Report of the

Postretirement and Active Employee Health Care Task Force

December 15, 2000

Submitted in accordance with Chapter 461, Article Five, Minnesota Session Laws 2000

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As required by Minnesota Statute 3.197: This report was the culmination of a six month project. The total estimated cost of the project was $85,400. These costs include expenditures for preparing this report including staff time, printing and mailing expenses.

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Introduction and study charge

The Postretirement and Active Employee Health Care Task Force was created with the adoption of Senate File 2796 in the 2000 Minnesota legislative session (subsequently codified as Chapter 461, Article Five, Minnesota Session Laws 2000).

Under the statute, the Commissioner of the Department of Employee Relations (DOER) was charged with convening a task force to:

- identify strategies for providing postretirement and active employee health care; and,
- make recommendations regarding the most appropriate and efficient manner for providing postretirement and active employee health care.[1]

The law also stipulated the task force membership and configuration, with one-half to be comprised of employees, and one-half of employers. The task force included representatives of: pension plans; the Legislative Coordinating Subcommittee on Employer Relations; DOER; associations representing local units of government; exclusive representatives of affected public employees; major public employers; and the Minnesota State Retirement Association. A total of 49 members served on the Task Force. The Task Force was chaired by Wayne Simoneau, a former Commissioner of two state agencies and former state legislator.

The task force was charged with reporting its findings and recommendations to the State Legislature by November 15, 2000. The report is to address:

- alternative methods of providing and paying for postretirement and active employee health care;
- the most efficient administrative structure for providing for postretirement and active employee health care; and
- issues of adverse selection, cost containment, consumer choice, and options for dealing with other employee concerns.

The Task Force met nine times during the period June – November, 2000. The Task Force also created two subcommittees, one focusing on Health Care Purchasing Pool concepts, and the other on Postretirement Health Care.

The remainder of this report is comprised of three sections: a summary report of the Task Force process, findings and recommendations; a series of “issue briefs” describing key study concepts and findings in more detail; and a section reserved for correspondence of positions, proposals, or additional information submitted directly from Task Force members.

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Issues leading to this Task Force and study

A number of bills were introduced during the 2000 Minnesota legislative session that focused attention on issues of active and retiree public sector health coverage in Minnesota. In particular, the Minnesota State Retirement System, which oversees the pension plan for State employees and administers deferred compensation programs for local units of government, introduced a bill to create a funding plan for postretirement health care. Education Minnesota, representing public teachers and other public education workers, introduced a separate proposal to establish a statewide health care purchasing pool for teachers and others. Another legislative proposal called for a study of these issues.

While only the proposal for a study passed the Legislature in 2000, the other legislation raised the level of awareness and debate regarding health care coverage for the state's public sector employees and retirees, and no doubt contributed significantly to the overall interest in addressing this issue in more detail through the Task Force. However, legislative interest in this area is not new. In fact, DOER convened a similar legislatively-required task force on these issues in 1986, which reported to the legislature in 1987. (See issue brief with highlights of the 1987 report.)[2] Key issues leading to the current policy study include many that were also raised for the 1987 report.

Key issues of interest leading to the current task force study:

- the large and growing costs of health care for public sector employees, employers, and retirees;
- an aging population, and corresponding aging of the workforce, with a large number of retirees anticipated in the next ten to twenty years;
- limitations of the federal Medicare program in meeting the health care needs of retirees;
- lack of pre-funding of postretirement health care;
- lack of access by retirees to a group health insurance plan with group rates.

These perceived challenges are further summarized below.

The large and growing costs of health care for public sector employees, employers, and retirees

Health insurance costs and rates of health care cost increases vary across the state's public sector. However, in recent years, double-digit rates of annual health care cost increases have become widespread among both private and public employers.[3] Costs of health coverage available through one commonly cited benchmark, the State Employee Group Insurance Program (SEGIP), currently range from $266 to $362 per month for single coverage in 2001, and from $666 per month to $906 for family coverage. SEGIP's health insurance costs have increased approximately 20 percent each of the last two years. Some school districts report family health coverage that now costs over $12,000 annually.[4] There are many explanations for the health insurance rate increases, but an aging population, along with increasing costs for pharmaceuticals and high technology, are perhaps most frequently cited.[5]

Rising health care costs are stressing public sector budgets and affecting local decisions and priorities. For example, double-digit annual increases in health care costs put significant pressure on local government budgets that may be constrained by limits on the unit of government's ability to levy property taxes. If levy limits prevent local governments from levying taxes to cover the increased costs, those costs must either be passed through to employees in the form of increased employee contributions, covered through reductions in services, or covered by increases in fees the unit of government charges for services.

An aging population, and corresponding aging of the workforce with a large number of retirees anticipated in the next ten to twenty years

Over seventy percent of the workers in Minnesota state government are now over age forty, and it is projected that by the year 2015, over half the state government workforce will be over age sixty.[6] In total, about half of all public sector employees in Minnesota will be eligible to retire within the next 20 years.[7]

An aging workforce will likely incur higher levels of health care

costs as it approaches retirement. The large projected number of retired public sector workers in the relatively near future will also face significant health care costs, most of which have not been adequately budgeted or pre-funded (see next section, below).

Meeting the needs of an aging workforce in a period of anticipated labor shortages also creates a number of dilemmas for employers. In a tight labor market, it is increasingly difficult to replace retiring workers. Employers might therefore want to make retirement less attractive, or offer incentives designed to encourage workers to delay retirement. This strategy is potentially at odds, however, with efforts to also attract and retain younger workers, who might be more interested in benefits that allow them to retire earlier, or benefits that are much different than those desired by older workers.

Limitations of the federal Medicare program in meeting the health care needs of retirees

The federal Medicare program established in 1965 provides a primary source of health coverage for persons over 65. It is comprised of two parts: Part A – Hospital Insurance, a nearly universal program covering hospitalization available at no additional cost to enrollees who have paid Medicare payroll taxes; and Part B – Medical Insurance, a federally subsidized optional coverage for physician and other services currently available for $45.50 per month. (Medicare Part B costs will increase to $50.00 per month in 2001.) However, Medicare does not include prescription drug coverage, a major cost for many seniors. It also has significant out of pocket cost sharing in the form of deductibles and co-pays. As a result, the majority of seniors also purchase insurance that supplements Medicare.

Like other forms of health insurance, Medicare supplemental coverage is also becoming increasingly expensive. Costs for one retiree health care program – SEGIP for State retirees for example – increased between fifteen to thirty percent this year, depending on the particular insurance product purchased. Premiums for the coverage range from $175 to $307 per person per month for persons over age 65, in addition to the $45.50 monthly for Medicare Part B.

For many retirees, the cost of health care – including Medicare, supplemental insurance, and other out of pocket costs not covered by insurance – is often their single largest expense, surpassing food, transportation, housing, or other needs. The problem is exacerbated by low federal rates of reimbursement to Minnesota HMOs, which do not permit Minnesota seniors to access the same level of Medicare-paid benefits that seniors in other parts of the country can. (See related issue brief.)

Lack of pre-funding of postretirement health care

The Postretirement and Active Employee Health Care Study Task Force study process did not determine the extent to which public sector employers currently contribute to retiree health care options. At the national level, however, there has been a decline among large firms that make employer-provided health care coverage available to retirees, particularly retirees over age 65.[8]

The decline has come about following recent increases in health care costs, as well as a change in accounting standards by the Financial Accounting Standards Board (FASB) that became effective in 1992. The change required employers to disclose as a current liability the unfunded portion of future non-pension post-employment benefits. A ruling is expected in the near future from the Government Accounting Standards Board (GASB), requiring units of government to also abide by similar standards when reporting on any retiree health care obligations,[9] and could have similar impact on postretirement health care as did the FASB standard earlier.

Where there are no employer contributions to retiree health coverage, retirees will have to purchase their coverage out of savings, pension payments, and any other income available. Many retirees have not adequately anticipated or saved for their health care costs in retirement. This may be due to several factors, including lack of knowledge about the limits of Medicare coverage, or not anticipating the full impact of no longer receiving an employer contribution to health insurance after retirement.

For example, the loss of an em-

ployer contribution not only means that the retiree will have to pay a greater share of the premium costs, but it has important tax consequences as well. The value of employer-provided retiree medical coverage is not considered taxable income. By contrast, if the retiree must buy the coverage, the cost of that coverage will be paid for with after-tax dollars. (See additional discussion in the study findings and outcomes section of this report about possible savings vehicles to pre-fund retiree health care that also provide important tax advantages.)

Unless funded in advance, the costs of retiree health care will pose significant unfunded liabilities for public sector employers and taxpayers providing retiree health care benefits, and/or for employees paying for their health care when they retire. Pre-funding is important because funds can be collected and invested prior to when they are needed to pay for retiree health care. The investment earnings can then be used to also help pay for postretirement health care.

The expense of retiree health coverage, coupled with a lack of pre-funding, is also affecting employment opportunities in the public sector as some retirees choose to delay retirement in order to continue working and receiving employer sponsored health insurance.

Lack of access by retirees to a group health insurance plan with group rates (including access to Medicare supplemental plans at group rates)

Health coverage can be purchased on an individual basis, or as part of a group plan. Individual policies are generally underwritten, meaning that coverage can be denied or restricted. Group plans generally have few, if any, such restrictions except that enrollment in group plans may only be open at certain times, and to persons who meet certain eligibility criteria. Generally, retirees must elect to participate in their employer's plan immediately upon retirement or risk exclusion permanently. Personal circumstances and insurance needs will determine which type of coverage – individual or group – is the perceived better buy, and perceptions may change over time as circumstances change.

Legislation was enacted in 1992 (known as "Chapter 488" of the 1992 Minnesota Session laws, now codified as Minn. Stat. § 471.61) requiring public sector employers to continue retirees on their group health insurance plan indefinitely. The law allows for different premium rates for retirees over age 65 than for the active employee group, and does not require any employer contribution to the costs of retiree coverage. The law also requires that retirees who wish to participate in their former employer's group plan must continue their insurance soon after retirement, and cannot leave the group and then subsequently re-enroll. These requirements are intended to prevent the group plan from experiencing a form of "adverse selection" in which individuals seek to enroll in the plan only when they have become higher risk or need medical care.

Despite the Chapter 488 provisions, public sector retirees still face gaps in obtaining affordable group health insurance. One gap exists if retirees do not meet the Chapter 488 requirements for joining and continuing their former employer's group plan. Retirees over age 65 may be most interested in purchasing Medicare supplement plans at group rates, but Chapter 488 does not require public sector employers to offer them. Insurers must offer opportunities for seniors to enroll in Medicare supplement products on a group basis. Seniors who miss these windows of opportunity may be restricted in their ability to purchase the supplements on a group basis. Additionally, individually purchased Medicare supplement plans may not cover prescription drugs or the cost is often prohibitive.

The Public Employees Insurance Program (PEIP), which is administered by DOER, offers a health insurance purchasing pool for local units of government. Retirees of local units of government are also eligible to purchase Medicare supplement products through PEIP at group rates. However, PEIP has the same requirements to protect against adverse selection as does Chapter 488, and retirees who do not enroll in PEIP when they have the opportunity, or who leave PEIP and attempt to re-enroll, are no longer eligible for the program.

In addition, it should be noted that even at group rates, health insurance costs may be prohibitive for retirees on limited incomes if they are paying the full premium without an employer contribution. The Task Force found that public sector group health rates varied from under $200 per month for single coverage (often with substantial employee cost sharing in the form of deductibles and co-pays), to approximately $1,000 per month for family coverage in some cases. Medicare supplement group rates including prescription drugs ranged from $175 per month to over $300 per month per person in the SEGIP retiree plan.

Study process

The Task Force determined very early on in the study process to focus primarily on two key interest areas, which also related to key legislative interests during the 2000 session: pooled health care purchasing; and pre-funding postretirement health care. Pooling was of interest because of its potential to provide greater risk sharing and potential administrative efficiencies. Pre-funding of retiree health care was of interest because of the large cohort of state public sector retirees anticipated over the next two decades, and because the health care costs of these future retirees are largely unfunded.

While the two areas are interrelated, they also provided a useful division of labor to make the Task Force more productive and efficient. Beginning with the August meeting, the Task Force first convened at each meeting as a committee of the whole, and then met as separate subcommittees devoted to the interest areas above. Following the subcommittee meetings, the group then reconvened as a committee of the whole to share information and perspectives.

The Task Force was limited by the lack of comprehensive, current, readily available information to fully address the study questions. In-depth research to fill these information gaps – such as a comprehensive inventory of current public sector health insurance arrangements, or an extensive actuarial analysis of health care claims among public employers to address questions about pooling in more detail – was beyond the scope of the study's available resources and time. In lieu of this level of research, the Task Force relied to a great degree on existing studies and data, conceptual level analyses, and comparisons or assessments based on key indicators or benchmarks in order to meet the study objectives. The study process was aided by Task Force members, other state agencies, and outside consultants to DOER. The consulting firm of Deloitte and Touche LLP is under contract to provide a variety of consulting services to DOER and assisted in this study. Consultants from Deloitte and Touche participated in task force meetings, conducted reviews and analysis on a number of issues, including possible options for pre-funding retiree health care, and modeled preliminary hypothetical purchasing pool scenarios.

Overview of Minnesota's public sector and public sector health insurance arrangements

Minnesota's public sector is large and diverse. It is comprised of over 3200 governmental units, including state government, institutions of higher education, 87 counties, 853 cities, 435 school districts, 1792 townships, and a number of other jurisdictions such as regional governments, soil and water conservation districts, public hospitals and nursing homes, libraries, and others.[10] An estimated 320,000 people work in public sector jobs in Minnesota. The State is the single largest employer in Minnesota. It administers health benefits through the State Employee Group Insurance Program (SEGIP) on behalf of over 62,000 state employees and employees of the University of Minnesota. Other public sector employment by major jurisdictions includes:

- Cities: 33,228
- Counties 47,405
- School districts 122,316

Most of Minnesota's local units of government employ 100 or fewer employees, and a substantial number have as few as 1-2 employees. The state's public sector workforce is highly unionized, and health care benefits are negotiated through collective bargaining for approximately 70 % of full-time public sector workers.[11]

Health insurance has been cited by employees as the most important fringe benefit in national surveys of employee benefits,[12] and the overwhelming majority of local units of government offer health coverage to employees and dependents. It is a significant item in collective bargaining of wages and benefits, and in worker recruitment and retention in a tight labor market.

Levels of health benefits, their costs to public sector employers, employees, and retirees, and other aspects of existing public sector health coverage arrangements often vary significantly. These variations are the result of differences among local health care and employment markets, collective bargaining outcomes, and other factors. For example, some employees have comprehensive managed care offerings with minimal employee out of pocket cost sharing. Public sector employees in other jurisdictions may have more traditional indemnity or major medical coverage with deductibles and co-pays, or a mix of other options. Some employers contribute substantially to comprehensive first dollar coverage. Other employers may provide only relatively minimal contributions to the cost of employee health coverage, or may provide a flat dollar amount that is the same whether the employee is purchasing single or family coverage.

Key study findings and outcomes

Pre-funding of Postretirement Health Care: An important option to help address retiree health care needs

- *The anticipated large number of public sector retirees over the next ten to twenty years will result in a large future postretirement health care cost. The Task Force considered a variety of options for funding postretirement health care costs and concluded that the "most appropriate and efficient manner" for providing postretirement health coverage is to pre-fund it to the extent possible, especially through the use of vehicles which offer tax advantages and opportunities for investment earnings.*

Pre-funding of postretirement health care is needed to avoid significant future unfunded liabilities for either public sector employers and taxpayers, or employees. Pre-funding is also important because investment earnings that compound over time can help defray future costs. In addition, there are a number of postretirement health care savings plans that provide valuable tax advantages, including tax free contributions to the plan, and tax free withdrawals. Contributions by the employer to such a plan would usually be tax-free to the employee/retiree so long as the benefits could only be used for health care. Distributions from such a plan reimbursing the retiree or paying medical benefits directly for the retiree generally would be tax-free when made. These tax advantages, coupled with compound investment earnings, provide an important opportunity for active workers and their employers to prepare for future health care costs.

- *Public sector employers desire flexibility and choices in making decisions about pre-funding of postretirement health care, including whether or not to participate in some type of pre-funding, and if so, what types of pre-funding vehicles or arrangements to use. The Task Force explored two possible approaches to setting up and administering savings mechanisms for pre-funding postretirement health care consistent with the objectives of choice and flexibility:*

1) Employers could utilize postretirement health care savings products and services currently being marketed and administered through private sector mutual funds, insurance companies, and other organizations.

2) Alternatively, the Task Force also discussed the establishment of a special "public sector trust" to serve State and local units of government by offering and administering an array of postretirement health care savings vehicles and plans. The trust would be responsible for:

- hiring an administrator(s);
- taking in contributions;
- record keeping;
- selecting an investment vendor; and
- paying out reimbursements for health care premiums and expenditures.

The trust could conceivably be one of the public employee pension plans, or a new entity. (A longer description of the trust concept is provided in the correspondence section of the report.) The trust could potentially offer convenience, low cost technical support, an array of savings vehicles and/or a defined benefit plan, and economies of scale in administering programs on behalf of local units of government. Again, however, the Task Force felt that it would be important to allow local units of government to choose the type of delivery system and administration that they felt most appropriate.

Mandatory Health Insurance Pooling: A controversial and unresolved strategy

A key question of interest in the study was whether, and the extent to which, some forms of mandatory pooled health care purchasing and risk sharing on a statewide or regional basis might further improve health care coverage for public sector employers and employees.

- *The Task Force reviewed a variety of pooling models, as well as the experience of a variety of current pools. After several months of review and debate, the question of mandating pooled health care purchasing among public sector employees has not been resolved. At issue are two potential offsetting outcomes, both of which are very difficult to quantify in advance, and both of which can be markedly*

influenced by changes in assumptions or design features of the pool. Mandatory state-wide pooling is of interest to some because of the perceived advantages of broader risk sharing, and because of potential cost savings, especially in administrative costs. Others are less convinced that savings can be realized in practice, and are concerned that benefits design and risk sharing decisions may lead to an overall increase in cost, and a loss of local autonomy and control. These two contrasting positions are briefly presented in more detail below.

Mandatory pooling is of interest because intuitively, it would seem that "bigger is better," and that more statewide or regional pooling of public sector employers might result in even greater administrative savings and better rates from providers. In addition, mandatory pooling addresses a concern about voluntary pooling known as "adverse selection." In a voluntary pool, the healthier groups that can find better rates on their own will have incentives to leave (or not join) the pool. As a result, the voluntary pool could become increasingly concentrated with higher risk, higher cost groups, resulting in higher costs for those groups that continue to share risk with one another in the pool.

A large, mandatory state-wide pool for one or more public sector jurisdictions might result in a reduction in health care administrative costs, which generally now account for 10-15% of premium costs. The cost savings might result, for example, from common administration of a smaller number of benefits designs through the single pool, rather than the large number currently in use by individual employers and smaller, voluntary pools that now exist. A large, mandatory pool would be more likely to anticipate its risks, and set a premium accordingly, or absorb the impact of any high cost cases to a greater degree than a smaller group or pool, and therefore have lower reinsurance costs. Other costs, such as agent and broker commissions, might also be reduced or eliminated under a large, statewide pool. In addition, it is possible that a larger pool may be able to negotiate better discounts with health care providers and administrators. (However, it is also important to note that the health care market has become increasingly consolidated in recent years,[13] and purchasing leverage seems to be increasingly difficult to apply.)

The offsetting concern is that while a large statewide pool may result in some administrative savings, the overall impact on many groups would be a net increase in costs and a loss of local autonomy and control. Individual employee groups or smaller pools may currently have a combination of benefits design and/or relatively better health among their eligibles that results in lower premium rates. They would experience a net increase in costs if the benefits sets available through the mandatory pool were more generous than what these employers previously provided, and/or if the employers were forced to now pool with other less healthy, more costly groups.

The issue is further complicated by the fact that even significant one-time improvements in administrative cost savings may be quickly eroded by rapidly increasing health care costs. Recent experience has also shown that large pools are not immune to large cost increases. The State Employee Group Insurance Program (SEGIP), which covers over 150,000 State and University of Minnesota eligible employees and their dependents, has recently recorded two successive years of nearly 20% annual increases, and its pattern of premium increases over the last decade has mirrored that of some smaller pools.

Possible additional strategies to address issues of postretirement and active employee health care

The study charge to the Task Force was broad, and touched on a variety of interests. During the course of the study, a number of additional issues and options also emerged and were briefly examined. They included:

- the adverse impact of low federal Medicare reimbursement rates to Minnesota "Medicare Plus Choice" health plans;
- the importance of addressing the underlying costs of health care through strategies such as prevention, wellness, and health promotion;
- a possible statewide reinsurance pool for spreading the risks of high cost cases;
- a "phased retirement" concept

that would allow retirees to resume working in a special, limited classification so as to be eligible for some level of employer-paid health coverage; and

- issues of local public sector health care purchasing strategies as they relate to health care cost containment, access, and local community development objectives.

While the Task Force did not have the opportunity to fully develop these options, they were viewed as important adjuncts to the main concepts of pre-funding and pooling described above, and deserving of further research and consideration. Those which were discussed to the greatest degree are briefly summarized below.

1. Health benefits designs

Health benefit designs play an important role in health care utilization and costs, and in employee recruitment and retention. Comprehensive health benefits with minimal out of pocket cost sharing for enrollees provides important protection for persons with high health care needs and persons with limited disposable income. These benefits can also be an important public sector employee recruitment and retention tool, especially where wages and other forms of compensation may be lower than for comparable private sector positions. However, extensive health coverage can also be one of several factors contributing to increased health care utilization and health care costs. Other factors include an aging population, technological advances, administrative costs, and changing market forces.

In efforts to reduce health care spending and costs, many employers are instituting greater out of pocket cost sharing for enrollees in the form of increased co-pays, deductibles, and coinsurance. This has a dual impact in shifting some costs to enrollees, but also in reducing demand for medical care. Employers are also exploring "defined contribution" and "flexible" benefits strategies in which they provide a set allocation for enrollees to use in purchasing an array of benefits, including health care. The balance between the perceived costs and benefits of comprehensive, first dollar coverage and other health benefits designs needs more evaluation and discussion.

2. Addressing the cost of health care through prevention, wellness, and health promotion

Pooling is typically associated with potential health care cost savings by reducing the administrative costs associated with claims adjudication, member records, communications, and other overhead costs. However, administrative costs, while often substantial in aggregate, typically account for only 10-15% of health care expenditures. The majority of health insurance expenses (85-90%) are for claims associated with health care services and treatments. Much of these costs are associated with injuries and illnesses that are preventable, or detectable and treatable at early, more cost-effective stages. Greater emphasis on health promotion, wellness, and prevention could improve health outcomes and potentially result in savings on future health care costs.

3. Establishing a reinsurance pool

As part of its more general discussions of health insurance pools, the Task Force also explored on a preliminary basis a mandatory statewide pool for "reinsurance" of high cost cases, similar to the Workers' Compensation Reinsurance Association (WCRA) established in 1979 for workers' compensation programs.

Reinsurance is typically purchased by self-insured employer groups, voluntary pools, and insurers specifically to spread the costs of high cost cases more broadly. A number of these entities have experienced recent rate increases or difficulties obtaining reinsurance in the current market.

One suggestion raised during the study process was to establish a mandatory statewide pool for reinsurance, similar in concept to the state's WCRA for workers' compensation insurance. The Task Force identified a number of parallels between pooling of high cost cases, and the broader pooling of all health care claims discussed above. A number of policy, implementation, and operational issues were raised which require further analysis and discussion, including:

- What is the impact on the market for aggregate reinsurance? and
- When should state insurance

regulations apply to pools or employer groups that – because of significant reinsurance – become in effect "insured" and therefore subject to sate regulation like other health insurers?

4. Creating pooling opportunities for Medicare eligibles who cannot access a Medicare supplement group plan with group rates

The Task Force considered the issue of Medicare eligibles who cannot access a Medicare supplement group plan with group rates as described above in the issues section of this report. Possible options to address this issue included :

- Pre-funding of retiree health care.
- Greater education and awareness among current and future retirees regarding:
  - the availability of group-rated Medicare supplemental coverage such as the Public Employees Insurance Program (PEIP);
  - the limited time window within which retirees can enroll in either the PEIP Medicare supplement or in their own employer's retiree coverage, and the current inability to enroll later if retirees do not take advantage of the opportunity when it is first offered;
  - what Medicare does and does not cover;
  - the costs of health care and health coverage generally, including the impact of changes in (or loss of) an employer contribution as an employee transitions from active status to retiree;
  - other retiree health insurance products that may be available.
- Explore possible one-time options to allow retirees to join PEIP or their employers' group plan outside the existing windows of opportunity. However, because of the significant risks of adverse selection and resulting higher claims costs, more actuarial study is needed to determine the potential costs and feasibility of this approach.
- Provide greater publicity regarding federal and state financial assistance programs to assist with Medicare costs and the costs of prescription drugs for low income persons.

5. Exploring "Phased retirement"

The Task Force discussed a "phased retirement" concept that would allow retirees to work part time in a special, limited classification to be eligible for some level of employer-paid health coverage while also being paid a public sector pension. The concept is designed to help meet an anticipated worker shortage as the current generation of "baby boomers" retires, while also providing retirees an option for employer-based, tax-sheltered health insurance. Minnesota Statutes Section 354.445 currently permits retired faculty members of the Minnesota State College and University System to continue to teach on a part time basis and to be eligible for health coverage.

A number of "phased retirement" issues require further exploration including:

- Increasing pension benefits with longer service, and the impact on calculations of "high five" years of service for determining pension amounts;
- The negative perception of employees collecting both their public sector pensions, and public sector wages as "double dipping";
- Equal pay considerations;
  - In discussing the phased retirement concept, a suggestion was made that retirees might be able to work part-time in exchange for some level of health benefits only, or some level of benefits and reduced wages. However, current law does not allow employers to pay employees only in benefits (employees would have to be paid at least minimum wage). Concerns were also raised that if an employer did negotiate or other otherwise establish a low rate for former employees, the employer might open to charges of age discrimination under the Age Discrimination in Employment Act of 1967, (ADEA);
- Administering a program to direct the earnings of part time workers to pay for health insurance on a pre-tax basis.

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[8] Minnesota Department of Health, Health Economics Program, Minnesota’s Health Care Market: Employer – Based Coverage, Overall Health Care Costs and Trends, and Retirement Health Care Benefits, July 24, 2000 (presentation to Task Force).
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Henry J. Kaiser Family Foundation, Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits, October 1999.
[9] Milliman and Robertson, “Pre-funding Retiree Health Benefits”, PERiScope (Public Employee Retirement Systems), April 2000.
[10] Based on data from: Minnesota Department of Economic Security, Minnesota Department of Children, Families and Learning, Association of Minnesota Counties, Minnesota Association of Townships, League of Minnesota Cities, Public Employee Retirement Association, Minnesota State Retirement System, Teacher’s Retirement Association, Education Minnesota.
[11] Communication from Minnesota AFSCME Council 6.
[12] Minnesota Department of Health, Health Economics Program, Minnesota’s Health Care Market: Employer – Based Coverage, Overall Health Care Costs and Trends, and Retirement Health Care Benefits, July 24, 2000 (presentation to Task Force).
[13] Deloitte and Touche, Post retirement and Active Employee Health Care Task Force, July 24, 2000 (presentation to Task Force).

List of issue briefs

The following briefs provide additional information regarding concepts, findings, and recommendations of the Task Force:

- Pre-funding Retiree Health Benefits
- Health Insurance Pooling
- Health Care Cost Trends
- Illustrative Health Care Benefit Plan Arrangements Among Minnesota Public Sector Employers
- Medicare Payment Disparities
- The Importance of Health Promotion, Wellness, and Prevention
- Highlights of *Report of the Statewide Health Insurance Task Force for Public Employers*, February, 1987

Issue Brief

Prefunding Retiree Health Benefits

The issue brief below was prepared for the Postretirement and Active Employee Health Care Task Force established under Chapter 461, Article Five, Minnesota Session Laws 2000. The Task Force met during the period June-November, 2000. Issue briefs were prepared to supplement the Task Force report with additional information and perspectives regarding issues of interest to the Task Force.

A growing number of retirees and escalating health care costs have contributed to "dramatically" increased costs[1] of postretirement health care. This trend is likely to continue into the future and may become especially evident in Minnesota's public sector workforce as a large number of public sector workers retire in the relatively near future.

Currently, seventy percent of the workers in Minnesota state government are over age forty. It is estimated that approximately 18 percent of current state employees will be age sixty or older by 2005. By 2010, an estimated 37 percent of state workers will be age 60 or over, and by 2015 over half the current state workforce will be over age 60. The Teachers Retirement Association (TRA), a statewide pension plan with over 70,500 active employee members, reports that the average age of nearly half (48 percent) the group is 45 years old or older. The TRA estimates that over 29,000 teachers will retire during the next ten years.[2]

The Postretirement and Active Employee Health Care Study Task Force study process did not determine the extent to which public sector employers currently contribute to retiree health care options. At the national level, there has been a decline among large firms in making available employer-provided health care coverage to retirees, particularly retirees over age 65.[3] The decline is traced to an increase in health care costs, as well as a change in accounting standards by the Financial Accounting Standards Board (FASB) that became effective in 1992. The change required employers to disclose as a current liability the unfunded portion of future non-pension post-employment benefits. A ruling is expected in the near future from the Government Accounting Standards Board (GASB), requiring units of government to also abide by similar standards when reporting on any retiree health care obligations,[4] and could have similar impact on postretirement health care as the FASB standard earlier.

Unless funded in advance, the costs of retiree health care will pose significant unfunded liabilities for any public sector employers and taxpayers providing retiree health care benefits, and/or employees paying for their health care when they retire. Pre-funding is important because funds can be collected and invested prior to when they are needed to pay for retiree health care. The investment earnings can then be used to also help pay for postretirement health care. Depending on the amount invested, the duration of the investment, and the investment rate of return, it is possible that the investment earnings may far exceed the amount that was originally invested.

Currently, many public sector employees may already be contributing to retirement savings plans such as deferred compensation programs or individual "Roth IRAs." The difference between these general retirement savings plans and other more specialized forms of pre-funding retiree health care costs, is that in some cases,

postretirement health care savings plans can be constructed to provide greater tax savings. In particular, the Task Force was especially interested in options that can be established so that any employer contributions to the plan are tax-free and retiree withdrawals after retirement for health care expenses are also tax-free.[5] Some options are also exempt from federal payroll (FICA) tax, providing additional savings to both the employer and the employee. The effect of the tax savings is like freeing up more funding (that would otherwise have been paid in taxes) to pre-fund or pay for retiree health care, or to offset these costs. However, it should also be pointed out that those options that have the effect of reducing gross taxable income may also have an effect on contributions and benefits under public pension plans available in the state of Minnesota.

The Task Force reviewed a variety of approaches to fund postretiree health care, ranging from "pay as you go" options to a variety of pre-funding options. The relative advantages and disadvantages of these options are briefly summarized in the accompanying definitions and table. In reviewing the options in the table, it is important to note that:

- Decisions about whether to participate in some form of retiree health care funding, and the type of vehicle to participate in, can be made at the level of each local unit of government in bargaining with its individual bargaining units and setting compensation;
- A variety of benefit designs can be implemented under a variety of savings vehicles. Funding can consist of employer contributions, employee contributions or a combination of both.[6]
- In order to receive tax advantages, all members of a bargaining unit or group negotiating a contract with a unit of government must agree to the terms for participation in a postretirement savings option (participation in the vehicle must be mandatory at some level for all members of the bargaining unit). (See also the definition of "constructive receipt doctrine" in the definition section, attached.)

Several public sector employers on the Task Force indicated that they desired flexibility and choices in making decisions about pre-funding of postretirement health care, including whether or not to participate in some type of pre-funding, and if so, what types of pre-funding vehicles or arrangements to use. The Task Force explored two possible approaches to setting up and administering savings mechanisms for pre-funding postretirement health care consistent with the objectives of choice and flexibility:

1) Employers can utilize postretirement health care savings products and services currently being marketed and administered through private sector mutual funds, insurance companies, and other organizations.

2) Alternatively, the Task Force discussed the establishment of a special "public sector trust" to serve State and local units of government. The trust would be responsible for: hiring an administrator(s); taking in contributions; record keeping; selecting an investment vendor; and paying out reimbursements for health care premiums and expenditures. The trust could conceivably be one of the public employee pension plans, or a new entity. The trust could potentially offer convenience, low cost technical support, an array of savings vehicles and/or a defined benefit plan, and economies of scale in administering programs on behalf of local units of government. Again, however, the Task Force felt that it would be important to allow local units of government to choose the type of delivery system and administration that they felt most appropriate.

A proposal was submitted by one Task Force member as a possible model for the public sector trust above and described the concept in more detail. (The proposal is provided in a separate section of the report which includes correspondence and positions that Task Force members wished to have presented directly to the reader.)

Definitions Relevant to Retiree Medical Funding

115 Account – A trust available to state and local governments set up under Internal Revenue Code section 115, the earnings of which are not taxable so long as they are used for "any essential governmental function and accruing" to that government; providing employee and retiree benefits has been recognized as such an essential function

401(h) Account – An account within a defined benefit retirement plan, funded with assets that exceed plan liabilities, and used to pay for retiree medical coverage; set up under IRC sections 401(h) and 420

Constructive Receipt Doctrine – A federal tax law principle that holds that income will be taxable in the year in which it is credited to a taxpayer's account or set apart or otherwise made available so that the taxpayer may draw on it at any time. Consequently if an employee is offered cash or some other benefit, the employee will be treated as having received taxable income regardless of whether he chooses the cash or the offered benefit, even if the offered benefit would otherwise have been nontaxable. However, income is not constructively received if the taxpayer's control of its receipt is subject to substantial limitations or restrictions.

GASB (Government Accounting Standards Board) – The entity which establishes generally accepted accounting rules for government entities

IRC (Internal Revenue Code) – Federal law tax code; governs tax treatment of individuals, employment taxes and a limited number of state actions

"Pay-as-you-go" – Paying for benefits from a general operating budget as the bills for the benefits are tendered by the providers or by beneficiaries for reimbursement, as compared with "pre-funding"

Pre-funding – The practice of setting up accounts or trusts and contributing funds to those accounts at the time the rights to benefits are earned by the employee or other beneficiary.

VEBA – Voluntary employees' beneficiary association; a tax-exempt organization providing for the health benefits, life insurance, disability or other benefits to employees authorized under IRC section 501(c)(9) and usually funded under IRC sections 419 and 419A, which set out strict limits on the amount of funding the trust may receive in any year.

DRAFT— Existing Retiree Medical Funding Mechanisms 2000 — DRAFT

Options	Funding	Prerequisites	Retirees' Tax Treatment	Advantages	Disadvantages
Pay As You Go	Employer pays each year from current year budget	Steadily increasing funding	No tax on employer contributions or on benefits; no ability for retiree to pay his or her portion with pretax dollars	◆ Clear, straight-forward ◆ No trust or other financial accounts required	◆ Must pay each year out of operating funds ◆ Uncertainty of medical costs ◆ No opportunity to create earnings that might offset part of the costs ◆ If GASB requires accounting for retiree medical benefits as accrued (rather than as paid), credit worthiness of government entity could be damaged (creates an unfunded future liability)
Insured Plans/ HMOs	Employer contracts with insurers/HMOs each year for fixed fee	Adequate market suppliers	No tax on employer contributions or on benefits; no ability for retiree to pay his or her portion with pretax dollars	◆ Fixed costs for year ◆ No internal or external fund management costs	◆ Must pay each year out of operating funds ◆ Must contract each year ◆ No opportunity to create earnings that might offset part of the costs ◆ To the extent that the employer contributions are promised into the future, creates the same issue under GASB as noted for Pay-as-you-go
VEBAs	Trust set up under Internal Revenue Code §419 with employer and/or employee contributions	None	No tax on contributions to VEBA or on benefits; no ability to fund retiree/employee contribution with pretax dollars.	◆ Money held in trust to pay for benefits ◆ Trust earnings help pay for benefits ◆ May pre-fund based as active employees earn rights to retiree medical benefits	◆ Funding limited to actual experience, plus funding over working lives of active employees eligible for retiree medical benefits
Collectively Bargained VEBAs	Trust set up under Internal Revenue Code §419 with employer and/or employee contributions	Most employees are collectively-bargained	No tax on contributions to VEBA or on benefits; no ability to fund retiree/employee contribution with pretax dollars.	◆ Money held in trust to pay for benefits ◆ Virtually no limits on funding Trust earnings help pay for benefits	Does not work for noncollectively-bargained employees

DRAFT— Existing Retiree Medical Funding Mechanisms 2000 (continued)

Options	Funding	Prerequisites	Retirees' Tax Treatment	Advantages	Disadvantages
Employee Pay All VEBAs	Trust set up under Internal Revenue Code §419 with employee only contributions	Employees must bear all costs	No tax on benefits	◆ Money held in trust to pay for benefits ◆ Virtually no limits on funding ◆ Trust earnings help pay for benefits	◆ Employees must fund all, raising issues of cut-backs, etc. ◆ Employee contributions probably must be made with after-tax dollars
Government Trust-Annual contribu-tions	Government entity contributes to a trust; contributions and earnings on the trust used to pay a portion of the retiree medical costs	Authority under state law to establish trust	No tax due for retirees or employees	◆ Money held in trust to pay for benefits ◆ Virtually no limits on funding ◆ Trust earnings help pay for benefits	◆ Must budget for and fund the trust ◆ Manage trust and its expenses
401(h) Accounts	Excess assets in defined benefit pension plan moved to fund current year retiree medical costs	Overfunded defined benefit plan; need plan assets of at least 125% of liability after the transfer	No tax on contributions or benefits. (There is no employee or retiree contribution.)	◆ No additional cost to employer ◆ Enables employer to use assets that might not be available to employer	◆ Reduces pension assets; may require more funding in the future ◆ Must set up separate 401(h) account in pension plan ◆ Must vest all current pension plan participants at the time assets transferred to 401(h) account ◆ Pay only current year ◆ Must maintain same or equivalent benefits ◆ Scheduled to expire in 2005, although has been extended several times
Unused Leave - Contribu-tions Employee/ Retiree Choice Of Cash (e.g., in situations where severance packages exist)	At retirement employees' unused leave (severance) is transferred to pay employees' costs of retiree medical coverage (e.g., as severance where such arrangements have been bargained/establi-shed	Significant amounts of leave usually available to retirees	Under the tax doctrine of "constructive receipt," if employee/retiree has an option to receive cash instead of benefits, cash will be taxed at time cash available	◆ No additional cost to employer (if severance pay out of unused leave already bargained/established and in place) ◆ No additional cost to employee	◆ Must track individual accounts ◆ Retiree account may be depleted after a period of years ◆ Employer still has a future unfunded liability if cash is transferred at time of transaction ◆ Potential cost to employer if contributing unused leave is new benefit

Options	Funding	Prerequisites	Retirees' Tax Treatment	Advantages	Disadvantages
Unused Leave - Contribu-tions Mandatory (E.g., in situations where severance packages exist)	At retirement employees' unused leave (severance) is transferred to pay employees' costs of retiree medical coverage(e.g., as severance where such arrangements have been bargained/establi-shed)	Significant amounts of leave usually available to retirees	If transfer of leave mandatory, no tax on transfer or on benefits.	◆ No additional cost to employer (if severance pay out of unused leave already bargained/established and in place) ◆ No additional cost to employee	◆ Must track individual accounts ◆ Retiree account may be depleted after a period of years ◆ Potential cost to employer if contributing unused leave is new benefit ◆ Employer still has a future unfunded liability if cash is transferred at time of transaction
Government Trust - Debt Issue	Government uses debt instruments (bonds, certificates of participation) paying fixed rate; invests in equities and uses the difference between earnings and the interest payments on the debt to pay retiree costs	Authority under state law to issue debt	No tax due for retirees or employees	◆ Money held in trust to pay for benefits ◆ Virtually no limits on funding ◆ Trust earnings help pay for benefits	◆ Complex funding and underwriting; significant management fees ◆ Considerable market risk ◆ May adversely affect government entity's debt rating
Medicare Buy-In	Government entity arranges for retirees not eligible for Medicare to buy into both Parts A & B and pays part of the cost	Significant number of retirees who are not automatically covered by employers	No tax due on government part of payments; retiree's payment is with after-tax dollars	Medicare pays part of medical treatment, thereby reducing state/local government cost	No significant cost savings unless large numbers of retirees are otherwise ineligible for Medicare
Cafeteria Plan	Prior to the release of IRS guidance this year, some employers withheld payment for medical benefits from retirement plan payments and treated such "withholdings" as deferrals under IRC §125. Employers treated these medical benefits as nontaxable to the retiree. The IRS issue paper makes clear that such payments are taxable to the retiree.				

References

[1] Milliman and Robertson, “Pre-funding Retiree Health Benefits”, PERiScope (Public Employee Retirement Systems), April 2000.

[2] Information prepared by Minnesota Department of Employee Relations (“The State of the State Work Force: 45 and 15 to Go, MN DOER, 11/27/00) and data provided by the Teachers Retirement Association (correspondence, 11/28/00)

[3] Minnesota Department of Health, Health Economics Program, Minnesota’s Health Care Market: Employer – Based Coverage, Overall Health Care Costs and Trends, and Retirement Health Care Benefits, July 24, 2000 (presentation to Task Force).

and,

Henry J. Kaiser Family Foundation, Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits, October 1999.

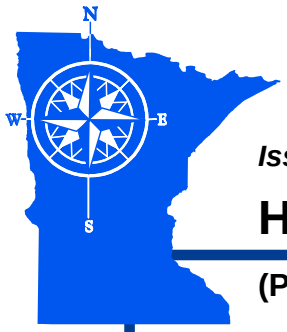
[4] Milliman and Robertson, “Pre-funding Retiree Health Benefits”, PERiScope (Public Employee Retirement Systems), April 2000.

[5] Discussions with Martha Patterson, consultant, Deloitte and Touche.

Also note the following from Milliman and Robertson, “Pre-funding Retiree Health Benefits”, PERiScope (Public Employee Retirement Systems), April 2000:

> “If employee contributions are required to help pre-fund retiree health benefits, these contributions may or may not be included in the employee’s gross income for income tax purposes, depending on the design of the program.” The PERiScope article also references the following vehicles specifically as “exempt from tax” the “will provide health benefits to members on a tax-free basis if properly set up”: A VEBA as provided in Section 501© (9) of the Internal Revenue code (IRC); A special purpose municipal trust exempt from income tax under section 115 of the IRC; A separate account within the retirement plan (401(h)Account): A separate account on the books of the local or state government.

[6] Milliman and Robertson, “Pre-funding Retiree Health Benefits”, PERiScope (Public Employee Retirement Systems), April 2000.



Issue Brief

Health Insurance Pooling

(Pooled health care purchasing, health insurance pools)

The issue brief below was prepared for the Postretirement and Active Employee Health Care Task Force established under Chapter 461, Article Five, Minnesota Session Laws 2000. The Task Force met during the period June-November, 2000. Issue briefs were prepared to supplement the Task Force report with additional information and perspectives regarding issues of interest to the Task Force.

The Insurance Model and Pooling of Risk

The health insurance concept is based on broad sharing risk of illness or injury. From an insurer's perspective, it is important that the group sharing risk is not limited to just those with the highest health care needs, but includes a mix of both healthy and less healthy individuals. Broader risk sharing helps reduce the impact of any single high cost case among those sharing in the risk, and helps result in more stable premium rates.

This aggregation or "pooling" for insurance purposes is typically accomplished in one of three ways in the current insurance market, as briefly summarized below.

Current forms of health insurance "pooling"

1. Large employers

Employers with a large number of employees are often considered a natural risk-sharing group for insurance purposes. The State Employee Group Insurance Program (SEGIP), which administers health coverage on behalf of state workers, retirees, and dependents and those of the University of Minnesota, is the single largest group purchaser in Minnesota, with over 60,000 employees and 160,000 covered lives.

There are a number of other large public sector employers, including: the Minneapolis, St. Paul, and Anoka-Hennepin public school districts; Hennepin and Ramsey County governments; Minneapolis and St. Paul city governments, and others.

Together, the enrollment in SEGIP and other large public sector employer groups with over 1,000 employees is estimated at approximately 106,000 employees, or about one-third of all public sector employees in Minnesota.

2. Voluntary pools

Alternatively, employer groups, especially smaller groups, may pool together and collectively purchase or arrange health coverage for the member groups in the pool. Currently, Minnesota laws permit a number of voluntary pooling arrangements among local units of government. In addition, legislation provides for two health insurance pooling options specifically for local units of government — the Minnesota Service Cooperatives, and the Public Employee Insurance Program (PEIP).

Other separate pools have been independently established and are available to cities (e.g., League of Minnesota Cities Insurance Trust, and Local Government Information Systems (LOGIS) pools), and counties (the Minnesota Counties Insurance Trust). Additional public sector pooling options are possible through joint powers agreements, or through statutes allowing the formation of "health care purchasing alliances." (See also Table 1 with relevant legislation and Table 2 with a brief summary of voluntary purchasing pools through which public sector employ-

ers may purchase coverage.) Over 70,000 public sector employees in local units of government are currently receiving their health coverage through one of the voluntary arrangements described above, with the following distribution by jurisdiction:

Jurisdiction	Percent of employees receiving health coverage through an existing voluntary pool available to local units of government (Includes the following pools: MN Service Cooperatives, PEIP, LMCIT, MCIT, LOGIS)
Cities	34%
Counties	20%
School districts	41%

More than half of all public sector workers in the state (approximately 176,000 employees of the estimated total 320,000) receive their health coverage either as: a) part of a large employer group with over 1,000 employees, or b) as part of an employer group participating in one of the pools noted above.

3. Insurers

Insurers also pool employer groups together in a variety of ways to spread risk and aid in developing premium rate structures. Prior to 1992, insurers could deny coverage to small groups and could also set premiums at very different rates for each group, reflecting the estimated costs of each. In 1992, Minnesota passed a number of small group insurance reforms to improve the insurance opportunities for employers with 2-25 employees (subsequently expanded to employers with 2-49 employees). The reforms required that insurers offer insurance coverage to small groups that met certain group participation and employer contribution level requirements (the small group market became "guaranteed issue").

The reforms also established "rate bands" or pricing corridors within which premium rates quoted to small groups had to fall.

Other perceived advantages of pooling

In theory, pooled health insurance purchasing is often expected to offer additional advantages to purchasers and consumers beyond broader risk sharing and more stable premium rates. Pooling a number of employers together to jointly purchase health coverage is often considered in efforts to:

- save on administrative and overhead costs by reducing or eliminating duplications of effort, administering fewer different options or different benefits designs, achieving economies of scale, and maintaining a larger enrollee base over which to spread fixed costs; and
- exercise more purchasing leverage in the health care market, to better negotiate discounts or other preferred arrangements with health plans and providers.

However, as discussed below, a number of pooling issues remained controversial and unresolved throughout the study, including:

- the extent to which these potential benefits are likely to be realized in practice;
- whether there is any particular size or type of pooling arrangement most likely to maximize these benefits;
- the overall impact of pooling to help contain rising health care costs.

Key questions

- *A key question of interest in the study was whether, and the extent to which, some forms of mandatory pooled health care purchasing and risk sharing and on a statewide of regional basis might further improve health care coverage for public sector imployers and employees.*

  The Task Force reviewed a variety of pooling models, as well as the experience of a variety of current pools to address the question above. After several months of review and debate, the question has not been resolved. At issue are two potential offsetting outcomes, both of which are very difficult to quantify in advance, and both of which can be markedly influenced by changes in assumptions or design features of the pool, as briefly summarized below.

Mandatory pooling was of interest to the Task Force because intuitively, it would seem that "bigger is better," and that more statewide or regional pooling of public sector employers might result in even greater administrative savings and better rates from providers. Health care administrative costs generally now account for 10-15% of total health premium costs. In theory, it might be possible to reduce these administrative costs if a statewide, mandatory pool achieved:

- more common administration of a smaller number of health benefits designs, rather than multiple, different, benefit plans now in place among individual employers and voluntary pools;
- lower reinsurance costs. Groups or pools must typically purchase reinsurance to provide additional protection for high cost cases that they cannot adequately absorb and spread across their members. A large, mandatory pool would theoretically be more likely to correctly anticipate its risks, and set a premium accordingly to adequately cover its costs. It would be able to spread the impact of any high cost cases (by raising the deductible level and self-funding to the higher level, thereby reducing the risk margin with the reinsurance premium costs) to a greater degree than a smaller group or pool and therefore have lower reinsurance costs;
- a reduction or elimination of other administrative costs, such as agent and broker commissions.

In theory, it is also possible that a larger pool may be able to negotiate better discounts with health care providers and administrators. However, it is also important to note that the health care market has become increasingly consolidated in recent years, and even larger groups are finding it difficult to achieve further discounts or preferred arrangements with providers.

Mandatory pooling also addresses a concern about voluntary pooling known as "adverse selection." In a voluntary pool, the healthier groups that can find better rates on their own will have incentives to leave or never join the pool. As a result, the voluntary pool could become increasingly concentrated with higher risk, more costly groups, resulting in greater costs for those groups that continue to share risk with one another in the pool. The Task Force, however, did not attempt to determine whether, or the extent to which, there has been adverse selection among any of the voluntary pools available to units of local government noted above.

However, it is often difficult to achieve the theoretical advantages of mandatory pooling described above in practice. Moreover, the issue of the relative advantages or disadvantages of pooling is further complicated by the fact that even significant one-time improvements in administrative cost savings through pooling may be quickly eroded by rapidly increasing health care costs. Recent experience has also shown that large pools are not immune to large cost increases. SEGIP, which covers over 150,000 State and University of Minnesota eligibles, has recently recorded two successive years of nearly 20% annual increases, and its pattern of premium increases over the last decade has mirrored that of some smaller pools.

The theoretical advantages of a large, statewide, mandatory pool were offset by concerns that participating in the pool might actually increase health care costs for some employers and result in a loss of local autonomy and control. The potential adverse cost impact arises because some individual employers or smaller voluntary

employer pools may currently have a combination of benefits design and/or better health risks among their enrollees that results in more advantageous health coverage premium rates. These employer groups would experience a net increase in premium costs if the only benefits sets available through the mandatory pool were more generous than what they had previously provided, and/or if they were forced to now pool with other less healthy, more costly groups.

Illustrative mandatory pooling scenarios

This potential increase or decrease in any single group's health coverage costs as a result of differences in benefits levels or pooling mix was illustrated in hypothetical pooling scenarios. In the scenarios, SEGIP was used as a benchmark for comparison.

The predominant health coverage product for SEGIP enrollees is the "Select" plan, a comprehensive managed care product with 100% in-network coverage of medically necessary services, and no enrollee cost sharing (no deductibles, co-pays, or coinsurance) except for prescription drugs ($10 co-pay for formulary drugs, and a $21 co-pay for nonformulary drugs).

The average SEGIP rates for a Select product for active employees and retirees under age 65 for 2001 were calculated to be $288.17 per month for single coverage, and $715.59 per month for family coverage.

The SEGIP average monthly rates were then compared with three hypothetical, statewide, mandatory pools. The pools reflected the age and sex characteristics of active employees and retirees under age 65 enrolled in two State pension plans, the Teachers Retirement Association (TRA), and the Public Employee Retirement Association (PERA), as well as a combination of the two. For comparative purposes, SEGIP's Select benefits levels were set as the hypothetical "standard benefits set" that would be offered through the hypothetical pools.

The table below shows:

- the enrollment in each of the hypothetical pools;
- the pool's age-sex factor (reflecting the degree to which the pool was more or less costly than a broad population average);
- the rates for Select-type coverage provided to everyone in the pool, based on the pool's age- sex factor;
- and similar information for SEGIP as a benchmark for comparison.

Public employer and employee reactions to the premiums and benefits levels in the pooling scenarios above will vary depending on current coverage levels and costs. For example, a number of school districts in northwestern Minnesota purchase a comprehensive major medical product through the Service Cooperative pool with a $1,000 annual individual deductible ($2,000 family), and 80% reimbursement of covered expenses to an annual out of pocket maximum of $3,000 individual ($6,000 family) and then 100% coverage of eligible expenses after the annual

Pool	Active employees/ retirees under age 65	Age/sex factor	Average Age	Premium rate - Single	Premium rate - Family
SEGIP	58,582	1.425	46	$288.17	$715.59
TRA (hypothetical)	76,544	1.483	48	$299.81	$744.49
PERA (hypothetical)	160,893	1.345	44	$271.92	$675.24
TRA/PERA combined (hypothetical)	237,437			$280.91	$697.56

out of pocket maximum. The premium rate for this level of coverage is $155.47 to $168.77 per month (single) and $ 422.31 to $458.53 (family). This is much less than the rates above, but does not take into consideration the benefit differentials between the Service Cooperative product and the models above.

At the other end of the cost spectrum, some school districts have been reported to be paying rates in excess of $1,000 per month for family coverage, or over $12,000 per year. These rates are much higher than the outcome of the scenarios above.

Any mandatory pooling scenario will likely result in a change in the rates that public sector employers are paying now, and/or changes from their current benefits levels and the range of options that are offered. Additionally, a mandatory pool may also set requirements around minimum employer contribution levels. As a result, the employers may seek to change their employer contribution to the cost of health coverage, or make other adjustments in employee compensation or services to taxpayers, to compensate for changing health care costs under a mandatory pool. The extent to which these impacts and corresponding changes are considered desirable will vary by employer and employee group, and could change over time.

Table 1. Excerpts from State Statutes which permit joint health care purchasing arrangements and health coverage pools for public sector employers

Statute	Excerpt
471.59 Joint exercise of powers	"Two or more governmental units, by agreement entered into through action of their governing bodies, may jointly or cooperatively exercise any power common to the contracting parties or any similar powers, including those which are the same except for the territorial limits within which they may be exercised."
471.617 Self-insurance of employee health benefits	"Any two or more statutory or home rule charter cities, counties, school districts, or instrumentalities thereof which together have more than 100 employees may jointly self-insure for any employee health benefits…"
123A.21 Service cooperatives	"Full membership in a Service Cooperative shall be limited to public school districts, cities, counties, and other governmental units as defined in section 471.59, but nonvoting memberships shall be available to nonpublic school administrative units and other partnership agencies or organizations within the Service Cooperative [An SC Provides:] (1) administrative services; (13) employee personnel services; (19) fiscal services and risk management programs; (21) health and safety services; (23) cooperative purchasing services."
43A.316 Public Employees Insurance Program (PEIP)	"… a statewide program to provide public employees and other eligible persons with life insurance and hospital, medical, and dental benefit coverage [for] …public employer ...town, county, city, school district...service cooperative ...intermediate district ...cooperative center for vocational education...regional management information center…or an education unit organized under the joint powers action ...or (2) an exclusive representative of employees, as defined in paragraph (b); (3) a county or municipal hospital; or (4) another public employer approved by the commissioner. "
62L.045 Associations	"...at least 100 people with some interest in common - organized and maintained for purposes other than that of obtaining insurance; (can also include governmental organizations)"
62T.01 Health care purchasing alliance	"A business organization created ...to negotiate the purchase of health care services for employers. (Does not) regulate or impose any requirements on a self-insured employer or labor union. An [HCPA] may include a grouping of: (1) businesses, (2) trade association members or church organizations … or union members who are not in a self-insured benefit plan; (3) multiple employer welfare associations...; (4) municipalities, townships, or counties; (5) other government entities; or (6) any combination of ... (1) to (5). "

Table 2. Summary of voluntary health care purchasing pools presented to the Task Force

Pool Name	Statutory Authorization	Year established and history	Public sector employers eligible	Current Enrollment: Employer groups, employees, covered lives (health coverage)
Public Employees Insurance Program (PEIP)	MS 43.316	Legislation passed in 1987, first groups enrolled in 1990	Public employers (cities, counties, school districts, other)	96 groups 2,800 employees
Service Coops (There are eight Service Coops providing health coverage. Figures listed are for all Service Coops in total)	MS 123A. 21	1975 - Legislation for Educational Cooperative Service Unit -ECSU. First insurance pool for schools in 1984. In 1995, legislative name change to Service Cooperatives, and added as eligible members: Cities, Counties, and other government units as defined in MS 471.59	Public employers (cities, counties, school districts, other)	312 school districts 250 other local units of government 64,303 (contracts) 160,757 lives
League of Minnesota Insurance Trust		Created in 1980	Cities	50 cities 2,500 covered lives
Minnesota Counties Insurance Trust	MS 471	Initiated in 1979 in response to tightening Workers' compensation market 1992 - Added health and benefits division	Members of MCIT counties with at least 50 employees	9 counties 1,624 employees 3,133 covered lives
Local Government Information Systems (LOGIS)		Created in 1989	Municipalities in the west metropolitan area	46 groups 3,000 employees 6,100 covered lives

Issue Brief

Rising Health Care Costs

The issue brief below was prepared for the Postretirement and Active Employee Health Care Task Force established under Chapter 461, Article Five, Minnesota Session Laws 2000. The Task Force met during the period June-November, 2000. Issue briefs were prepared to supplement the Task Force report with additional information and perspectives regarding issues of interest to the Task Force.

After experiencing very low — even negative — rates of annual health care cost increases in the mid-1990's, many employers are now experiencing double-digit rates increases. According to results of a study by Hewitt Associates, the costs paid by employers in the Minneapolis-St. Paul metro area to provide health benefits increased by an average of 17 percent in 2000. This follows average annual rates of increase of 6.7 percent and 9.2 percent for the periods 1997 to 1998, and 1998 to 1999, respectively.[1]

The Twin Cities metro area health insurance rates of annual increase have been higher than the national average each of the past three years, and are currently nearly double the national rate of increase of 9.4 percent. Despite these recent cost increases, the average annual health care cost per employee in the Twin Cities is $4,178, slightly below the national average of $4,200.[2] (See graphs at the end of this issue brief.)

The increases are falling on both small and large public sector employers. The State Employee Group Insurance Program (SEGIP) administers the largest group health plan in the state and is often considered a bellwether for employer health care cost trends. The state's share of costs for employee health coverage through SEGIP rose 23 percent in 2000, and a 19 percent increase is projected for 2001. This translates into substantial expenditure increases. The state's share of employee medical coverage costs will be approximately $278 million in 2001, an increase of $45 million over 2000.[3]

While SEGIP faced multimillion dollar health increases this year, many school districts were seeking permission from local taxpayers to increase taxes to help make up for revenue shortfalls. The shortfalls were often caused by losses of state aid tied to declining enrollment, but were exacerbated in a number of cases by sharply rising employee health care benefits costs.[4]

The health care cost increases are due to a variety of factors including an aging workforce, new technology, higher utilization of medical care (especially prescription drugs), and consumer and health care provider backlash to managed care.[5] While the current rates of increase may abate somewhat next year from their current levels, they are nonetheless expected to remain at the double-digit level into the near future.[6]

What are the Health Care Cost Drivers?[7]

- **Prescription Drugs**
  - **Fastest growing segment of health care spending** – estimated increase of 15% to 25% last year. Now makes up 15 % to 20% of all health care expenditures
  - **Direct Consumer Advertising** – Pharmaceutical companies now market directly to the consumer, creating new demand. Patient approaches physician, instead of

physician making initial diagnosis.
  - **Quicker approval of new drugs by FDA**
  - **Aging Population** – increased use of drug therapy for chronic illness
  - **Increase in Cost, and Less Use, of Generic Drugs**

- **Consumer Demand for More Choice and Less Constraints.**
  - One reason costs are going up faster locally than nationally may be our comparatively long history with Managed Care. Consumers are growing tired of the barriers they perceive to be in place by health plans that prevent them from receiving health care. They want more choice in providers and less constraints in getting to care providers. Consumers are also more informed and demand more service. Higher utilization of health care services has resulted.

- **Technology** – new and advanced procedures

- **Aging Population** – use more health care services for chronic illness

- **Providers Less Willing/Able to Negotiate Lower Cost Contracts for health care services.**
  - Tight Labor Market
  - Increased Physician Compensation
  - Less Willing to Accept Risk
  - Consolidation of Providers

- **Catastrophic Care**
- **Transplants**

References

[1] Hewitt Associates, "Employers to Face Double Digit Health Care Cost Increase for Third Consecutive Year", October 23, 2000 (press release).

[2] Hewitt Associates, "Employers to Face Double Digit Health Care Cost Increase for Third Consecutive Year", October 23, 2000 (press release).

[3] Minnesota Department of Finance, November Forecast, November 2000.

[4] Aamot, G. "Schools ask voters for more". Associated Press. November 3, 2000.

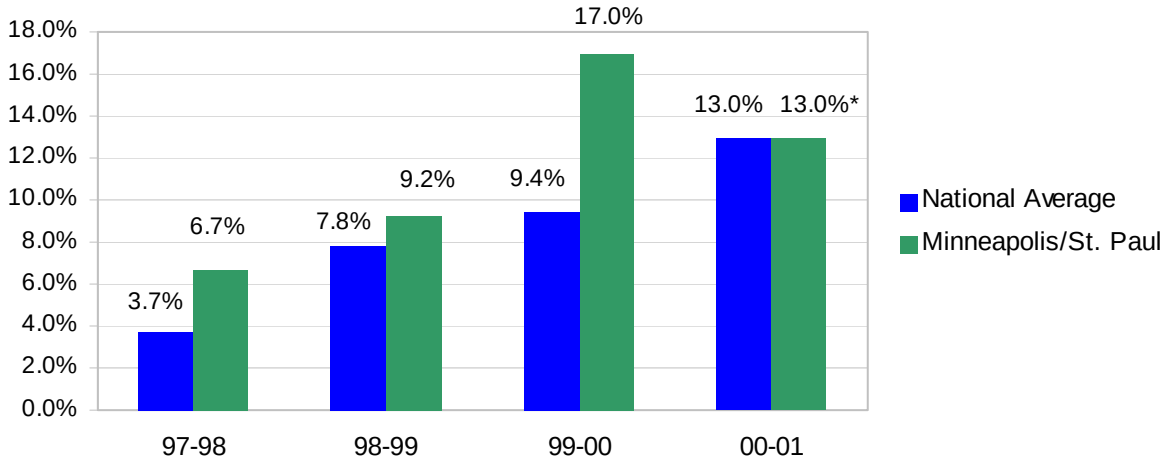
[5] Deloitte and Touche, Postretirement and Active Employee Health Care Task Force, July 24, 2000 (presentation to Task Force).

[6] Communication, Deloitte and Touche.

[7] Deloitte and Touche, Postretirement and Active Employee Health Care Task Force, July 24, 2000 (presentation to Task Force).

Hewitt

Annual Health Care Cost Increases
National Averages vs. Minneapolis/St. Paul Area

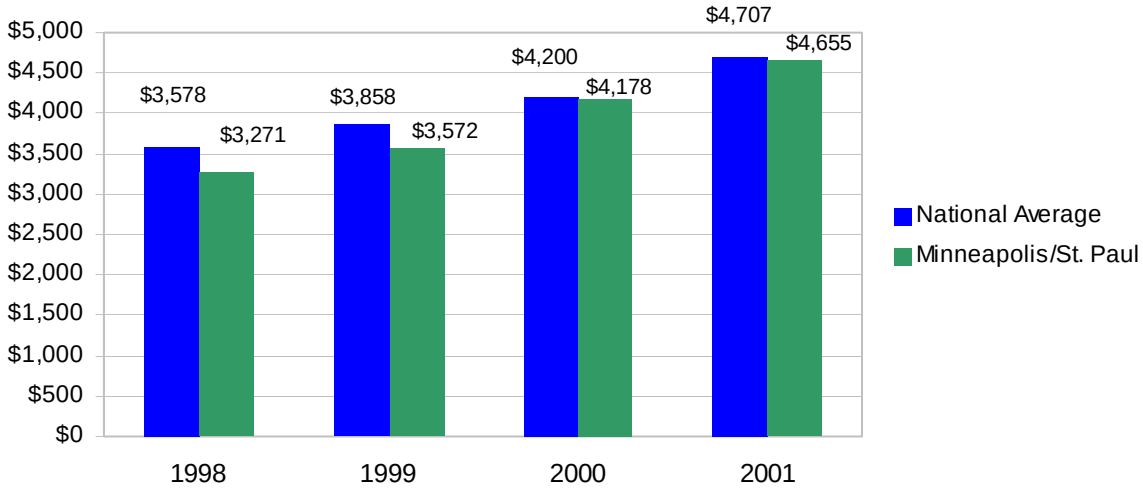


Source: Hewitt Health Value Initiative™

*With addition of Minneapolis/St. Paul area costs

*Projected

Annual Health Care Costs Per Employee
National Avearges vs. Minneapolis/St. Paul Area



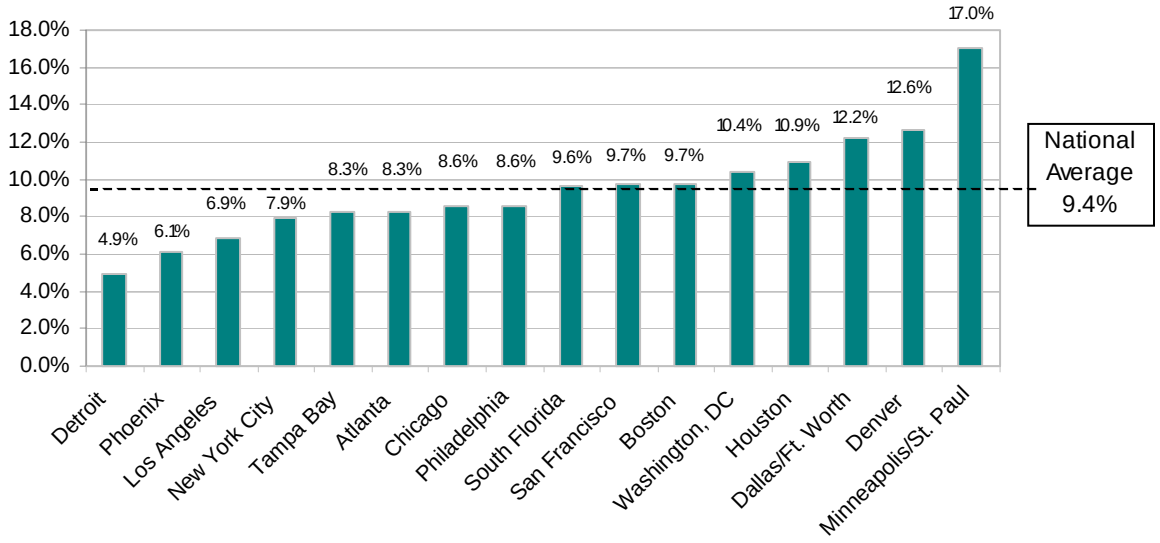
Source: Hewitt Health Value Initiative™

*With addition of Minneapolis/St. Paul area costs

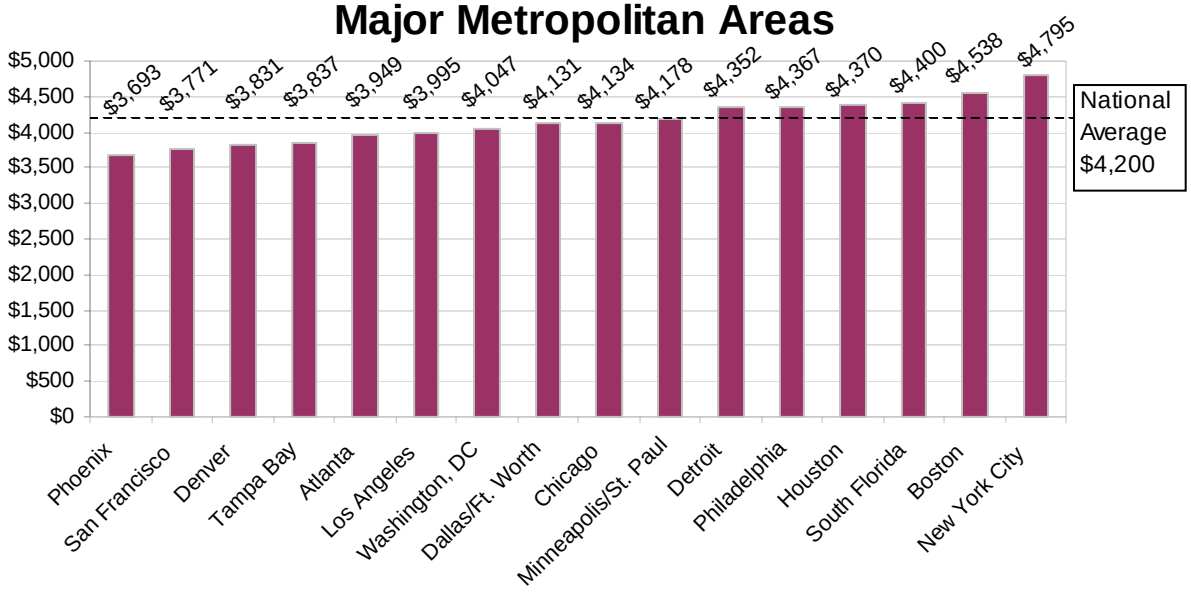
*Projected

Hewitt

2000 Health Care Cost Increases
Major Metropolitan Areas



2000 Health Care Costs Per Employee
Major Metropolitan Areas



Source: Hewitt Health Value Initiative™

Issue Brief

Illustrative Health Care Benefit Plan Arrangements

Among Selected Minnesota Public Sector Employers

The issue brief below was prepared for the Postretirement and Active Employee Health Care Task Force established under Chapter 461, Article Five, Minnesota Session Laws 2000. The Task Force met during the period June-November, 2000. Issue briefs were prepared to supplement the Task Force report with additional information and perspectives regarding issues of interest to the Task Force.

There are an estimated more than 3,200 units of government in Minnesota, ranging from State government, to counties, large and small cities, school districts, townships and other units, some with only a single employee. This large and diverse public sector has resulted in a wide range of health insurance offerings to public sector employees that vary by such factors as:

- benefits designs and levels of coverage;
- overall costs;
- cost trends over time;
- the levels of employer contributions toward the premium for employees, dependents, and retirees;
- levels of employee cost sharing at the point of service;
- and other features.

Some public sector employers offer comprehensive "first dollar" coverage with little or no cost sharing with the employee. Others have benefit plans with substantial cost sharing and significant deductibles, co-pays, and coinsurance. Some employers purchase managed care products that require the use of a specific network of providers, while others offer more traditional indemnity or broader access plans. In some cases, employers may offer some continuum of multiple choices across these two spectrums.

One of the biggest challenges facing the Task Force and the study staff was the lack of recent, comprehensive, comparable data on the wide variety of public sector employer health benefits arrangements, their costs, and changes over time. A number of annual surveys of health care benefits are conducted among the public sector jurisdictions, often as part of overall compensation surveys. However, they vary greatly in terms of their timing, detail, and comparability. For example, some provide information on overall costs, but little detail as to what benefits and coverage is being provided. Another extensive and otherwise detailed survey focused on descriptions of the highest cost health benefit options available, but lacked information about other options.

The Task Force did not undertake its own comprehensive survey of health benefits for public sector employees and retirees as it was beyond the scope of the study's available time and budget. In lieu of a more comprehensive study of this issue, a number of illustrative models were prepared to better portray the range of current public sector health benefit offerings and costs. Three sets of data are summarized below to help illustrate a representative cross section of current benefits arrangements, as follows:

1. Table 1 shows a cross section of the health benefits options available through different units of government from around the state. These units of government serve populations from 5,000 to over 100,000 persons. These public sector employers ranged in size from 65 full time employees to as large as 8,500 employees.

2. Table 2 summarizes health benefits

levels and costs for participating employer groups in a non-metro Minnesota area Service Cooperative, a type of health care purchasing pool established under Minnesota Statutes 123A.21 and available to units of local government. The Service Cooperative in this case reported data on health benefits available to school districts in the area.

3. Table 3 shows benefit plans available through the Public Employees Insurance Program (PEIP), another health care purchasing pool for local units of government, established under Minnesota Statutes 43.316. Table 3A shows representative costs for a variety of PEIP offerings for diverse employer types in the pool.

Table 1. Illustrative Examples of MN Public Sector Health Benefit Plan Arrangements From Around the State

The table below illustrates a range of health benefits offerings from a variety of public sector employers located across the state. Most of the offerings include some type of managed care features, ranging from traditional HMOs to the expanded network options of Point of Service (POS) plans to indemnity plans with some limited managed care features.

Premiums for the plans shown in the table vary greatly by benefits design, provider networks, and other characteristics. Costs for the selected examples below ranged from a low of $163 per month to a high of $392 per month for single coverage. Family coverage ranged from a low of $450 per month to a high of $897 per month. (It is not possible to compare these costs directly because of differences in benefit designs, provider networks, and other features.)

Table 1. Illustrative Examples of MN Public Sector Health Benefit Plan Arrangements

Region	*Population of Locality*	*# Employee*	*Type of Plan*	*Deduct.*	*RX Co-pay*	*Single & Family Premium*	*Employer Share*	*Early Retiree Contribution*	*+ 65 Retiree Contribution*
Metro	+ 100,000	8,500	3 POS plans	1 $300/600	$11 & $26	S $229 - 271 F $590 - 699	S $229 - 271 F $396 - 470	None	None
NE	5,000 - 10,000	115	POS	Varies By BU	$7.50	S $301 F $704	S $271 F $634	90% pdemployer	90% pd employer
NW	5,000 - 10,000	* Full 65 Part 210	Indemnity	$250/500	$10	S $265 - 290 F $609 - 665	S $250 F $250	None	None
Regional Center NW	25,000 - 50,000	210	2 HMOs	1 with 1 w/0	$11	S $163 F $549	S $163 F $284	None	None
NW	5,000 - 10,000	67	3 POS plans	$100 $250 $500	$5.50 to $12	S $293 F $840	S $293 F $472	None	None
Regional Center NE	50,000 - 100,000	977	4 plans 80/20 HMO	$100	$3 to $12	S $330 - 342 F $680 - 897	S 100% F $450 -565	Yes	Unused sick leave converted to pay for premium
SW	10,000 - 25,000	86	POS	$100	$5.50	S $286 F $859	S $286 F $759	Premium paid to Age 65	None
Central	50,000 - 100,000	504	POS	$300	$11	S $331 F $690	S $321 F $ 321	None	None
Central W	5,000 - 10,000	71	80/20 POS	$100 $300	$5.50 - $15.50	S $ 165 F $ 450	S $ 132 F $ 360	Employer Pays 50% 5 years	None
North	10,000 - 25,000	273	POS	Varies	$5.50 - $15.50	S $392 F $855	S $357 F $738	Yes	Yes

Table 2. MN Service Cooperative School District Benefit and Cost Comparison

Table 2 below illustrates health benefit plans available to a number of non-metro school districts in Minnesota through a Service Cooperative. Premiums vary from $155.47 to $266.55 per month for single coverage, depending on plan design and group medical claims experience, with family coverage rates from $422.31 to $697.93 per month. Managed care is present is some form in all plans and the prescription drug benefit is 100% after a $12 co-pay for formulary drugs.

Groups pay at different rates, depending on claims history. Groups with the best claims utilization over a three year average are in "tier one", while those with less favorable claims experience are in "tier two". Currently, the rates for tier one are about eight percent below those of tier two. Each group's location by tier is reviewed annually at renewal. Single premium rates in the table below are labeled with "S", and family rates are labeled with an "F".

Table 2. Health Insurance Rates and Benefits, Minnesota Service Coop July 1, 2000 to June 30, 2000

Tier 1: 12 ISD's, 1178 employees	S: $245.52 F: $642.87	S: $210.36 F: $560.68	S: $177.20 F: $481.36	S: $155.47 F: $422.31
Tier 2: 23 ISDs, 2231 employees	S: $266.55 F: $697.93	S: $228.37 F: $608.73	S: $192.37 F: $522.62	S: $168.77 F: $458.53
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
	Basic Plan Plus	**Comprehensive Major Medical**	**Comprehensive Major Medical**	**Comprehensive Major Medical**
Service	**Major Medical**	**$300 Deductible Plan**	**$500 Deductible Plan**	**$1,000 Deductible Plan**
Lifetime Max	NA	$2,000,000.00	$2,000,000.00	$2,000,000.00
Deductible	NA	$300 Individual - $600 Family	$500 Individual - $1,000 Family	$1,000 Individual - $2,000 Family
Co-Insurance	NA	80/20% to out-of-pocket maximum; 100% thereafter.	80/20% to out-of-pocket maximum; 100% thereafter.	80/20% to out-of-pocket maximum; 100% thereafter.
Out-of-Pocket Max	NA	$600 Individual - $1,200 Family	$1,500 Individual -$3,000 Family	$3,000 Individual - $6,000 Family
Preventative/ Routine Care	No coverage except prenatal visits and well-baby care to age 6; 100% coverage. Cancer screening subject to deductible and coinsurance.	No coverage except prenatal visits and well-baby care to age 6; 100% coverage. Cancer screening is subject to deductible and coinsurance.	No coverage except prenatal visits and well-baby care to age 6; 100% coverage. Cancer screening is subject to deductible and coinsurance.	No coverage except prenatal visits and well-baby care to age 6; 100% coverage. Cancer screening is subject to deductible and coinsurance.
Physician Services (surgery, anesthesia, obstetrics, in-hospital, medical care)	100% of Usual & Customary (U & C) charges	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.

Office Visits	Subject to deductible and coinsurance	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Inpatient hospital services	100% of U & C for 365 days	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Outpatient hospital services	100% of U & C	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Chiropractic services and P T	Subject to deductible and coinsurance. Nonpar providers - 15 services per yr.	Subject to deductible and coinsurance. Nonpar Providers - 15 services per yr.	Subject to deductible and coinsurance. Nonpar providers - 15 services per yr.	Subject to deductible and coinsurance. Nonpar providers - 15 services per yr.
Diagnostic **Lab and X-ray**	Inpatient: 100% of U & C Outpatient: First $200 covered in full. Remainder subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Prescription Drugs	Formulary only, $12 co-pay	Formulary only, $12 co-pay	Formulary only, $12 co-pay	Formulary only, $12 co-pay
Inpatient mental health care and chemical dependency treatment	100% coverage. No coverage when using a nonparticipating provider	Subject to deductible and coinsurance. No coverage for nonpar provider.	Subject to deductible and coinsurance. No coverage when for nonpar provider.	Subject to deductible and coinsurance. No coverage for nonpar provider.
Outpatient mental health care and chemical dependency treatment	Subject to deductible and coinsurance. No coverage for nonpar provider.	Subject to deductible and coinsurance. No coverage for nonpar provider.	Subject to deductible and coinsurance. No coverage for nonpar provider.	Subject to deductible and coinsurance. No coverage for nonpar provider.
Supplemental Major Medical				
Deductible	$100 Individual $300 Family aggregate	NA	NA	NA
Coinsurance	80/20 to out-of-pocket maximum; then 100%	NA	NA	NA
Out-of-pocket maximum	$600 Individual $1,200 Family	NA	NA	NA
Lifetime maximum	$2,000,000	$2,000,000	$2,000,000	$2,000,000

Tables 3 and 3A: Public Employee Insurance Program (PEIP) Benefit Comparison and Illustrative Costs

The last tables illustrate the health plan coverage choices available through the Minnesota Public Employee Insurance Plan (PEIP). PEIP plans are available throughout Minnesota to all local public jurisdictions. School districts, cities, counties, and other eligible local units of government of varying sizes currently purchase their benefits through this plan.

The PEIP offers four managed care products that vary by individual cost sharing levels. Each of the four managed care offerings also has a Point of Service Option for out of network (OON) access. PEIP also offers three major medical plans that vary by levels of out of pocket cost sharing. PEIP offers a choice of health plan options (benefits sets are standard across the health plans). Each health plan operates in a distinct, but often overlapping, geographic service area. As a result, employees in PEIP may have a choice of more than one health plan, depending on where they work and the service area boundaries of the health plans.

Premiums vary by plan design and characteristics of the group, and are shown for a selected sample of groups in Table 3A. For the illustrative sample of PEIP groups, premiums range from $211 to $299 per month for single coverage, and from $558 to $819 per month for family coverage. Depending on the product selected and the characteristics of the employer group, PEIP rates in general range from $147 per month for single coverage, to $819 per month for family coverage. Some of the individual employer examples in Table 3a show a range of premium rates for single and family coverage for a particular benefits design. The range of premium rates indicates that employees have a choice of health plans, and that different rates are charged for different health plans. (Benefits designs are standard across the health plans, but other factors, particularly provider networks, may vary by health plan.)

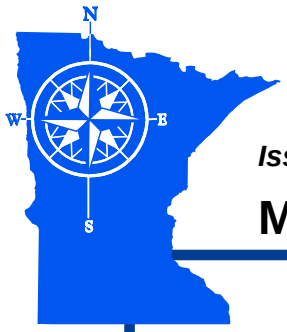
Table 3. Public Employee Insurance Program (PEIP) Benefit Designs

	A	A + OON	B	B+ OON	C	C + OON	D	D + OON	MMP 1	MMP 2	MMP 3
	Mgd Care: $0 co-pay, 100% hosp.	A for in-network; Limits below for OON	Mgd Care: $10 co-pay, 100% hosp.	B for in-network; Limits below for OON	Mgd Care: $10 co-pay, 90% hosp.	C for in-network; Limits below for OON	Mgd Care: $10 co-pay, 80% hosp.	D for in-network; Limits below for OON	Major Medical Plan $100/$200	Major Medical Plan $250/$500	Major Medical Plan $500/$1,000
Deductible	None	$300/$600	None	$300/$600	None	$300/$600	None	$300/$600	$100/$200	$250/$500	$500/$1,000
Preventive Care	100% coverage	80% after deductible	100% coverage	80% after deductible	100% coverage	70% after deductible	100% coverage	60% after deductible	See note	See note	See note
Physician Services Office Visit Urgent Care Surgery/Delivery	 No co-pay No co-pay 100%	 80% after deductible	 $10 co-pay $10 co-pay 100%	 80% after deductible	 $10 co-pay $10 co-pay 90 %	 70% after deductible	 $10 co-pay $10 co-pay 80 %	 60% after deductible	 80% after deductible	 80% after deductible	 80% after deductible
Hospital Services Inpatient/Outpatient	100%	80% after deductible (Inpt. ltd. to 120 days)	100%	80% after deductible (Inpt. ltd. to 120 days)	90%	70% after deductible (Inpt. ltd. to 120 days)	80%	60% after deductible (Inpt. ltd. to 120 days)	80% after deductible (must precertify)	80% after deductible (must precertify)	80% after deductible (must precertify)
Prescription Drugs	$10 co-pay	80% after deductible	$10 co-pay	80% after deductible	$10 co-pay	70% after deductible	$10 co-pay	60% after deductible	$10 co-pay (some are 80%)	$10 co-pay (some are 80%)	$10 co-pay (some are 80%)
Mental Health Inpatient Outpatient	 100% No co-pay	 80% after deductible (Inpt. ltd. to 120 days)	 100% $10 co-pay	 80% after deductible (Inpt. ltd. to 120 days)	 90% $10 co-pay	 70% after deductible (Inpt. ltd. to 120 days)	 80% $10 co-pay	 60% after deductible (Inpt. ltd. to 120 days)	 80% after deductible (must precertify)	 80% after deductible (must precertify)	 80% after deductible (must precertify)
Chemical Dependency Inpatient Outpatient	 100% No co-pay	 80% after deductible (Inpt. ltd. to 120 days)	 100% $10 co-pay	 80% after deductible (Inpt. ltd. to 120 days)	 100% $10 co-pay	 70% after deductible (Inpt. ltd. to 120 days)	 100% $10 co-pay	 70% after deductible (Inpt. ltd. to 120 days)	 80% after deductible (must precertify)	 80% after deductible (must precertify)	 80% after deductible (must precertify)
Emergency Room At Plan Hospital Out-of-Area	$40 co-pay (waived if admitted) 80% of first 2500, then 100%	N/A 80% of first 2500, then 100%	$40 co-pay (waived if admitted) 80% of first 2500, then 100%	N/A 80% of first 2500, then 100%	$40 co-pay (waived if admitted) 80% of first 2500, then 100%	N/A 70% of first 2500, then 100%	$40 co-pay (waived if admitted) 80% of first 2500, then 100%	N/A 60% of first 2500, then 100%	80% after deductible	80% after deductible	80% after deductible
OOP Maximum	Single: 1000 Family: 2000	Single: $3000 Family $6000	Single: 1000 Family: 2000	Single: $3000 Family $6000	Single: 1000 Family: 2000	Single: $3000 Family $6000	Single: 1000 Family: 2000	Single: $3000 Family $6000	Single: $600 Family: $1200	Single: $1250 Family: $2500	Single: $3000 Family: $6000
Lifetime max	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	$2M per person	$2M per person	$2M per person

Table 3A. Single/Family PEIP Rates for a Sample of Selected Groups From Around the State

(Employers may select among several PEIP plan design options. Depending on market conditions, more than one network/carrier may be available. If more than one carrier is available, the cells below will show a range of premiums for a given plan design. The premium for each employer will be somewhat different, based on the group's size and experience. Rates for singles appear to the left of the slash mark; family rates are below the slash mark.)

	A	**A + OON**	**B**	**B+ OON**	**C**	**C + OON**	**D**	**D + OON**	**MMP 1**	**MMP 2**	**MMP 3**
PEIP group	Mgd Care: 0 co-pay, 100% hosp.	A for in-network; Limits below for OON	Mgd Care: $10 co-pay, 100% hosp.	B for in-network; Limits below for OON	Mgd Care: $10 co-pay, 90% hosp.	C for in-network; Limits below for OON	Mgd Care: $10 co-pay, 80% hosp.	D for in-network; Limits below for OON	Major Medical Plan $100/$200	Major Medical Plan $250/$500	Major Medical Plan $500/$1000
1 (size: < 50 ee's)							$220-$229/ $581-$605			$211/$558	
2 (size: > 50 ee's)					$291-$303/ $766-797		$280-$292/ $736 -$767				
3 (size: < 50 ee's)					$281-293/ $740-$770		$268-$279/ $705-$733				
4 (size: > 50 ee's)			$258-273/ $619-$661								
5 (size: > 50 ee's)				$276 -$287 $613-$638							
6 (size < 50 ee's)			$287-$310/ $709-$797								
7 (size > 50 ee's)					$299 - $311/ $787 - $819		$277-$288/ $728 -$757				



Issue Brief

Medicare Reimbursement Disparity

The issue brief below was prepared for the Postretirement and Active Employee Health Care Task Force established under Chapter 461, Article Five, Minnesota Session Laws 2000. The Task Force met during the period June-November, 2000. Issue briefs were prepared to supplement the Task Force report with additional information and perspectives regarding issues of interest to the Task Force.

(Sources: Substantial portions of this brief are drawn from the Minnesota Senior Federation web site at www.mnseniors.org, and U.S. Government web sites for Medicare at www.medicare.gov and the Health Care Financing Administration (HCFA) at www.hcfa.gov.)

Nearly every American who earns a paycheck pays the federal Medicare payroll tax, and every Medicare beneficiary who enrolls in Medicare Part B pays the same monthly Medicare Part B premium of $45.50. However, what Medicare beneficiaries receive varies dramatically depending on what part of the country they live in. In parts of Florida, New York, California, Michigan, and Arizona seniors enrolled in HMOs get prescription drugs, dental, vision, and hearing services free of an additional premiums. At the same time seniors in Minnesota, Wisconsin, and Oregon (among others) pay large HMO premiums to get similar benefits.

This happens because of the Medicare funding formula. Originally established based on the cost of health care in the various states, the formula penalizes states that have been successful at medical cost containment, like Minnesota. When Medicare entered into managed care contracts with insurers they established monthly reimbursement rates to the carriers in each state who would provide health care for seniors for an established monthly amount. These are termed Medicare Risk Products. Medicare refers to them as Medicare+Choice products. Senior citizens essentially “turn over” their Medicare to the insurer and receive all their care through the heath plan and must abide by the managed care rules of the plan. They no longer have stand-alone Medicare health coverage. The insurers provide all health care for seniors in the Medicare+Choice plan for the flat monthly reimbursement rate provided by Medicare for each state. Thus the insurers are at risk to cover all costs. The benefit levels in these plans are much higher than traditional Medicare supplemental plans.

The problem arises when the reimbursement rate in a state is too low to cover the cost of providing health care. In 2000 Medicare insurers in Hennepin County, Minnesota, received $458 per beneficiary per month, while an HMO in Florida received $795 per beneficiary per month, almost twice as much. The cost of delivering health care across the country is estimated to vary 15 percent, but the reimbursement by Medicare to physicians, hospitals and HMO’s varies 211 percent.

Medicare has created a two-tier health care system based simply on where one lives. In counties in states that have high Medicare reimbursement rates Medicare recipients have access to coverage at no additional cost that is unavailable to other areas of the country. Beneficiaries living in high-cost reimbursed areas have health plans that cover prescription drugs, eyeglasses, hearing aids, and even health club memberships at no extra cost above their monthly Medicare premium of $45.50.

This is particularly important given the current debate about prescription drug coverage for seniors. Seniors in Minnesota without access to a Medicare + Choice product could pay thousands of dollars a year in drug costs, but if they lived in Florida they would have free prescription drugs if they belonged to a Medicare + Choice HMO.

Health insurers in Minnesota have struggled with the unequal Medicare reimbursement for a number of years. A policy passed as part of the 1997 Balanced Budget Amendment, called “blended rates,” was supposed to address part of the Medicare inequity. Under the “blend” formula Medicare reimbursement rates in low-reimbursed counties (all of Minnesota) should have been “blended” upwards toward average Medicare reimbursement rates in the country by restraining reimbursement increases in high- reimbursement communities. However, blended rates were not funded in 1999 and the Health Care Finance Administration (HCFA) is proposing that current minimum rate increases of 2 percent in urban areas and 3.3 percent for rural areas not be funded this year (partially because of the federal budget cap limitation.) With annual health care inflation at over 7% and prescription drug costs up 200% in some cases, the result is even more disparity in Medicare reimbursement.

Because of this disparity in Medicare funding many managed care plans have dropped their Medicare+Choice plans in areas where reimbursement does not cover the cost of providing care at the higher level. The insurers have gone back to offering traditional Medigap or Medicare Supplement plans. Approximately 934,000 Medicare beneficiaries across the country will lose their coverage when managed care plans leave the Medicare+Choice program in 2001. 15,000 seniors alone in Minnesota will lose their coverage when Medica withdraws from the program. These seniors will be offered the option to join another program, but at lower benefit levels offered in the supplemental plans.

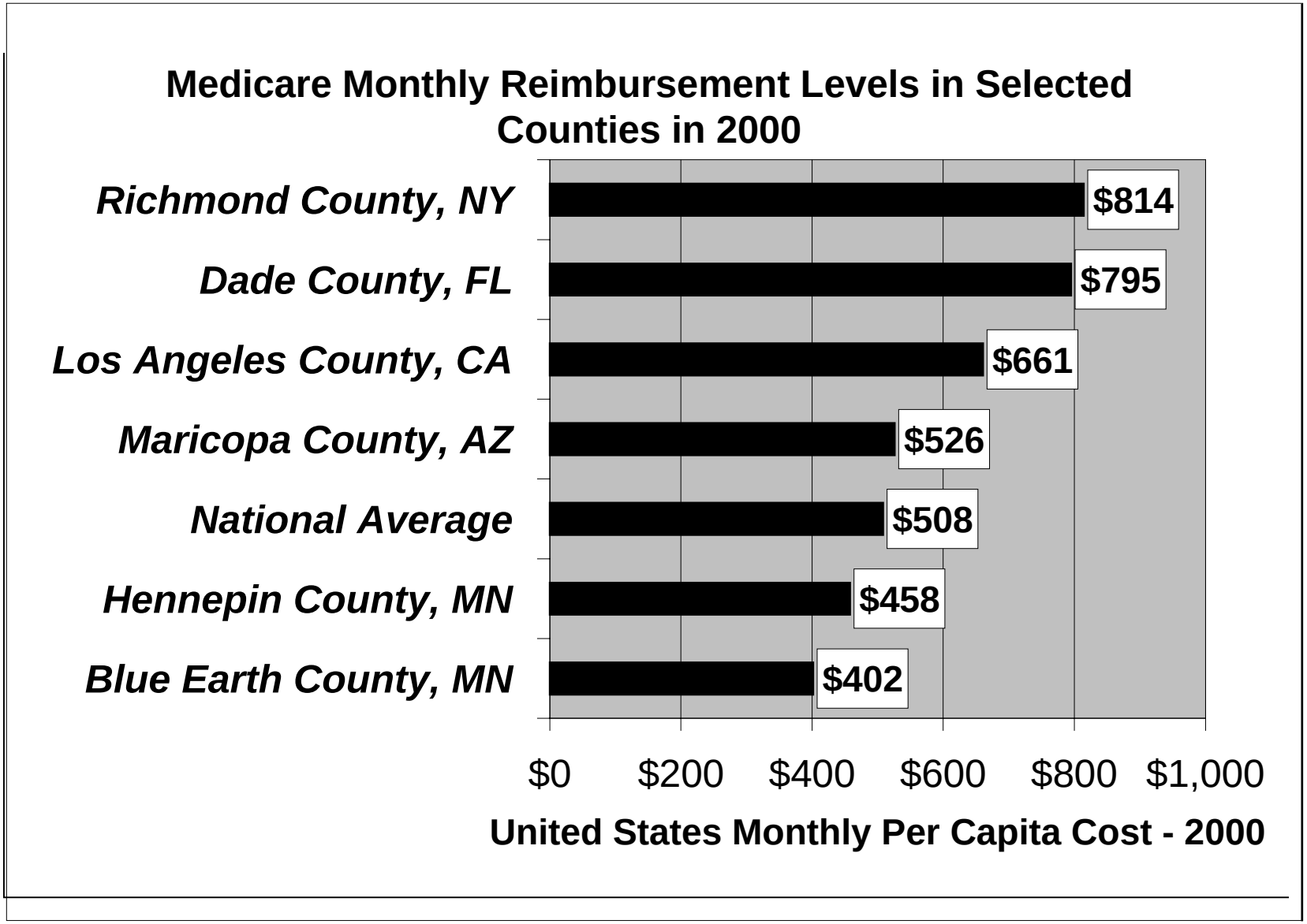
Legislation is working its way through Congress at this time that would help address this disparity issue. The legislation would raise the minimum monthly reimbursement from $401 to $525, improve fee-for service reimbursements, and lift the budget neutrality provisions of the 1997 Balanced Budget Amendment. All of these would encourage some health plans to re-enter the Medicare+Choice market. The fate of the legislation is unknown at this time. (November 2000).

EXAMPLES OF UNEQUAL MEDCIARE FUNDED BENEFITS IN MEDICARE "C" PRODUCTS*

Gross Revenue/Premium *(Per month)*	**Dakota County, MN** HealthPartners Partners for Seniors - Standard Option	**Dakota County, MN** HealthPartners Partners for Seniors High Option	**Maricopa County, AZ** PacifiCare of AZ, Inc. Plus Plan 2000	**Dade County, FL** Blue Cross Blue Shield Medicare and More
Medicare Payment to HMO**	**$438.75**	**$438.75**	**$526.09**	**$794.02**
Per-Person Premium to HMO	**$ 94.75**	**$270.00**	**$ 20.00**	**$ 0.00**
Total Monthly Gross Premium	**$533.50**	**$708.75**	**$546.09**	**$794.02**
Benefits (summary):				
Physician Services	$10 per visit co-pay	$10 per visit co-pay	$5 per visit co-pay	No co-pays
Specialist Doctor	$10 per visit co-pay	$10 per visit co-pay	$5 per visit co-pay	No co-pays
Hospital Services	covered	covered	covered	covered
Out-Patient Prescription Drugs:				
Formulary Generic co-pay	No coverage	80% coverage	$7 co-pay	No co-pays
Generic Annual Limit	NA	unlimited	unlimited	unlimited
Formulary Brand Name co-pay	No coverage	80% coverage	$15 co-pay	No co-pays
Brand Annual Limit	NA	unlimited	$2,500	unlimited
Preventive **Dental Coverage**	2 dental exams annually $10 co-pay per exam	2 dental exams annually $10 co-pay per exam	2 dental exams annually $20 co-pay per exam	unlimited coverage $5 co-pay per exam
Hearing Exams	Covered- $15 co-pay	Covered- $15 co-pay	Covered- $25 co-pay	Covered- no co-pay
Hearing Aids	50% coverage	50% coverage	$100 allowance	2 hearing aids per 3 years
Routine **Eye Examinations**	Some coverage	Some coverage	Covered- $5 co-pays	Covered no co-pay
Eye Glasses & Contacts	20% discount	20% discount	$120 allowance	covered
Transportation	No coverage	No coverage	24 one-way trips- $5 per trip to doctor or health club	Ambulance rides- - no co-pay
Health Club Membership	No coverage	No coverage	Covered- no co-pay	No Coverage

- *** This is a brief comparison summary-** See The Senior Federation's **2000 Health Care Choices for Minnesota Seniors** or specific plans for details and limitations for Minnesota Plans. For other state comparisons see Medicare's web site: www.medicare.gov
- **** Includes Part "B" premium of $45.50 per month in 2000**

Source: HCFA Medicare Compare Plan Specifics 2000 data & information provided by specific health plans.



Source: Minnesota Senior Federation Website at www.mnseniors.org

Issue Brief

Addressing Health Care Costs Through Prevention and Health Promotion

The issue brief below was prepared for the Postretirement and Active Employee Health Care Task Force established under Chapter 461, Article Five, Minnesota Session Laws 2000. The Task Force met during the period June-November, 2000. Issue briefs were prepared to supplement the Task Force report with additional information and perspectives regarding issues of interest to the Task Force.

The rising cost of health care is again a major issue of concern for employers in Minnesota. After seeing a slowing of health care cost inflation in the mid 1990's, double digit inflation has become the norm for employers around the state. A recent study by Hewitt Associates reported that health care costs in the Minneapolis- St. Paul area rose 17% in 2000 from 1999, leading the nation in the rate of increase.[1]

There are many reactions to this problem and suggestions to address it. Some employers are considering reducing benefit plan levels for employees, instituting higher, and more co-pays for medical services within plans, and raising the employee contribution to health care premiums.

However, these strategies typically do not account for the fact that the majority of health care spending is due to illnesses, injuries, or conditions that are largely preventable, or if caught at earlier, more treatable stages, would be much less expensive. Medical interventions, no matter how state-of-the-art or sophisticated, often have far less influence on health status and health outcomes than personal behaviors and lifestyle. As a result, interest is also growing in health promotion and prevention to promote better health outcomes, improve productivity, and potentially address rising health care costs.

Advocates of health promotion programs believe it makes sense for employers to institute these types of programs because they can reach employees at the worksite, where approximately 110 million men and women spend a major portion of their day.[2] This provides a convenient place to educate employees, and has been found to be particularly effective in reaching people at high risk by providing peer support needed to start and maintain a healthy lifestyle.[3] Studies have shown significant positive rates of return on employment-based investments in prevention health promotion, and several illustrative examples of such findings are included at the end of this issue brief. In addition, health promotion and prevention is often viewed as an important method of improving broader community health outcomes, irrespective of whether it also provides additional cost savings.

While a number of studies suggest the potential positive return on investment for health promotion and prevention efforts, they cannot guarantee success, and other research findings are more equivocal. Many employers and employees may feel that the return on investment for investing in health promotion may occur too far into the future, or be too limited, to be of value. In addition, a significant share of health care costs are due to a relatively small percent of persons with complex, chronic health care conditions that are often the most difficult to prevent or manage. Employees may also be concerned that health promotion or prevention efforts will

"blame the victim" and may perceive the efforts as punitive. Many employers would also argue that much of what is included in prevention and health promotion programs produces no cost savings at all. The programs may be helpful to employees and even save lives, but not save money.

Other more traditional health care cost containment techniques still are often aimed at "after the fact" health care interventions, and do not address the root causes of ill-health. As the population ages, and the costly impact of greater health care utilization becomes even more pronounced, the interest in broader applications of health promotion and prevention may likely increase.

Examples of the potential impact of prevention and health promotion

- **HealthPartners Research**[4]

Researchers from HealthPartners, Inc. found that health risks such as physical inactivity, obesity and tobacco use are significantly related to increased health care charges within just 18 months:

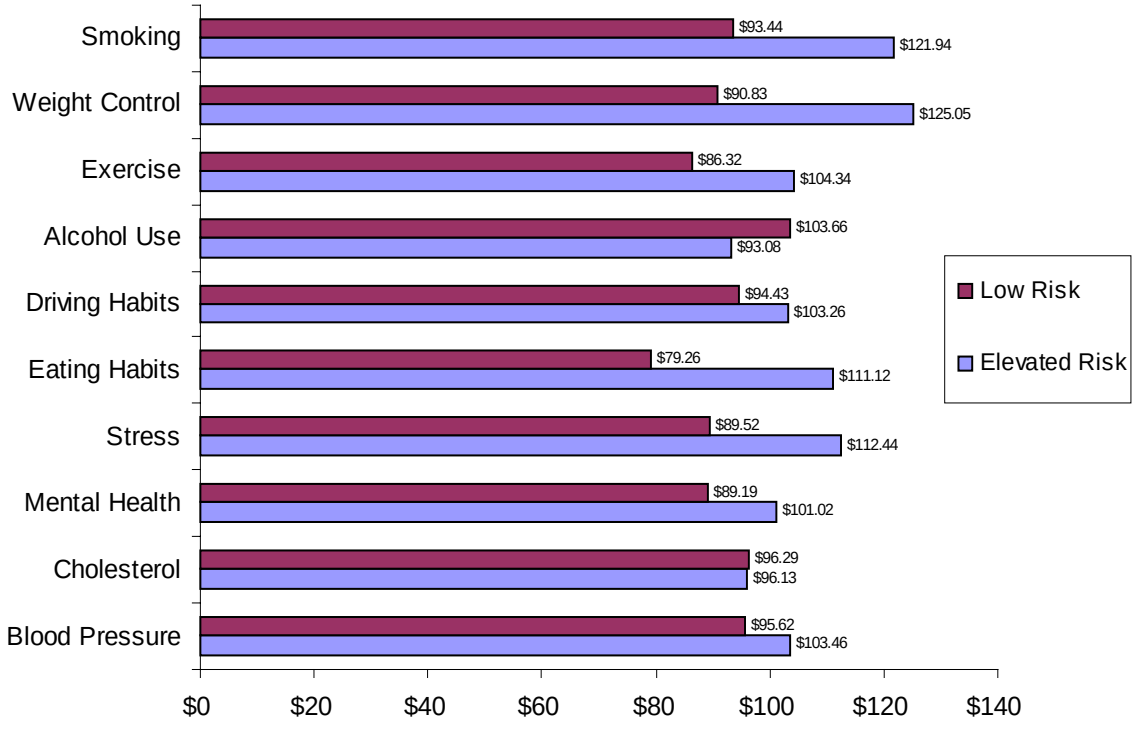
- Physically active employees (one day per week) account for *4.7 % less* health care costs than those who are sedentary.
- Employees who smoke have health care charges *18% higher* than nonsmokers.
- Employees who are deemed to have *high risk* behaviors account for *49% more* in health care costs than those with *low risk*.

(Examples of *low risk* behaviors include: normal weight, not smoking, engaging in physical activity 3 times per week. While *high risk* behaviors include border-line obesity, smoking, and no physical activity.)

- **Chrysler Corporation**

A study by Milliman & Robertson, Inc. of Chrysler Corporation employees documented lower medical claims associated with low risk behaviors.[5]

Note: The lower cost attributed to elevated risk of alcohol is presumed to be caused by those employees with alcohol use problems avoiding the health care system to avoid detection. While costs in this chart associated with a cholesterol risk factor appear approximately equal, it can be difficult to make assumptions on a single risk factor. However those with elevated cholesterol levels who smoke and don't exercise are shown to be at significantly higher risk for increased medical claim costs.



Worksite Health Promotion Examples [6]

- **General Electric**

  In only an 18 month period, health care costs for employees who participated in a fitness program were reduced by 38 percent, saving $184 annually per member. Conversely, health care costs rose 21 percent for those employees not participating.

- **Steelcase Industries**

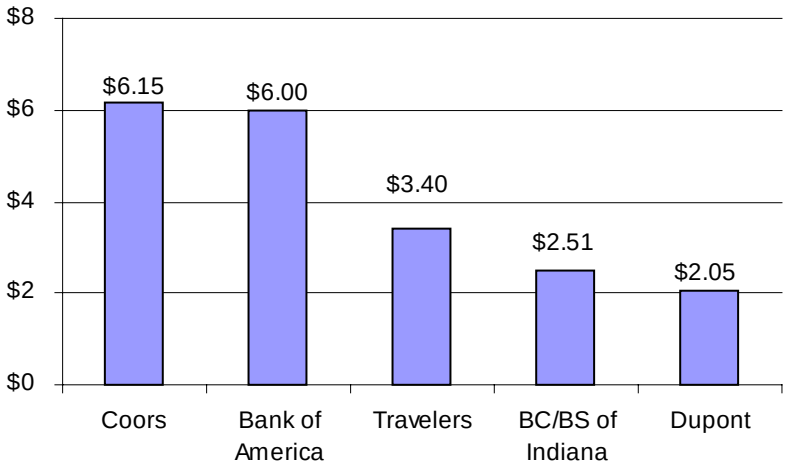
  In a study correlating health risk and lifestyle assessments with medical costs, employees who shifted from high risk assessment to low risk saw much lower medical claim costs in just a three year period. While claim costs remained about the same for low risk individuals, those who moved from the low risk category to high risk had claims increase almost 250%. Employees in the high risk category incurred 75 percent more medical claims cost than low risk individuals.

- **Sunbeam/Oster Company**

  Maternity-related health care costs were reduced from $27,000 to $3,500 *per case* for pregnant employees participating in a wellness program. The cost to implement the program was $13,000 and 129 healthy babies were delivered.

Other organizations have found health promotion programs to be of value to their fiscal health.

Health Promotion Programs Return on Investment per $1 invested [7]



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[1] Hewitt Associates, "Employers to Face Double Digit Health Care Cost Increase for Third Consecutive Year", October 23, 2000 (press release).
[2] Association for Worksite Health Promotion brochure, (Sources: William M. Mercer, Inc, and HealthPartners).
[3] Association for Worksite Health Promotion brochure, (Sources: William M. Mercer, Inc, and HealthPartners).
[4]Pronk N, Goodman M, O'Connor P, Martinson B. "Relationship Between Modifiable Health Risks and Short-term Health Care Charges". Journal of the American Medical Association. 1999;282:2235-2239.
[5] "Health Risks and Their Impact on Medical Costs," A study by Milliman & Robertson, Inc., Staywell Health Management Systems, Inc. in conjunction with the Chrysler Corporation and the International Union of Auto Workers, UAW, 1995.
[6] Association for Worksite Health Promotion brochure.
[7] Association for Worksite Health Promotion brochure, (Source: Pelletier, K.R. American Journal of Health Promotion, 1993, 8(1): 50-62.

Issue Brief

Report of the Statewide Health Insurance Task Force for Public Employees (February 1987)

Source: Minnesota Department of Employee Relations, *Report of the Statewide Health Insurance Task Force for Public Employees*, February, 1987

The Department of Employee Relations convened a task force in 1986 to study the feasibility of establishing a statewide health insurance program for public employees of local jurisdictions. Interest was expressed by the legislature in exploring the option of securing better health insurance coverage by possibly joining together in larger pooling arrangements. The task force was to examine the current state of health insurance for local jurisdictions, explore options for a statewide plan or plans, and analyze future costs, benefits and how the plans might be administered.

Report Highlights (data for 1986)

- Number of local government employees: 183,000, in 1600 jurisdictions (cities, counties, school districts, townships, and other), about 30% of whom were part-time

  Local Government Employees, full and part-time:

- Counties	34,620
- Cities	41,191
- Townships	10,605
- School Districts	85,550
- Other	11,319
Total	*183,285*

- Number of employees in the State of Minnesota Group Insurance Program: 50,000 State Employees and 7,500 retirees

- "Gaps" (problems) found in 1986:
  - Retiree Health Coverage
    - Non-Medicare eligible
    - Cost
    - Out of area coverage
    - Prefunding of benefits
  - Lack of health coverage
    - 17% of local government employers did not offer health coverage
    - Retirees were not enrolled in plans offered by local units of government
  - Level of coverage
    - Some high deductibles
  - Lack of leverage on providers
    - Purchasing power
    - Provider choice
    - Stability (rates, provider continuity)
  - Bid law issues (subsequently addressed)
  - Lack of expertise

- **Options Considered**
  Three options were presented as a means of dealing with the problems above:

1. *No change, each jurisdiction provides health insurance on its own or in existing pools.*

   - Pro: The advantages seen in making no changes included retaining autonomy and accountability, no additional billing and enrollment mechanism, flexibility is plan design and eligibility, and labor and management can negotiate plan features.

   - Con: Disadvantages included less bargaining power with providers and carriers and less potential flexibility in plan design.

2. *Fill in the gaps or fix problem areas —*
   - *Proposed changes regarding bid law and ability to modify retiree (a number of the proposed changes were enacted)*
   - *Other alternatives included: mandate coverage for all active public employees and retirees, prefund retiree health insurance premiums, and create a Statewide Medicare Retiree Plan for Public Employees.*

     - Pro: Advantages included: all public employees would having health coverage; better coverage at lower cost; provide greater access to health care for retirees; raises retiree incomes; eliminates a potentially large unfunded liability for employees and employers; and provide cushion for future potential medicare reductions.

     - Con: Disadvantages included: the potential for reduction in public employment; possible reduction in take home pay to cover premiums; adding retirees could affect premium for all employees; possible less flexibility in plan design; and difficulty in accurately prefunding health insurance costs.

   - *The third option was to establish a statewide insurance plan for local governments.*

     - Pro: Advantages noted included greater negotiating power with carriers, retirees retaining coverage, benefit levels rising for some groups, foster competition with existing pooling arrangements, and greater choice in health plans for employees.

     - Con: Many disadvantages were noted, among them no guarantee of lower premiums, loss of local control, need to maintain master eligibility and billing system, and the unknown affect on current members rate.

➢ **Final recommendations:**

"The task force identified the need for reform of the local government insurance bid law. The task force did not reach consensus on a statewide insurance plan for local government."

Correspondence from Task Force members

- League of Minnesota Cities
- Education Minnesota
- Minnesota Service Cooperatives
- Minnesota School Boards Association
- Russ Stanton, Inter Faculty Organization
- Lois McCarron, Association of Minnesota Counties

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Comments on the proposal for a mandatory statewide health benefit plan for state and local government employees

One of the issues facing this Task Force was whether to recommend creation of a mandatory statewide health benefit plan for state and local government employees. While there was not consensus among the Task Force participants on this issue, some participants strongly support the idea. Because it will likely continue to be an issue for the Legislature, we feel it will be useful to include in the Task Force report this explanation of the League of Minnesota Cities' position on this issue.

Moving to a mandatory statewide health plan for all state and local government employees would mean major changes for public employees and employers. Costs would increase for some public entities and their employees and would decrease for others. Some public employees might see improved benefits compared to what they presently have; others could see reductions in benefits. Before making this kind of radical change, we must have a very clear idea of what the benefits are that this change would be expected to bring, and a clear explanation of exactly how a mandatory statewide plan would be expected to produce those benefits. That case has not yet been made.

For the reasons outlined below, there seems little reason to expect that a mandatory statewide government plan would reduce total costs appreciably, or that a statewide group would be more "stable". Nor is it clear what other advantages it would offer to cities or to city employees, or to other governmental employers and employees.

Could a statewide plan appreciably reduce the total cost of health coverage for governmental employees and employers?

Regardless of what kind of mechanism is used, health coverage premiums reflect the same basic cost elements:

- the cost of health care itself, which is by far the biggest single component;
- reinsurance, excess insurance, or stop-loss costs;
- administrative costs; and
- "profit" or "margin."

There seems little reason to expect that a mandatory statewide plan would appreciably reduce the cost of any of these elements.

The cost of health care

Simply lumping all state and local employees together obviously doesn't reduce what those employees' total health care costs will be. The only apparent way in which lumping all these employees together might save costs would be if that larger group were able to negotiate lower charges from the hospitals, doctors, clinics, and other health care providers. However, that seems implausible.

DOER estimates that approximately 320,000 people work in public sector jobs in Minnesota. Including dependents, this might represent a block of 750,000-850,000 individuals.

Most Minnesotans are currently covered by one of the "big three" health plans. According to their respective web sites, Blue Cross has about 1.8 million enrollees; Medica has about one million; and HealthPartners has about 660,000. Each of these plans negotiates rates and charges with the health care providers that make up their respective networks.

A combined state and local government plan would be comparable in size to the smaller of the "big three" plans, and not quite half the size of the largest. There seems little reason to think that this state and local government employee group would be able to negotiate appreciably better rates with providers than any of the existing plans are able to do. And even very large HMOs seem to be having limited success in negotiating with the pharmaceutical companies to control prescription drug costs – one of the major factors driving the increase in health care costs.

The trend toward increasing consolidation of health care providers makes it even more doubtful that a mandatory state and local government plan would be able to negotiate substantially lower costs from hospitals, clinics, and doctors. To an increasing extent, any network must necessarily deal with the same health care providers; and those providers are increasingly organized into what amount to either geographic or specialty-based monopolies.

Perhaps there's an expectation that a mandatory statewide group would reduce the cost of health care in some other way than by exercising "negotiating clout" with health care providers. However, it's not clear how that would be accomplished.

There are certainly other strategies that can be used to try to control claim costs; managing care more effectively is one possibility, and promoting wellness is another. But none of these strategies are dependent on having a mandatory statewide group. And if such a group charged uniform rates for all employers and employees, it could even be a disincentive for any employer to commit resources to promoting wellness.

Reinsurance, excess insurance, or stop-loss costs

These are a relatively small part of health coverage costs. For the League of Minnesota Cities Insurance Trust's relatively modest-sized group, excess or stop-loss costs are about 4% of the total premium. A larger group might be able to reduce those costs somewhat, but even if these costs were cut in half – an extremely optimistic estimate – it would translate into only about a 2% reduction in the total premium cost.

The Workers Compensation Reinsurance Association (WCRA) might be a better model to consider as a way to address reinsurance for health coverage. I.e., consider creating a mandatory statewide health reinsurer for all health carriers and self-insurers, including private as well as public employers. That would provide the benefit of an even larger group and broader spread of risk.

The market for purchasing health benefit reinsurance is becoming more difficult. We understand that even very large health carriers and HMOs are beginning to have problems with being able to purchase the reinsurance coverage and limits they need, particularly for cases involving ongoing catastrophic expense. A state-wide health reinsurer modeled after the WCRA could be very useful in making the needed reinsurance and limits more readily available, though it seems unlikely it would have a significant effect on the ultimate premium cost to employees and employers.

Administrative costs

Administrative costs are also a relatively small piece of the total cost. For the LMCIT group, administration costs make up slightly under 8% of the premium. Network access charges add not quite another 4%, for total fixed costs of just under 12%. We understand that the service coops' program's fixed costs for administration and network access are similar. HealthPartners' administrative costs are about 8.9%, according to their web site. Any information we've seen indicates that administrative costs tend to fall in the same range of about 8-15% for virtually any health benefits plan.

There seems little reason to think that the state would be able to administer a group more cheaply than anyone else is able to. But even if a very substantial reduction in administrative costs were possible, it would still translate into a relatively minor savings in the total premium. E.g., if a larger group were able to reduce administrative costs by 25% - a very optimistic assumption, especially for a plan that would be covering over 3200 separate employers - that translates into 3% of premium or less.

Profit or margin

We understand that all three of the "big three" health plans in Minnesota have either lost money or barely broken even in each of the past several years. The Mayo Clinic recently announced that they are shutting down their HMO operation because of significant ongoing losses. Obviously, if the concern is that health coverage from those carriers is too expensive, there isn't much room to reduce those costs by removing "profit" from the equation.

In short, there's little reason to think that a mandatory statewide plan would reduce costs appreciably. We understand that the study conducted by Towers Perrin for the Minnesota Statewide Healthcare Coalition Advisory Committee reached the same conclusion.

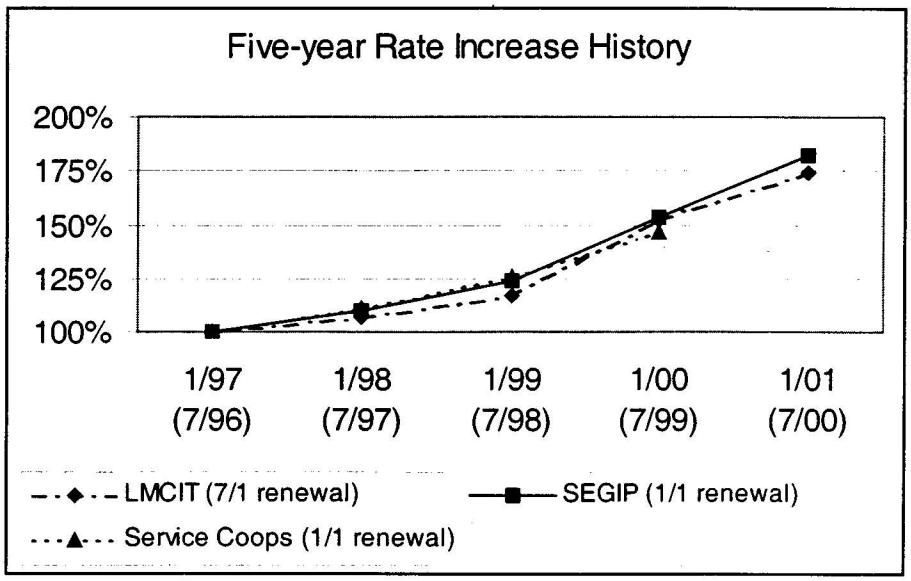
Would a mandatory statewide plan be more "stable"?

It has been suggested that if a larger statewide pool were created, the law of large numbers could allow more accurate rate setting and greater rate stability. In theory, that's certainly true. The larger the group, the more predictable claims become; and the more accurately we can predict claims, the smaller the "risk margin" we need to build into the rates in order to be reasonably confident that premiums will cover claims.

But a simple comparison of premiums and paid claims for virtually any existing plan will make it clear that the reason health coverage premiums are high and rising is because health care costs are high and rising – not because plans are building big risk margins into their premium rates.

Nor is there much reason to think that a larger plan would be more "stable" than existing plans – that is, that there would be less year-to-year fluctuation in premiums and premium increases.

Task Force members received information on recent rate increases for three different public employee health benefit plans: LMCIT, the state employees' plan (SEGIP), and the service coops' plan. The pattern of rate increases for each of these plans over the past several years is remarkably similar, as the accompanying chart shows.



If the problem were that these plans are too small to be stable, their respective rate increase patterns should look very different from each other, and should show significant variation from year to year. Clearly, that's not the case. It's equally clear that all three plans' premiums are being driven by the same underlying cause: Premiums have gone up sharply because the cost of health care has gone up sharply.

The significant increases in health coverage premiums that public employees and employers have seen for several years have clearly not been caused by instability resulting from the health coverage plans' being too small. Those premium increases are the direct result of the rising cost of health care itself. And as discussed above, simply having a bigger group by itself does nothing to address this underlying issue of how much health care costs.

Might a statewide plan offer other advantages for public employers and employees?

Some published comments from representatives of Education Minnesota indicate that their concern is not so much the absolute cost of health coverage, but rather the disparities both in benefits and in the cost of coverage among different school districts. If those disparities among school districts are the real concern, they could be addressed by simply creating a statewide plan for school employees.

The only possible reason we can see for including employees of the state, counties, and cities would be if it were believed that state employees and other local government employees were as a group healthier than school employees. If so, it would be to the schools' advantage to be pooled with the state employees and other local government employees. If in fact that's the concept, we should be very clear that we're talking about shifting costs among different governmental entities – effectively asking the state, city, and county employee groups to subsidize the school employee group.

Reducing or eliminating cost disparities among groups has a potential downside to consider as well: If everyone is paying the same rate, there's no financial incentive for any individual employer or employee group to devote resources to wellness or health promotion activities.

Concluding comments

The high and rising cost of health coverage is a very important issue for cities and their employees, as it is for other governmental units and their employees. We need to look for solutions to that problem. But we see little reason to think that creating a mandatory statewide pool of state and local government employees would or could do anything to help solve that problem. We've outlined above some reasons to be skeptical about this proposed solution.

But the burden is not on those who are skeptical about this proposal. Mandating state and local government employees into a single pool would mean a radical change for public employees and employers. The onus is on those advocating that radical change to make the case: to explain what the benefits are that this change would be expected to bring, and to provide a clear, plausible explanation of how it would produce those benefits.

If a mandatory statewide pool of public employees is intended to reduce costs, how exactly will it reduce costs and by how much? Where will those savings come from? If the expected savings are in claims costs, how will that be accomplished? By paying less for the health care that's provided? By providing less health care? If it's intended to reduce the rate of cost increases in the future, how will it accomplish that? How will it affect the increasing costs of prescription drugs and other health care service? If the goal is something other than cost savings, what is that goal and how will it be produced?

The proponents of a mandatory statewide pool of state and local government employees need to answer these questions. Generalities about "negotiating leverage" or "stability" or "the law of large numbers" are not enough to make the case for a change as significant as what's proposed.

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Comments on the task force recommendations regarding retiree coverage

The task force report makes several recommendations intended to improve retired public employees' access to health coverage on a group basis and to give retirees better tools to plan for and to pre-fund their retirement health coverage costs. The League of Minnesota Cities strongly supports these goals. However, for any specific proposals and programs to achieve these goals, it is important that participation in the program be optional, and that the program be flexible enough to meet the needs of cities and their employees in widely varying circumstances.

More specifically, these principles should guide any proposals:

1. *The state should not impose new mandates on cities.* This includes both mandates that would require city participation in any program, and mandates for changes in the rules or guidelines governing underwriting, eligibility, premium, funding, or other aspects of the city's existing benefits programs.

2. *The state should not require additional employer contributions for or toward retiree coverage.* It should be up to each city and the city's employees to determine whether funding for retiree coverage comes from employee contributions, employer contributions, or a combination of both.

PST – 11/21/2000

Comments on Task Force Report Submitted by Education Minnesota

1. Education Minnesota wishes to reiterate that the key issues regarding health coverage for active and retired public sector employees are: Statewide pooling for preK-12 employees, A common benefit set, Common Rates, Access, Centralized Administration, and Quality healthcare coverage.

2. Education Minnesota understands that the key issues that should be addressed by the study were stated in the law. Education Minnesota believes that at a minimum the Task Force needs to compare the cost of a benefit set for pooling of all preK-12 employees in one group or in a statewide public employee group to current purchasing. Options for pooling may include all preK-12 employees in one pool, all preK-12 employees pooled with all state employees, all preK-12 employees pooled with all public employees. An estimate the costs of a benefit set, such as the State Plan, for all active and retired preK-12 employees, and a comparison of benefits and an analysis of the

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3. current system of Healthcare Coverage with the proposed system of a statewide common plan will be necessary to make the required recommendations to the legislature.

4. Education Minnesota realizes most important outcome the study should achieve is: To identify strategies for providing, and make recommendations regarding the most appropriate and efficient manner for providing postretirement and active employee health care; To address alternative methods of providing and paying for healthcare; To estimate the cost of providing healthcare; To determine most efficient administrative structure for healthcare system; while considering issues of adverse selection, cost containment, consumer choice, and options for dealing with other employee concerns. These are the legislative requirements.

5. Other information that Education Minnesota feels relevant to the issue is: The Lewin Group report of other statewide plans, which we have already provided to DOER; and The fact that across the state we are facing increases in premiums averaging about 20%. (At a 15% inflation rate the increase cost of healthcare in preK-12 schools is $67,500,000 for 2000-01.)

Group Size effects premium growth. *

		Increase	increase	increase
	Workers	1996	1998	1999
Small Groups	3-199	2.1%	5.2%	6.9%
Mid-size Groups	200-4999	1.1%	3.5%	4.7%
Large Groups	5000+	0.3%	2.6%	4.2%

* - Data from Kaiser Family Foundation, "Employer Health Benefits, 1999"

Why are we in Minnesota seeing such high increases as compared to the rest of the nation?

This Task Force Report states "A large, mandatory state-wide pool for one or more public sector jurisdictions might result in a reduction in health care administration costs, which generally account for 10 - 15 % of the premium costs." For our preK-12 public schools this could save the State of Minnesota and school districts in excess of $ 60,000,000.00.

6. Education Minnesota goal remains a state funded affordable healthcare program for all preK-12 public school employees that provides for universal coverage, cost procedures to assure affordable coverage for all retirees. Education Minnesota has lobbied for and will continue to lobby for a solution to this important issue. In the long term putting off these difficult decisions will result in all of us losing. The bottom line is that without mandatory pooling, the coming insurance rate increases may wipe out many group's ability to purchase insurance at all. If public employers do not step up to the plate on the healthcare issue, we will not be able to recruit and retain a viable work force. This would be devastating for public employment.

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COMMENTS REGARDING THE POST RETIREMENT AND ACTIVE EMPLOYEE HEALTH CARE TASK FORCE REPORT AND OTHER FINDINGS

Date: November 27, 2000

The Minnesota Service Cooperatives (formerly ECSU's) have provided Health Care Pooling to their members for the past fifteen years. The Minnesota Service Cooperatives currently provide pooling to approximately 307 School Districts, 130 cities, 42 counties and 82 other Governmental Agencies. There are approximately 65,000 employees and 168,000 covered individuals participating in pooling arrangements with the Minnesota Service Cooperatives.

The 2001 average renewal increase for the Minnesota Service Cooperatives' City, County, and other Governmental Agency Pool Members was 8.9% compared to the State of Minnesota Group Insurance Plan's increase of 19%. The past three average renewals for the Minnesota Service Cooperatives' Pools have been approximately 20% less, each year, than the State of Minnesota Group Health Plan (SEGIP) average increases in health insurance premiums.

Towers Perrin's study of the Minnesota Service Cooperatives' Pools sponsored by Education Minnesota, Minnesota School Boards Association, Minnesota Association of School Administrators, the Minnesota Service Cooperatives, and Minnesota Association of Business Officials found:

> "Based on this study, consolidation into a mandated statewide plan offers no financial advantages over the current service cooperative model. Consolidation into the current plan offered to state employees would result in a 4% claims increase ($8.2 million), resulting in an overall cost increase of $7.4 million (3%)." 1

Based on this analysis on today's current volume of business the Minnesota Service Cooperative pool school members would pay an additional annual premium of approximately 3% or $10, 684, 074.00 for SEGIP's restricted managed care plans compared to the current plans that provide freedom of choice of medical providers and unrestricted care that is medically necessary. This report includes a comparison between the current average monthly premiums paid by Minnesota Service Cooperative pool members compared to SEGIP's average monthly premiums.

The Post Retirement and Active Employee Health Care Task force report restates Towers Perrin findings and infers that there may be some savings by putting all State and Local employees in a mandated State Plan although only on an intuitive level and over time the cost may actually increase.

Further, SEGIP currently allows health plans to provide competitive plans for State Employees. In the metropolitan area Health Partners, Blue Cross Blue Shield, Medica, and Preferred One own, partner, and assist in managing medical facilities and compete for medical consumers. In greater Minnesota most pool members receive medical care from local hospitals and local medical clinics. As a result there is very little competition for medical consumers in greater Minnesota. In addition to this problem, most medical facilities in greater Minnesota d[1]o not provide HMO contracts with significant discounted savings. So practically speaking the SEGIP m[3]odel would provide very little savings from competition between medical providers or from offering the current HMO contract provided to state employees.

The Minnesota Service Cooperatives and pool members are also interested in continuing to maintain accessibility to medical care locally. Efforts to undermine or reduce medical care delivered at the local level may have a long-term effect of major impacts to local medical providers. Everyone can agree that there are no simple solutions to managing complex health care costs.

Other items for consideration:

- Mandatory Pooling vs. voluntary – there would need to be a full analysis (SEGIP rates vs. other pool rates for the same products)

- Voluntary Pool retention rates– There would need to be a complete analysis done regarding retention charges for all pools including SEGIP.

- The Service Cooperative pool arrangements allow for negotiating as one large pool and also address regional issues such as local control, and area rating.

- Group participation in a voluntary pool/ adverse selection – The Service Cooperatives have a group participation retention rate of 96%

for schools over the past 15 years. This would certainly indicate that current pool members have not readily left the Minnesota Service Cooperative voluntary pools.

- Present state program design produces adverse selection resulting in increased costs due to multiple selections of products and carriers.

- The Health Care Task Force did not do a utilization/claims analysis of the various pool products and SEGIP products as part of the report.

- The Health Care Task Force members could not agree to support a mandatory pool for all public employees.

The Minnesota Service Cooperatives believe in the open market approach to providing health care to Minnesota public employees. Today these employees have numerous options including pools provided by LMC, AMC, PIEP, LOGIS, Minnesota Service Cooperative and others, as well as independent fully insured or self insured programs.

Footnote # 1 Towers Perrin, Minnesota Statewide Healthcare Coalition Advisory Committee final Report – Page 6.

MINNESOTA SCHOOL BOARDS ASSOCIATION

2001 LEADERSHIP CONFERENCE JANUARY 11 & 12, 2001

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Date: December 12, 2000

To: To Whom It May Concern

From: Minnesota School Boards Association

Regarding: Postretirement and Active Employee Health Care Task Force

The Minnesota School Boards Association (MSBA) would like to thank both the Minnesota Legislature and the Minnesota Department of Employee Relations for their efforts relative to the Task Force noted above. There is little question but that representatives of Minnesota's public sector employers and employees need to jointly address the costs associated with providing health insurance, and the Task Force is to be commended for its efforts. The issues were daunting, but the exploration of them was sincere and forthright.

Nevertheless, the MSBA supports the positions of both the Minnesota Service Cooperatives and the League of Minnesota Cities. Basically, the limited scope of the Task Force study did not provide clear evidence that a mandatory statewide governmental employee health insurance pool would be any more successful in controlling health insurance costs than the programs that are currently being offered. Further, the existing open market approach has been very successful in providing options for public employers and their employees.

While solutions to the issues that were addressed may possibly be found, the Task Force had neither the time nor the resources to pursue them fully and, therefore, reached no overall consensus.

170 The Inter Faculty Organization

Serving the Faculty of the Minnesota State Universities

Proposed model: Post-Retirement Employee Savings Trust

By Russ Stanton, Inter Faculty Organization

Draft 10/13/00

Creation

The legislature should authorize the creation of a Post-Retirement Employee Savings Trust (PREST). The plan would be established as a multiple trust plan under the sections of the IRS Code that authorize VEBA's, Government Trusts, and other forms of tax free savings for post-retirement health care costs.

DOER (or perhaps MSRS) should assist in setting up the plan by:1) assisting in setting up the initial board; 2) calling together and staffing the initial meetings of the board; 3) developing by-laws and operating procedures; 4) establishing the trust(s) with the IRS; 5) selecting third-party administrator(s), and 6)making state and local governmental units and employee groups aware of the plan. The state should provide a one-time appropriation of $250,000 to DOER (or whichever agency is deemed appropriate) for assisting in setting up the plan.

Governance

The plan should be governed by a board consisting of 6 members elected by the plan participants for six year terms. The initial board shall be appointed by the Governor; two for a two year term, two for a four year term, and two for a six year term.

Powers of the Board

The PREST board should be authorized to select and contract with one or more third-party entities to collect contributions, keep records, provide investment options, pay out benefits, and perform any other duties necessary for the management of the plan. Third party administrators may be either public or private entities. The pension funds are in a unique position to collect contributions, keep records, and pay claims, since they already perform these functions and have an infrastructure in place to interface with state and local employers; however, private entities should not be precluded, as they may have unique advantages in particular areas. The investment accounts provided under the plan should include the State Board of Investment SIF funds, and, at the discretion of the Board, include investment funds offered by private vendors.

The board should be authorized to charge fees to participants to cover the ongoing expenses of operating the fund. The board should have the option of the type and level of fees charged, such as annual account fees, asset based fees, transaction fees, etc., or combinations thereof.

The board should be authorized to set rules regarding minimum contribution size, frequency of withdrawals, and other matters pertinent to the efficient operation of the plan.

Participation
The PREST should be a multi-employer, multi-plan operation.

Participation in the PREST should be voluntary on the part of unions and employers, and unions and employers should have the right to participate in other post-retirement health care savings plans if they so choose. However, IRS rules require that if a collective bargaining agreement or personnel plan provides for participation, the participation is mandatory for all members covered by the contract or personnel plan.

All state and local government employees should be allowed to participate in the savings trust(s), pursuant to their collective bargaining contract or (in the case of unorganized employees) personnel policy adopted by their employer.

Employee groups could negotiate to have their employer contribute to the RHCSP as a percent of salary, a flat dollar amount, a percent of unused sick leave, or as a combination of these methods of contribution. Employers could contribute to the fund on behalf of unorganized employees. Each employer and bargaining unit could have a different method and/or rate of contribution.

The PREST should offer both defined contribution plan and a defined benefit plan approach, and possibly a hybrid defined contribution/defined benefit approach. Each participating group should have the choice of which type of plan it participates in.

In the defined contribution plan, all contributions, and earnings thereon, should immediately vest to the employee. Defined benefit plans should be allowed to require a vesting period, and should offer a life-time benefit which the participants cannot outlive.

Withdrawals
Withdrawals should only be allowed for: 1) reimbursement of post-retirement health care costs of the participant and his/her legal dependants, and 2) (for defined contribution benefits) a death benefit to the participants' dependents or beneficiaries.

Reimbursable health care expenses shall include: premiums for Medicare Part B, Medicare supplemental insurance, long term care insurance, dental insurance, etc.; medical co-pays, deductibles, and prescription drugs not covered by insurance; hearing devices and prescription eyewear; and any other health care related expense allowed for on a non-taxable basis by IRS rules.

ASSOCIATION OF
AMC
MINNESOTA COUNTIES

Market and provider consolidation:

There were several issues that received only minimal comments during the Task Force discussions that would probably be of interest to various participants to study or analyze more thoroughly. These comments are not presented as the position or opinion of the Association of Minnesota Counties, but rather represent areas of interest that need further consideration and information.

There has been considerable provider consolidation since public policies were adopted in the early 1990s to purchase health services through managed care organizations or health plans. This approach provided incentives for health plans to acquire provider clinics, hospitals and other providers and for providers to organize as health systems, resulting in both vertical and horizontal integration. The trend toward extensive consolidation has resulted in less competition among available resources in Minnesota's current market.

The status of provider consolidation in the marketplace is not necessarily permanent or constant without opportunity for change. Providers are continuously changing their alliances with each other or with health plans in response to reimbursement and purchasing strategies which influence them.

Examples:
Perhaps the two most dramatic examples of consolidation are Mayo's acquisition or control of medical clinics/providers in southeastern Minnesota and Allina/Medica's ownership of hospitals and clinics throughout Minnesota.

Pipestone County constructed a new medical clinic, recruited physicians and established a private corporation to offer additional (competitive) medical services to the existing medical clinic in their county in the mid 1990s.

Cardiac specialists in Sioux Falls left a South Dakota hospital and established a separate specialty hospital for treatment of heart diseases during the past year or two.

One of the two health plans in southeastern South Dakota (Sioux Falls) established (or is establishing) a new medical clinic in Worthington (Nobles County) where there is a clinic owned or controlled by the other health plan in southeastern South Dakota.

Competition or Duplication?
In the latter example, the development of a new clinic may be viewed as competition or unnecessary and costly duplication by competing health plans whose goal is to utilize the clinics as a feeder system to their hospitals and health plan system in South Dakota.

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Economic Development Issues

In Minnesota communities and counties, the health care delivery system plays a significant role in economic development in several ways:

- A quality health service system is as important as a quality educational system for attracting and retaining new businesses and industry to the communities.
- Local health services (clinics, nursing homes, hospitals) provide a local labor work force, professional and non-professional, which hopefully will maintain local residences and contribute to the local economy.
- If county residents go to centers away from the local area for health services, it is likely that they will purchase clothing, furniture, groceries and other necessities in a distant geographic area rather than support the economy in the local communities.

Along the borders of Minnesota, not only counties and communities, but the State of Minnesota should assess the economic impact of financial resources leaving the state and benefiting bordering states. This issue is especially evident in northwestern and southwestern Minnesota, but to some degree could also affect Minnesota's eastern border, especially the northeast, although higher prices and diminished competition could eventually impact the east central and southeastern borders.

Purchasing Strategies to Impact Competition and Economic Development

Employer purchasers of health services for their employees, both public and private, may continue to face higher prices and less competition in the current Minnesota market. Employers may find it beneficial to explore other methodologies, incentives and strategies for purchasing health services.

In Minnesota, there are two major examples, one private and the other public, in which employers utilize direct contracting with providers to purchase health services within a local area. One example is the Buyers Health Care Action Group (BHCAG) for large employers and the other is Itasca County, which purchases services through direct contracting for residents eligible for Medical Assistance.

In Itasca County, the County Board is responsible for purchasing Medical Assistance health services for all county residents who are eligible. Contracts are made directly with providers which offers choice for consumers and market competition for the purchaser. This approach may be of benefit to county government or others in purchasing for public and private sector employees.

There may be other strategies in Minnesota or other states that should be explored to develop solutions for purchasing health services that would align incentives for promoting competition and local economic development.

Submitted by Lois McCarron, Policy Analyst
December 8, 2000