees that agencies pay for the administrative costs of insurance benefits. The fees, \$8.02 per employee per month, or approximately 1.3% of total premium costs,

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have not increased since 1999 and did not increase after the upgrade project was completed.

Access to less expensive Canadian prescription drugs

In May, 2004, SEGIP became the first state employee insurance program in the nation to cover less expensive Canadian prescription drugs. State employees and their covered family members can obtain prescription drugs through this special service, Advantage-meds.com. In 2004, 1,861 employees ordered 3,166 prescriptions through the service which resulted in a savings of over \$300,000. About half of these savings accrued to the state and the other half to employees.

Creation of the Governor's Health Cabinet

In February, 2004, Governor Tim Pawlenty created a special subcabinet. The Health Cabinet is comprised of six state agency commissioners with health care delivery, purchasing, and regulatory responsibilities to work together to coordinate activities and to use the state's health care purchasing power to improve the overall value of health care delivered in the state. Governor Pawlenty named DOER Commissioner Cal Ludeman as chair of the Health Cabinet. The Health Cabinet is exploring areas for health care regulatory streamlining and improved health care purchasing that incorporate new pay for performance and value-based purchasing strategies. Advantage's tiered health benefits design for state employees implemented in 2002 and health risk management initiatives are examples of new approaches that are being explored for broader use.

I. Overview of SEGIP

Eligibility for benefits

Eligibility for insurance benefits administered by SEGIP and the amounts contributed to their costs by the employer and employee respectively are determined through a combination of: statute, collectively bargained labor agreements, and compensation plans for unrepresented employees. Generally, for the purposes of this report, the "employer" refers to the State of Minnesota, but in some cases also refers to quasi-state agencies that also obtain benefits through SEGIP. SEGIP provides eligibility and enrollment services for 48,000 employees, 60,000 dependants, 10,000 retirees and over 500 COBRA participants.

Approximately 90% of all state employees belong to unions, and Minnesota law¹ 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 the negotiated benefits are extended to the 10% of employees who are not represented by unions.

Insurance benefits with employer contribution

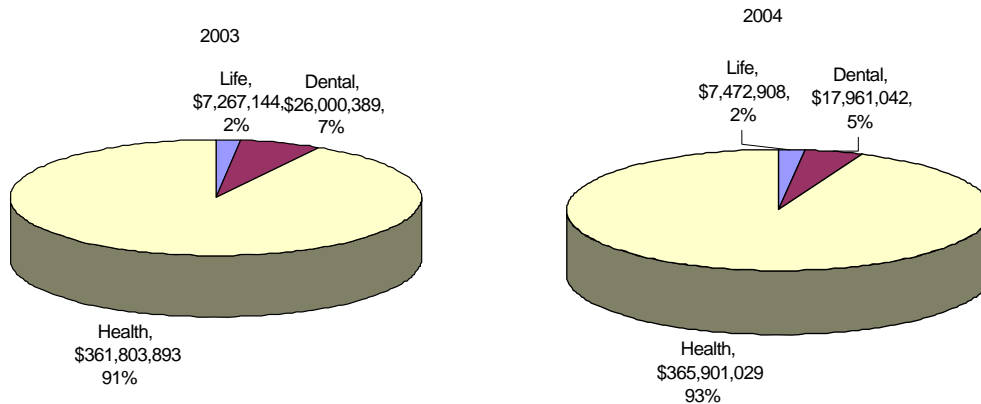
During 2003 and 2004, the state contributed – in whole or in part -- to the monthly cost of premiums for:

- Employee and dependent health insurance
- Employee and dependent dental insurance
- Employee life insurance

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Employees could also purchase additional group life, short- and long-term disability, and long term care insurance at their own expense through programs administered by SEGIP. Also available are pre-tax accounts that allow employees to set aside some of their compensation on a pre-tax basis to fund certain daycare, transportation, health, and dental expenses. Finally, SEGIP provides assistance to employees and their families for insurance-related issues through services of contracted health plans and other vendors, and through in-house resources, such as the Employee Assistance Program (EAP).

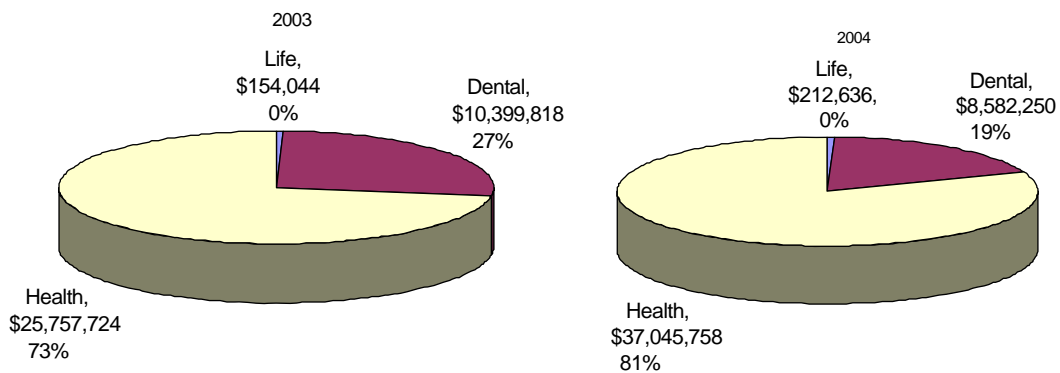
Figure 1 / State-paid costs for life, dental and health, 2003 and 2004



Health insurance – Minnesota Advantage Health Plan

The most costly and perhaps most visible insurance benefit is health coverage. When the state first began offering “medical insurance” in 1945, the cost of health care was relatively low and coverage was optional and paid entirely by enrollees. Since then, health coverage has evolved into an integral part of employee compensation, on a national basis, comprising 6.6% of employees’ total compensation.² The state’s cost of SEGIP health insurance provided to employees and their families during 2003-2004 was over \$727 million. Employees paid more than \$62 million over this time period for their share of the premium costs.

Figure 2 / Employee contributions for health and dental, 2003 and 2004



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SEGIP offers one health insurance plan, known as the Minnesota Advantage Health Plan. Advantage was implemented in January, 2002 and has since undergone changes that became effective in January 2004 in response to the largest budget shortfall in state history.

Under Advantage, primary care clinic systems available to state employees are placed into different "cost levels" based on their actual risk-adjusted costs of delivering care and as negotiated in collective bargaining. Advantage members may then choose any primary care clinic that is available, but they pay higher copays, deductibles, and coinsurance for more costly choices. The program saves money and enhances the value of health benefits for state employees in two ways:

- It gives employees and their families a choice of health care providers, as well as information and incentives to select more cost-effective providers; and,
- It provides more transparency of health care costs, creating incentives for providers to deliver value and quality at a more affordable price or risk loss of market share.

During 2003 and 2004, a description of Advantage was prepared and submitted before a competitive, national awards program of the Council of State Governments to recognize outstanding Innovations in State Government. Advantage was one of only eight states nationwide to receive the 2004 CSG award from among 237 applications.

Other coverages

Dental insurance

SEGIP provides employees with optional group dental insurance for insurance eligible employees and their dependents. Three dental plans are offered: HealthPartners Dental, Blue Plus Dental Care and State Dental Plan (Delta). The rates for each program are comparable and each offers the same benefit set but there are some administrative differences between the programs. All of the plans maintain a network of dentists and, in some cases, referral providers, through which members receive care. Coverage provided for most conditions requiring dental diagnosis and treatment, including orthodontic treatment for children. Each plan design places an emphasis on preventative services including full coverage for regular exams, x-rays and teeth cleaning.

Life insurance

In most cases, insurance-eligible employees participating in SEGIP receive group term life insurance paid in-full by the employer. The amount of the insurance is determined by the collective bargaining agreement or plan that covers the employee's job and is based on the employee's annual salary.

Optional coverages

SEGIP offers eligible employees a variety of optional insurance benefits, including:

- ◆ Additional employee, spouse, and child life
- ◆ Long and short-term disability
- ◆ Manager's Income Protection Plan
- ◆ Pre-tax benefit account
- ◆ Accidental Death and Dismemberment
- ◆ Long-term care insurance

The amounts and terms of optional life insurance may vary by collective bargaining agreements and plans. To obtain optional life insurance, applicants are usually required to provide satisfactory evidence of good health.

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Short-term disability insurance provides employees with income when injury, sickness or pregnancy results in continuous total disability. Benefits begin on the first day of disability due to accident, or the eighth day of a disability due to sickness or pregnancy. Benefits do not continue for more than 180 days for any one period of total disability.

Long-term disability insurance provides employees with income when an injury or sickness results in continuous disability beyond 180 days. Benefits begin on the 181st day of total disability due to injury, sickness or pregnancy and are generally payable until age 65.

Manager's Income Protection Plan is part of the employer paid benefits for managers. The plan is a combination of life insurance and long-term disability insurance. Managers have two options under the plan:

1. Coverage at two times the member's salary with a waiver of employer paid long-term disability coverage. (Disability coverage can still be maintained at the employee's cost.)
2. Coverage at one and one half times the member's salary and receive employer paid long-term disability coverage. (Employees also have the option to buy down the elimination period on the long-term disability coverage.)

Accidental Death and Dismemberment insurance (AD & D) provides additional coverage for death and dismemberment due to an accident. AD & D insurance is available for employees and spouses. In addition to the optional coverage, accidental death coverage is automatically included in the premium for all employee and spouse life insurance coverage, and doubles the benefit amount in the event of accidental death.

Long-term care insurance pays for a variety of services for individuals who are unable to care for themselves due to an injury, a chronic illness, an acute episode, or a cognitive impairment. Long term care services may include assistance in a home, adult day care center, an assisted living facility, or nursing home. Eligible persons include employees, their spouses and parents, and retirees and their spouses.

Program administration

SEGIP administers all its insurance benefits in part through a combination of DOER staff and contracts with vendors. SEGIP is divided into three primary areas: Contracts and Networks, Administration, and Health Risk Management.

Contracts and Networks manages SEGIP's purchasing functions by negotiating contracts with vendors and monitoring them for compliance with collective bargaining agreements, plan contracts, and federal and state requirements. The unit prepares labor contract proposals for management and cost estimates for labor negotiations and legislative initiatives. The unit also manages medical and dental provider networks.

Administration is responsible for enrollment, billing and services to members. Its Benefits Services provides communication, training and is the primary liaison to SEGIP plan administrators. Enrollment and Billing provides eligibility and enrollment services for employees. Insurance Systems provides support for the insurance application and

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supporting software tools. Combined, these areas provide eligibility and enrollment services for nearly 118,000 participants.

Health Risk Management provides programs and benefits that focus on healthy and productive lifestyles for plan participants. In doing so, the unit focuses on strategies and interventions that reduce employee absenteeism, increase employee productivity, reduce claims costs and other factors that impact administrative costs within all Minnesota state agencies. The Unit oversees three areas: Disability Management, Safety and Industrial Hygiene, and Employee Assistance.

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. Program oversight was provided by a board consisting of elected officials and agency commissioners.

1957 SEGIP began to promote use of managed care by offering coverage through one of the first health maintenance organizations, Group Health.

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

1967 University of Minnesota employees joined SEGIP.

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

1986 SEGIP created the Joint Labor Management Committee on Health Plans to explore various approaches to health care cost containment outside the formal collective bargaining environment. State self-insured one of its plans.

1987 SEGIP began to contribute only 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 phased out the last of its indemnity plans so that all SEGIP members were enrolled in managed care plans.

1991 SEGIP began to survey members to assess satisfaction and quality.

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

1997 SEGIP began a thorough study of better models for purchasing health care benefits

2000 SEGIP self-insured all of its health plans. SEGIP began to build data warehouse to compile information so that health care costs across all provider groups could be analyzed.

2001 Employees went on strike, in part due to a larger share of insurance costs being shifted to employees. Advantage tiered health plan introduced during bargaining.

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2002 SEGIP implemented Minnesota Advantage health care plan to address rapidly rising health care costs and to maintain access to as many healthcare providers for state employees as possible. University of Minnesota left SEGIP.

2003 SEGIP began disease management programs.

2004 SEGIP became the first public employer in the country to implement a Canadian drug program.

2004 SEGIP won the 2004 Innovations in State Government Award from the Council of State Governments.

II. Summary of local and statewide market trends

SEGIP is influenced by larger local and national health care market trends. At the same time, these trends provide an important context and backdrop for SEGIP benchmarking and strategic planning.

Key market trends and developments during 2003 and 2004 included:

- Slightly moderating, but still high annual rates of health care cost increases;
- A major impetus to the growth of high deductible “consumer driven health plans” with the adoption at the federal level of Health Savings Accounts; and
- Increased awareness of significant safety and quality problems in US health care and efforts to bring about systemic changes to improve health care quality and outcomes.

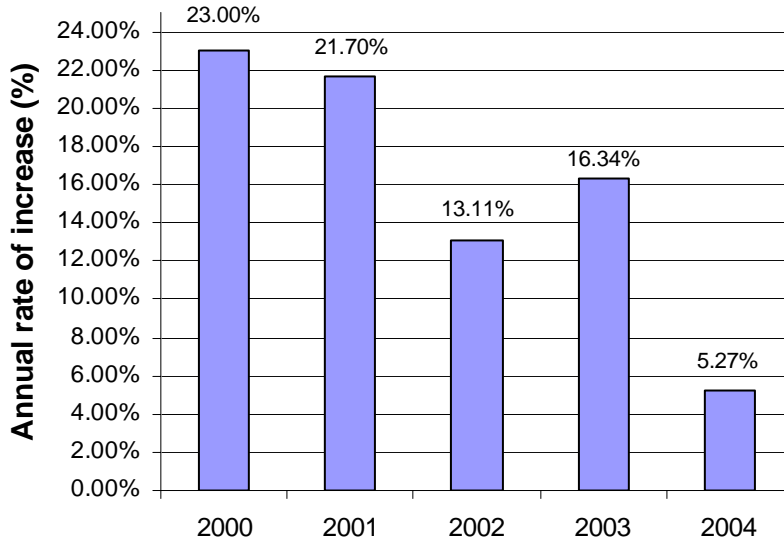
These trends are an important backdrop for SEGIP benchmarking, health care purchasing, and planning. SEGIP continues to monitor key health care market trends in order to anticipate, respond to, and help shape the health care environment in which it operates.

Continued high rates of health care cost increases

Rates of premium increase and comparisons with other economic indicators

While SEGIP health care cost increases during 2003-2004 moderated somewhat from previous levels, they remained well above rates of wage increases or job growth, at a time of relatively slow overall economic growth.³

Figure 3 / Annual SEGIP Premium Increases



Individual share of health care costs

A widely used strategy for controlling private health insurance premium increases, both nationally and in Minnesota, has been to increase the share of health care costs paid directly by covered individuals. In Minnesota, average per person shares of the cost of health care increased from \$152 per person in 1997 (about 9.1% of the total) to \$382 per person in 2003 and \$440 per person in 2004 (about 12.6% of total costs).⁴

Nationally, the annual Kaiser Family Foundation employer health benefits surveys also reported that employees on average paid larger amounts for their share of monthly premiums for health coverage. The average amount paid by employees nationally ranged from: \$37 per month for single (employee-only) coverage in 1996, to \$47 per month in 2004; and from \$122 per month for family coverage in 1996 to \$222 per month in 2004. While the amount of the monthly premium paid by employees increased, so did overall premium costs. As a result, from 2000 to 2004 the percent of monthly premium costs paid out of pocket by employees was relatively constant, at 14-16% for single coverage, and 26-28% for family coverage.⁵

The Kaiser Family Foundation annual survey also reported that other forms of average member cost sharing for health care services increased over the period 2001 to 2004. In particular, annual deductibles for the most common type of insurance plan – Preferred Provider Organizations (PPOs) – rose 40% over this period, to an average of \$287 in 2004. The percent of employees with at least a \$20 doctor office visit copay increased from 19% in 2003 to over 27% in 2004. Most workers also faced separate cost sharing for inpatient hospitalizations, which averaged \$224 per hospital admission in 2004.⁶

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Contributors to health care costs and rates of increase

As shown below, private health insurance spending in Minnesota during 2003-2004 was concentrated in the following three primary areas: physician services, hospital services (including both inpatient and outpatient services) and pharmacy. Spending levels in each of these areas remained relatively unchanged during this period.

Distribution of Minnesota Private Health Insurance Spending by Service, 2003-2004⁷

Category of Service	2003	2004
Physician	34.9%	32.3%
Inpatient Hospital	18.0%	18.2%
Outpatient Hospital	12.2%	12.7%
Prescription drugs	15.5%	16.1%
Other medical*	10.0%	10.2%
Administrative and other	9.3%	10.5%

*"Other medical" includes: skilled nursing facilities; home health; emergency services; other health professionals; durable medical equipment; chemical dependency and mental health services

The single fastest growing component of Minnesota private health insurance spending from 2002 to 2004 was administrative costs, which increased 14.5% per person with private insurance. According to the MDH-HEP, the "primary drivers of increased administrative spending were product management and marketing, claim processing, and spending for wellness and health education."⁸

From 2002 to 2004, costs in Minnesota per person with private health insurance grew at the following rates: outpatient hospital services increased 12.9%; prescription drugs grew 12.8%; inpatient hospital services increased 9.6%; and other medical services grew 13.1%. Physician services grew at only 2.8%.⁹

The MDH-HEP reported that it was not possible to determine from the data available the specific reasons for spending growth. However, other national studies have used a variety of literature reviews, survey data, and expert opinion to arrive at estimates of the impacts of various factors on health care spending growth.

For example, a 2002 study by a major national consulting firm reported that health care costs increased from 2001 to 2002 based on several key factors. In particular, the following four categories below were reported together as accounting for nearly 75% of increased health care spending:

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Key Factors Nationally Driving Rising
Health Costs in Health Care Premiums, 2001-2002¹⁰

Factor	Percent of health care spending increase
General inflation (CPI)	18%
Prescription drugs, medical devices, and other medical advances	22%
Rising provider payments <ul style="list-style-type: none"> ▪ In particular, hospitals that have consolidated to negotiate higher payments 	18%
Increased consumer demand <ul style="list-style-type: none"> ▪ Aging population ▪ Advertising pressures and media coverage ▪ Increased preventive and diagnostic activity ▪ Consumers moving away from less expensive managed care products 	15%

According to the 2002 study, other factors accounting for the remaining 25% of health care spending growth included: government mandates and regulation; litigation and risk management; and “other”, including fraud and abuse.

The report above notes the impact of provider consolidation and the resulting ability of health care providers to negotiate higher payment rates. As required under the statutory charge for this report, DOER also attempted to address issues of provider concentration and consolidation in the Minnesota market during the 2003-2004 biennium.

Little recent in-depth information was available on provider consolidation in Minnesota for the 2003-2004 time period. The most recent MDH-HEP study of this topic, a 1999 report using 1998 data, noted that “Minnesota’s health plan market is one of the most consolidated in the country,” and that the state’s hospital market was heavily concentrated as well.¹¹ At the time of the 1999 HEP report, nearly 2/3 of all Minnesotans were enrolled in one of three large health plans, and 2/3 of the metro area hospital market was controlled by three large hospital systems.

More recent data on the issue of the impacts of health care consolidation are limited and often based on national studies. The state’s largest health insurer, Blue Cross and Blue Shield of Minnesota, reported in 2003 that more than “half of Blue Cross’ total trend increases over the past three years have been due to increases in provider payments and changes in the types of services.”¹² The report also noted that an important factor in “rising clinic/hospital costs” was “consolidation leading to less competition and increasing leverage for hospitals and clinics to negotiate higher payments from health plans.”¹³ In addition, other national studies published during 2003-2004 have also noted increased prices paid to hospitals “because of their growing leverage in contract negotiations”¹⁴ and have raised concerns regarding the “potential negative consequences of extensive hospital consolidations”¹⁵ and higher costs.¹⁶ The potential impacts of health care provider consolidation on the Minnesota

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market, and on SEGIP health care purchasing, continue to be of interest and require further study.

Health Savings Accounts

Interest in high deductible “consumer driven health plans”, designed to help control health care costs by more directly involving individual consumers in health care decisions and payment of their health care costs, was expected to increase dramatically as a result of federal legislation passed in late 2003. In December, 2003, the federal Medicare Modernization Act authorized the creation of Health Savings Accounts (HSA's), effective in 2004. By the end of their first year in existence, an estimated nearly 500,000 HAS policies had been sold. Like most state employer groups in the upper Midwest (Iowa, North Dakota, South Dakota and Wisconsin), SEGIP was not using HSA's in 2004.¹⁷ The U.S. Treasury Department has projected that 14 million HSA policies, covering 25 to 30 million people, will be in force by 2010.¹⁸

Improving health care quality

In 1999 the National Institutes of Medicine (IOM) published the first of several landmark studies regarding significant quality failures in U.S. health care. The report, To Err is Human: Building a Safer Health Care System examined high rates of preventable medical errors occurring in the country's hospitals, leading to 44,000-98,000 preventable deaths each year.

In 2001, the IOM followed with a second major report, Crossing the Quality Chasm: A New Health Care System for the 21st Century that outlined quality problems in US health care in the starkest terms possible. According to the report, “[h]ealth care harms patients too frequently and routinely fails to deliver its potential benefits. Indeed, between the health care that we now have and the health care that we could have lies not just a gap, but a chasm.”

In 2003 and 2004 efforts intensified at both the state and national levels to rectify the country's serious health care quality problems. In 2003, Governor Pawlenty created a special health care task force, headed by former US Senator Dave Durenberger, known as the Minnesota Citizens Forum on Health Care Costs, to make recommendations to improve health care in the state and make it more affordable. The task force report articulated clearly the inadequacies of current health care purchasing and financing, noting:

“The current system focuses on volume rather than on value. The quality of treatment varies widely and many people do not receive the best quality of care...On average, Americans receive the recommended medical treatment based on evidence-based guidelines only about one-half of the time. Gaps in service delivery are found in all aspects of medical care: preventive, acute, as well as chronic. Mistakes in health care cause injuries, complications and death. Our quality improvement system is complicated at best, ineffective at worst. Minnesotan hospitals are subject to over 26 different quality measurement and patient safety projects for which they collect and disseminate information. There is no coordination between organizations or requests, which results in duplication and increased administrative costs. ...”¹⁹

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The Citizens Forum recommended that the State organize its collective health care purchasing strength to serve as a catalyst and lead a transformation to more value-based health care purchasing. In 2004, Governor Pawlenty created a special sub-cabinet of six state agency heads with health care responsibilities, known as the Health Cabinet, to help lead state health care purchasing to better identify and reward value in health care. DOER Commissioner Cal Ludeman was named to chair the Health Cabinet.

The state's Health Cabinet concept was expanded in late November 2004 with the launch of a public-private health care purchasing coalition to work in concert on driving greater value in the health care market. The coalition, known as the "Smart Buy Alliance," includes the state's two largest health care purchasers, DOER, for state employees, and the Department of Human Services (DHS) for Medicaid, MinnesotaCare, and other programs. It also includes private groups such as the Minnesota Chamber of Commerce, Buyers Health Care Action Group, and the Minnesota Business Partnership, representing large, mid-, and smaller size employers, and the Labor Management Health Care Coalition of the Upper Midwest, representing Taft-Hartley labor union trusts. Together Smart Buy members represent approximately 3/5 of all Minnesotans.

The Health Cabinet and the Smart Buy Alliance developed plans in late 2004 to pursue four key health improvement and efficiency strategies:

- Require and reward best in class certification;
- Adopt uniform measures of quality and results;
- Empower consumers with easy access to information; and,
- Require the latest technology.

III. Important SEGIP developments in 2003 and 2004

During 2003 and 2004 SEGIP continued to be a leader among employer health care programs. SEGIP developed innovative programs that controlled costs and improved the health of state employees and their dependents.

- ◆ Moved from a health promotion focus to a health risk management focus, thus affecting the health of state employees more directly. The former health promotion program worked with agencies to implement programs in such areas as exercise and healthy eating, but provided no measurement of effectiveness. In contrast, the health risk management approach is based on an analysis of members' claims data in order to manage certain diseases, resulting in a higher quality of life for employees and family members, and savings of health care dollars for the State and employees. The targeted diseases were diabetes, asthma, chronic obstructive lung disease, coronary heart disease and 15 rare, complex chronic diseases. The initiative resulted in a total savings of \$30 million in 2004.
- ◆ Completed a gap analysis of all health plan services, resources and disease management programs available to SEGIP. This analysis helped the new health risk management unit identify programs and other available options that could be used to help control health care costs and improve health outcomes for members.

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- ◆ Won the *2004 Innovations Award* from Council of State Governments for the Minnesota Advantage Health Plan. This national award recognizes programs and initiatives that demonstrate significant, creative, and effective solutions to pressing public policy concerns.
- ◆ Wrote risk management-related provisions into the contracts between the state of Minnesota and its health plans. Included performance guarantees for each disease management program to clearly delineate expected outcomes, as well as performance measures to ensure those guarantees were met.
- ◆ Became the first public employer in the country to implement a Canadian drug program, with over 1,900 members enrolling and saving approximately \$300,000.
- ◆ Performed an extensive review and analysis of the Employee Assistance Program that resulted in a redesign of the program. The review addressed the increasing cost of the program and its inability to provide services state-wide. The redesigned program integrates its services with those provided by the health plans, allowing for improved and streamlined services that are available statewide. This redesign also eliminated the general fund appropriation for EAP in favor of funding the program through health insurance premiums.
- ◆ Conducted a pilot health assessment on approximately 500 volunteering state employees. This pilot health assessment identified employee interest in learning about their health and follow-up programs to address identified issues.
- ◆ Upgraded employee benefits software enabling employees to enroll and update benefit information online. This operability provides members with better customer service at a lower cost and ensures that SEGIP complies with employee benefit laws.

IV. SEGIP's cost containment efforts

In an effort to combat the ever rising cost of health care coverage SEGIP has worked to be proactive and innovative. SEGIP has been a state leader in developing plan features that help hold down costs while increasing the health of its members and improving customer service. Overall, SEGIP's documented return on investment for disease management programs and integration of medical and behavioral health care programs resulted in more than \$30 million in savings during 2004.

Targeting high cost, high prevalence conditions

Analysis of SEGIP claims data found that a relatively small number of chronic conditions accounted for a large share of its health care costs and that a relatively large number of members had one or more of these conditions. Twenty percent of plan participants incur 78% of the medical costs. The analysis also found that 37.6% of members had one or more of these conditions in 2003 and that number increased to 38.2% in 2004. If addressed early, many chronic conditions can be managed and their expense can be reduced, if not eliminated.

Figure 4 / High Cost, High Prevalent Conditions, 2003 and 2004

Condition	Percent of cost	Percent of members
Hypertension/Cholesterol	42.1%	17.6%
Mental Health – Other than depression	26.5%	11.1%
Low Back Pain	25.8%	13.1%
Severe Heart Condition - Other than coronary heart disease	18.2%	3.2%
Mental Health – Depression	12.2%	4.5%
Severe Heart Condition – Coronary heart disease	10.0%	1.7%
Diabetes Type II*	9.5%	3.1%
Asthma	8.6%	4.0%
Diabetes Type I**	4.2%	0.8%

* Diabetes Type II – adult onset is associated with older age, obesity and physical inactivity that can be controlled with diet and exercise.

** Diabetes Type I – insulin-dependent, juvenile onset diabetes and has no known prevention.

In response to this problem, SEGIP worked with its health plans to coordinate a targeted effort to address high risk and high cost diseases. By implementing better management for these conditions it was believed that costs could be mitigated and members could enjoy better health. This effort involved identifying persons with certain conditions and providing those interested with the proper resources to manage their diseases and encouraging them to follow that plan.

After determining the most prevalent and costliest conditions, SEGIP identified those which could best be affected by intervention. Management of asthma, diabetes, coronary heart disease and chronic obstructive pulmonary disease began in 2003. The following year the list of targeted conditions was expanded to include acid related disorders, atrial fibrillation anticoagulant therapy, chronic hepatitis and cirrhosis, fibromyalgia, inflammatory bowel disease, irritable bowel syndrome, low back pain and osteoarthritis. In addition, a separate disease management program was implemented for fourteen rare, complex and chronic diseases. Personalized prenatal programs were implemented for members through their health plans.

These interventions have demonstrated positive results both in terms of educating and supporting employees on their particular health conditions as well as a cost savings. During 2003 and 2004, SEGIP has estimated that these interventions have saved the program a total of \$10 -15 million for 2004.

Integrating behavioral and medical care services

The current health care system is fragmented and behavioral health care and medical care services are not well integrated at either the health plan or service delivery level. Research indicates that persons who use behavioral health care services use twice as much medical care as a person without behavioral health issues and their care accounts for over 20% of all health care annually. To combat this phenomenon employers are embracing health care “consumerism.” Consumerism takes a behavioral approach to health care including plan design, incentives, spending accounts, clinical intervention and program metrics.

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DOER's goal for health care integration included: elimination of duplicate services, streamlining the processes for care management, improvement of health outcomes and return to work potential of its employees, and a more strategic role for its Employee Assistance Program (EAP). Critical to the success of this initiative was the ability to measure improvement and savings. To achieve these goals DOER worked with its health plans, its disease and disability management vendors, and its worker's compensation and EAP programs.

The results were rewarding. Consistent use of common case management "triggers" were implemented for all vendors and a common consent form was developed resulting in a streamlined and consistent process. All health plans and vendors reported results in a consistent manner. Finally, consistent use of satisfaction and quality of life surveys to measure satisfaction were instituted.

Encouraging healthy lifestyles

The cost of preventable health problems is a significant cost for SEGIP and it continues to rise. Behaviors that can be modified such as smoking, being overweight, being inactive, and poor nutrition, account for 21% of SEGIP's health care spending. SEGIP has worked alone and in tandem with its health plans to provide information to help members take better care of themselves and to change behaviors that affect their health through the implementation of programs such as the flu vaccine campaign and the Do Campaign.

Providing flu shots

Recognizing the impact of the flu on employees' health and productivity, DOER initiated a flu shot campaign for employees in 2003. Between 1990 -1999 approximately 36,000 individuals in the United States died each year of influenza.²⁰ This annual campaign is intended to keep employees healthy and minimize lost work time due to the flu.

An employee ill with influenza usually takes sick leave from work. This can be costly as influenza illness typically last 3 - 7 days for most while a cough and malaise can last for more than two weeks.²¹ Moreover, an adult can be infectious from the day before symptoms begin through approximately 5 days after illness onset allowing one person to pass the illness to many coworkers causing further workplace disruption.²²

A flu shot is up to 90 percent effective in preventing the flu in healthy adults.²³ The greater the number of employees that get flu shots, the better the chance of maintaining a productive workplace through the flu season. It has been estimated that the cost savings per person vaccinated is \$46.85 (1995).²⁴

The cost of the flu clinics are included in SEGIP's contracts with the health carriers and are included in the administration fee paid to each carrier. DOER's direct cost for the campaign is in staff time and costs associated with communicating with employees about the clinics. In the fall 2004, DOER was the first employer to lead by example and cancel flu shot clinics during a vaccine shortage in order to provide flu vaccinations for those in high risk groups as defined by the Centers for Disease Control.

Promoting the do Campaign

In 2004, DOER partnered with the American Heart Association (AHA) and Blue Cross Blue Shield of Minnesota to encourage physical activity through an innovative public health initiative called the "do campaign."



The purpose of this awareness campaign was to instill into employees the need to be physically active. Physical inactivity and diet combined are the second-leading causes of preventable death and disease in the United States. This program focused on incorporating shorter bursts in ten minute increments of ordinary everyday activities to help people achieve moderate physical activity goals. The cost to the state for this program was minimal staff time.

Encouraging competition through unique plan design

In one of its most innovative approaches to the root causes of increasing health care costs, SEGIP is addressing the lack of competition among providers. In 2002, SEGIP took a bold step and moved from the “managed competition” model it had been using since 1987 in which the state contributed towards the lowest cost carrier in the employee’s county, to one in which providers are assigned to cost tiers and members pay more for using higher costing, less efficient providers.

The change to the new, award-winning (see Figure 5) 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, resulting in the potential loss of access to providers. Advantage shifted the focus from the health plan level to the care system level and empowered members to affect competition.

Advantage wins Council of State Governments Award



In 2004, the Minnesota Advantage Health Plan was awarded the 2004 Innovations Award from the Council of State Governments (CSG), Midwest Region. CSG's annual Innovations Awards showcase and share states' best programs and policies.

Advantage, was one of two programs selected as an Innovations Award winner by a panel of state officials at the CSG Midwestern Legislative Conference meeting in July, 2004. The two winning programs were selected from 20 Midwestern regional finalists that were initially part of a national competition of 237 applications.

Advantage classified providers into three cost levels, thereby identifying their performance, making them more accountable, and encouraging them to compete against each other for the SEGIP-eligible population. Clinics are placed into levels based on their risk-adjusted cost of care for the members receiving services from each provider group. Because costs are largely influenced by the health status of the enrolled members, the incurred costs for members assigned to each provider group are risk-adjusted using the Johns Hopkins ACG Case-mix System prior to assigning provider groups to benefit tier levels for the Advantage Plan. The goal of the risk-adjustment process is to account for the health status of a provider group’s members in order to compare costs between provider groups on a risk neutral basis. In other words, the process attempts to determine the costs that would be realized by the provider group if they had a population with the “average” health status of the plan.

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During 2002 and 2003, employees were guaranteed access to level 1 providers. In 2004, a fourth level was added and the guaranteed access changed to level 2, a higher cost level. To encourage employees to select low-cost providers and to decrease unnecessary utilization, SEGIP significantly expanded requirements for co-pays, deductibles, and co-insurance. As a result, Advantage passes more of the cost of care on to members who choose providers at the higher cost levels, but it offers choice and puts medical decisions closer to the physician/patient relationship.

If the state continued with its previous plan, costs for the state would have been much higher in 2004 and beyond. SEGIP estimates that Advantage reduced anticipated total health care costs by \$25 million in 2003 and 2004—about 3% of total expenditures.

Between December, 2003 and January, 2005, enrollment in Advantage cost levels dramatically shifted as members selected lower-cost levels. Between 2003 and 2005, 8.4% of members from the higher cost groups of levels 3 and 4 shifted to the lower cost groups, levels 1 and 2 – a net shift of 6,964 persons. Members were responding to the effect of higher out-of-pocket costs and choosing more efficient, cost-effective provider groups.

Encouraging consumerism

With the introduction of the tiered Advantage health plan in 2002, the state was also introduced to the “consumerism” movement through which members undertook more cost sharing. The theory behind this movement is that by including cost sharing features in plan designs, members take more personal responsibility over individual health care choices resulting in better choices for the employee’s health and lower program costs.

Almost all private health insurance plans require individuals to pay premiums and have consumerism or cost sharing features.²⁵ Although Advantage does not include a premium for the employee’s coverage the addition of some cost sharing brings plan features more into line with most private sector plans. The new cost sharing features included in Advantage are copayments for non-preventative office visits and hospital care beginning in 2002 and first dollar deductibles in 2004 (see Figure 6).

The combination of tiering and the increased cost sharing provided several benefits to both the state and its employees:

- A projected 15% increase in costs was reduced to 6% saving money for both the state and employees.
- Employees able to save additional dollars by selecting quality providers who were identified as being more efficient in delivering services.
- A wider choice of providers was made available.
- A new platform was established for future modifications and collective bargaining sessions.
- Additional savings were achieved when certain provider groups elected to renegotiate their fee schedules to be in a more favorable tier.

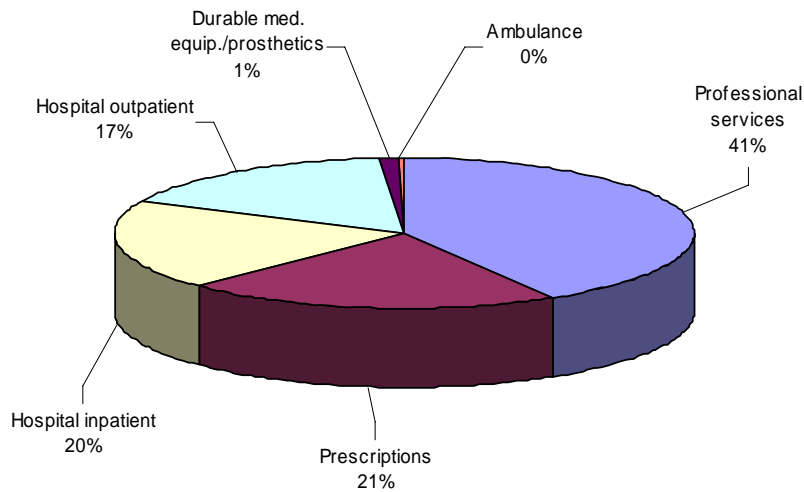
Figure 6 / Changes in SEGIP health out-of-pocket costs, 2000-04

Single coverage	2000 State Health Plan Select	2001 Primary Network	2002 Advantage level 1 of a 3 level system	2003 Advantage level 1 of a 3 level system	2004 Advantage Tier 2 of a 4 level system
First dollar annual deductible	\$0	\$0	\$0	\$0	\$80
Office copay	\$0	\$0	\$10	\$10	\$20
Urgent care copay	\$0	\$0	\$10	\$10	\$20
Outpatient emergency copay	\$0	\$30	\$50	\$50	\$50
Outpatient surgery copay	\$0	\$0	\$75	\$75	\$75
Inpatient hospital copay	\$0	\$0	\$200	\$200	\$150
Formulary drug copay	\$8	\$10	\$12	\$12	\$15
Non-formulary drug copay	\$8	\$21	\$25	\$25	\$30

Managing pharmacy

Drugs are the most rapidly growing component of health plan costs in Minnesota but professional services continue to make up the largest portion of the overall costs.²⁶ The same was true for Advantage, drugs accounted for 21% of expenditures in 2004 while professional services were 41% of costs (see Figure 7).

Figure 7 / Advantage's expenditures, 2004



Escalating drug costs are, in and of themselves, not necessarily a bad trend. Prescription drugs may be a replacement for more expensive treatments. They may, in fact, be the fulfillment of managed care's original promise, which was to manage disease through early intervention with medication thereby reducing costs in other areas.²⁷ Nevertheless, prescription drugs are a significant area of SEGIP spending and so care must be taken to contain that cost while not causing an increase in another area of spending.

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Some of the strategies to decrease drug expenditures that SEGIP has been using or studying include offering lower cost drugs from Canada, encouraging use of mail order drugs, and studying the use of a single pharmacy benefit manager.



"Minnesotans deserve affordable prescription medicine."
Governor Pawlenty

Offering lower cost drugs from Canada

In May of 2004, SEGIP became the first state employee insurance plan to offer its members Canadian drugs through a service, Advantage-meds.com. Members could choose from about 50 brand name maintenance drugs without having to pay the customary copayment of \$15/month. In the first half-year of operation, approximately 1,900 members enrolled and ordered over 3,200 drugs, thereby savings the program and members roughly \$300,000.

Encouraging use of U.S. mail order

SEGIP has encouraged the purchase of drugs that are not available through its Canada program from U.S. mail order firms. SEGIP's utilization of mail order has been somewhat below industry standards, so the program has tried to increase its use by having plans send information to members, publishing information on the state's Web newsletter, and promoting it though it's domestic and Canadian mail order program, Advantage Meds.

Currently SEGIP members purchasing prescription drugs through the mail order option receive a three month supply but only pay for two months of copayment charges. The program, however, incurs a slight overall loss as the copayment does not cover the cost. This option has been retained as it provides members a savings and some convenience.

Studying use of single pharmacy benefit manager

Since 2002, SEGIP has been studying whether the program would be better served by changing the arrangement it has between its plans and their pharmacy benefit managers (PBMs). SEGIP has identified a number of approaches, including the use of a single PBM. Staff continue to explore the possibility of a single PMB. For now, SEGIP has been able to successfully negotiate with each plan to limit pharmacy costs.

Encouraging self-service

In recent years, advances in technology have enabled SEGIP to change the way it interacts with its members and state agencies. The development of new technology enabled a movement towards members able to better serve themselves through the internet. This provides administrative efficiencies and improves service.

Like many employers, SEGIP conducted its yearly benefit enrollment on paper and tended to act as an intermediary between the benefit plan administrators. The program contracted with an outside vendor to design extensive enrollment materials and mailed each member a copy of plan materials. This approach was costly and resulted in uneven customer service, since SEGIP relied on personnel in agencies to administer benefits, and their knowledge and skill varied.

Beginning in 1997, SEGIP began to redesign its enrollment process. That year, the program began requiring members to complete their yearly benefit open 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 publishing this information on its website. In 2003, SEGIP eliminated telephone enrollment and continued to improve the resources on its webpage. This change not only increased the

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efficiencies in administration but also provided members with faster, fairer service and better protection of employee information. By 2004, 98% of employee enrollment was made electronically. (See Table 8)

Table 8 / Method of employee enrollment, 1999-2004

Method	1999	2000	2001	2002	2003	2004
Phone	46%	34%	19%	17%	8%	2%
Web	54%	66%	81%	83%	92%	98%

As part of this effort to encourage self service, SEGIP also began working in 2001 to install a new internet-based software package to administer employee benefits. The software, PeopleSoft, is used by many large employers and automates many processes and allows SEGIP to move toward centralized administration of benefits. By the spring of 2003 new employees were able to electronically enroll in benefits and current employees were able to make some changes to their coverage on-line. The department expects to phase in further enhancements over the next few years. Overall, these changes will save money and will provide members with better customer service while ensuring that SEGIP complies with the laws regulating employee benefits.

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 best practices has evolved, so has the program's approach. SEGIP is currently implementing plans to better measure outcomes quality by tracking outcomes for members receiving disease management services and provide members with tools to select higher quality services.

Aligning internal service delivery

In 2002, SEGIP took a new approach and began to assess total costs related to employee health. SEGIP worked to establish strategies that attempt to reduce health insurance and workers' compensation costs as well as state employee absenteeism and other factors that impact productivity and administrative costs within state government. This new approach included an organizational change that brought together separate work units. These units included Safety and Industrial Hygiene, Employee Assistance, and Disease and Disability Management. Previously these units worked separately.

These changes had a large impact on how services are delivered. Lines of communication and opportunities for collaboration were established within DOER and with the health plans so that overlap could be eliminated but more importantly, so that the most costly situations could be identified earlier. These units now work together under the umbrella of Health Risk Management to bring about quantifiable improvement to employee health and productivity. This new model integrates services and initiatives in the workplace with services provided by SEGIP's health plans.

Implementation of this new approach included an internal assessment of SEGIP's behavioral health services in late 2003 and early 2004. The assessment resulted in a plan for early identification and easier access to treatment for employees with behavioral health problems.

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SEGIP also conducted a gap analysis of the behavioral health services provided by the state and those provided by SEGIP's health plans including a reevaluation of the state's model for purchasing behavioral health services. This assessment set in motion more rigorous accountability for the quality of behavioral health services provided by the health plans.

Contracting for accountability

Another strategy that SEGIP has used to contain program costs is to include provisions in its contracts that provide vendors with financial incentives and penalties to meet specific goals. The contracts also include specific language outlining vendor duties, expectations and deliverables. These contract provisions better define responsibility and expected outcomes and tie financial incentives to ensure they are achieved.

Beginning in 2003, SEGIP health plan contracts included extensive provisions for health risk management. These provisions required health plans to develop, maintain, and refine programs concerning disease management, health promotion, health education, and other such efforts. The purpose of these measures is to reduce health care costs by improving the health of members and by educating members to be informed consumers of health care. The accountability measures in the contracts serve to put vendors on notice as to the importance of a provision.

Keeping administrative costs low

SEGIP strives to administer the program in an effective and efficient manner and keep the fees as low as possible. The overall 2004 administrative costs for both DOER and the health plans was approximately 8% of total premium costs, which is well below the industry standard of 10-15%. SEGIP's share of the administration fee is low. In 2003 it was 1.8% of health insurance program costs and 1.1% in 2004. The higher costs in 2003 reflect the costs associated with the upgrade to the electronic insurance management system.

The revenue for administrative costs is generated from two distinct sources. The administrative costs of the health plans are paid through premium dollars. Agencies are charged an administrative fee which supports SEGIP's administrative functions. This fee is \$8.02 per month for each insurance eligible employee. SEGIP has successfully held this fee low and has not increased it since 1999.

V. SEGIP complaints

Number of complaints remains low

As required by statute, SEGIP is to report on complaints relating to the insurance programs.²⁸ Figure 9 provides information regarding the number of formal and informal complaints received by DOER. The number of complaints received by the program represent less than 1% of total membership.

Figure 9 / Formal and informal SEGIP complaints

Informal complaints	2003	2004
Administration	7	4
Appeal	7	1
Benefit	12	14
Billing	7	9
Claim	23	17
COBRA	2	0
Eligibility – Dependent	1	1
Enrollment	8	5
Exception Request	1	0
Network	6	4
Prescription	2	2
Referral	3	2
Retirement	2	0
Transition of Care	1	0
Total	82	59
Formal complaints	160	224

Formal complaints are submitted in writing for review by the SEGIP review committee. Informal complaints come via phone, fax and internet and are addressed by staff.

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