MinnesotaCare

The MinnesotaCare Wellness Component: A Method to Incorporate Wellness Factors into the MinnesotaCare Premium Structure

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Department of Human Services
MinnesotaCare Project

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Executive Summary

The Minnesota HealthRight Act of 1992, landmark legislation intended to lay a new foundation for the delivery and financing of health care in Minnesota, provides for a wellness component in the form of premium discounts for both the private insurance sector and the state-subsidized health insurance plan, now called MinnesotaCare.

The Minnesota Departments of Commerce, Human Services, and Health collaborated in developing a strategy to approach the wellness component. An actuarial firm retained by the Department of Commerce conducted a study of seven healthy lifestyle behaviors and recommended an appropriate range of premium discounts for each behavior. The healthy lifestyle behavior associated with the greatest cost savings was nonuse of tobacco. The damaging impact of tobacco use on health status and health care costs was substantiated by data compiled by the MDH Section for Nonsmoking and Health.

DHS used the results of this information to develop a recommendation for incorporating the wellness component into the state-subsidized health insurance plan premium structure. The recommendation is:

> **A premium discount of 20% will be given when no one in the household has smoked for 6 months or longer.**

An additional recommendation is that another 5% premium discount be given to nonsmoking households in which there is a pregnant woman who had not used and would not use alcohol during her pregnancy. This is substantiated by further findings of the damaging effect of tobacco and alcohol use during pregnancy.

The cost savings of this initiative would be minimal. However, it provides an opportunity to promote health and educate the public about healthy lifestyle choices. Therefore, DHS and MDH recommend proceeding with the wellness discount, provided the systems modification cost is appropriated.

An implementation date of October 1, 1993, is proposed. A promotional campaign would inform both current enrollees and new applicants, giving them the opportunity to take advantage of the discount. The discount would end on July 1, 1997, when rate bands are phased out.

Monitoring of MinnesotaCare enrollees who receive the wellness discount must be approached so as not to revive the stigma of government involvement. Extensive monitoring is costly and not justifiable in the absence of significant cost savings.

This initiative presents government with the chance to take a leadership role in advancing the public health concepts of health promotion and health education. Incorporating a wellness component in the state-subsidized health insurance plan places Minnesota once again in the forefront of pioneering efforts to address the nationwide health care access and cost crisis.

Introduction

This document fulfills the requirement in Minnesota Session Laws 1992, Article 4, Section 1, Subdivision 1 that the Commissioners of Human Services and Health recommend to the legislature methods to incorporate discounts for wellness factors of up to 25% into the state-subsidized health insurance plan premium sliding scale. This document details the recommendation and provides the rationale.

Background

The Minnesota HealthRight Act of 1992

During the 1992 session, the legislature passed and the Governor signed into law landmark legislation which provided for increased access to health care for the uninsured, cost containment measures to reverse the spiraling costs of health care, reform of the private insurance industry, implementation of a rural health initiative, and evaluation of these efforts through research by a new health analysis unit.

Originally named "The HealthRight Act", this law was intended to lay a new foundation for the delivery and financing of health care in Minnesota. It was later given the permanent name "MinnesotaCare."

Article 4 of the HealthRight Act focuses on increasing access to health care for the uninsured by expanding a state-funded, state-administered outpatient health insurance plan for children called the Children's Health Plan (CHP). CHP was implemented on July 1, 1988, for uninsured and underinsured children ages 1 through 8 years. CHP was expanded on July 1, 1990 to include additional outpatient benefits, specifically certain mental health services. CHP was expanded again on January 1, 1991 to include children ages 9 through 17 years.

The HealthRight Act of 1992 provided for expanding CHP to include uninsured parents of CHP-enrolled children, and phasing in other uninsured adults over a two-year period. This expansion was implemented on October 1, 1992. Further expansion was implemented on January 1, 1993, when the income eligibility limit was increased significantly. On July 1, 1993, the benefit package will be expanded to include inpatient hospital and emergency medical transportation services. The final expansion will allow enrollment of uninsured adults and families without children effective July 1, 1994.

The Wellness Component

The first provision of Article 4 of the HealthRight Act is the Wellness Component. Pursuant to Minnesota Session Laws 1992, Article 4, Section 1, Subdivision 1, "The commissioners of human services and health shall recommend to the legislature ... methods to incorporate discounts for wellness factors up to 25% into the [subsidized state health insurance plan] premium sliding scale."

A similar provision required the same recommendation from the Minnesota Department of Commerce.

Minnesota Session Laws 1992, Article 3, Section 22 states that "...the commissioner of commerce shall study and make recommendations to the legislature regarding whether health benefit plans ... should be permitted or required to offer premium discounts in recognition of and to encourage healthy lifestyle behaviors."

The Departments of Commerce, Human Services, and Health collaborated in developing a strategy to approach the wellness component. The Department of Commerce took the lead by retaining an actuarial firm, Milliman and Robertson, Inc., to study healthy lifestyle behaviors in relation to premium reductions in the private sector insurance industry. Preliminary results of the study were reviewed and discussed by the Departments of Commerce, Human Services, and Health and it was agreed that the Department of Human Services (DHS) would use the findings of the actuarial study to develop a recommendation for the state-subsidized plan. The report of the actuarial study was completed in December 1992.

The results of the study indicated that there was a wide range of cost savings associated with various healthy lifestyle behaviors. Seven specific behaviors were analyzed, and a range of appropriate discounts was estimated. The table below lists the recommended premium discounts for each of the seven healthy lifestyle behaviors.[1]

Healthy Lifestyle Behavior	Range of Appropriate Premium Discounts
Nonuse of Tobacco	10 - 30%
Nonuse of Alcohol	1 - 12%
Regular Exercise	5 - 12%
Normal Body Weight	5 - 12%
Low Cholesterol	5 - 10%
Low Blood Pressure	5 - 10%
Regular Seat Belt Use	0 - 2%

As the table shows, the lifestyle behavior associated with the greatest cost savings is nonuse of tobacco. Although other healthy lifestyle behaviors were associated with some cost savings, nonuse of tobacco was the most likely to provide substantial savings in health care costs. This information provided the foundation for the design of a wellness component for the state-subsidized MinnesotaCare health insurance plan.

Nonuse of Tobacco Selected for Wellness Component

National studies repeatedly demonstrate the damaging impact that tobacco has on one's health.

> **"Smoking represents the most extensively documented cause of disease ever investigated in the history of biomedical research."[2]**

According to data compiled by the Minnesota Department of Health (MDH), Section for Nonsmoking and Health, approximately 23% of all Minnesotans were smokers in 1990. Furthermore, MDH has estimated that 6,052 or 17% of all deaths in Minnesota in 1988 were attributable to smoking. This translates into staggering financial figures: in 1988, the total economic cost of Minnesota residents' smoking added up to $805,029,557 , nearly $1 billion, or $187 for every state resident.[3]

The DHS and MDH Recommendation

The data regarding the cost impact of tobacco use provide justification for focusing on nonuse of tobacco in promoting healthy lifestyle behaviors through the state-subsidized MinnesotaCare health insurance plan. DHS and MDH recommend the following:

> **A premium discount of 20% will be given when no one in the household has smoked for 6 months or longer.**

DHS and MDH recommend adding another 5% premium discount to nonsmoking households in which there is a pregnant woman who had not used or would not use alcohol during her pregnancy.

The total maximum discount would be 25%. This additional discount is substantiated by the fact that smoking retards fetal growth and doubles the risk of having a low birth weight baby.[4] Furthermore, prenatal exposure to alcohol is the most prevalent cause of preventable mental retardation in children.[5] There is no documented level of alcohol that is safe during pregnancy, thus, encouraging total abstinence from alcohol during pregnancy and supporting this with a financial incentive is justifiable.

Cost of the Proposed Discounts

The 20% nonsmoking discount is projected to reduce revenues to MinnesotaCare by $2.5 million in FY 1995, $5.1 million in FY 1996, and $7.1 million in FY 1997. The additional 5% discount for households with a pregnant woman who has not used alcohol during pregnancy is projected to cost $140,000 in FY 1995, $210,000 in FY 1996, and $250,000 in FY 1997. These costs could be offset by adjusting the MinnesotaCare enrollee premium schedule in such a way that undiscounted premiums would be roughly 20% higher than the current schedule, while discounted premiums would be slightly lower than the current schedule. The Appendix provides more detail on the effect of an adjustment of the premium table.

Another issue to consider is the feasibility of applying such a discount to a plan that is already community-based in the premium rate schedule. Such discounts are feasible in individual private insurance plans because they apply different rates to classes of people who can be expected to have a different level of health care costs. Existing MinnesotaCare cost projections already assume an overall rate of claim costs which is influenced by the fact that most people do not smoke and that pregnant women are already discouraged from consuming alcohol.

Thus, these discounts will produce savings in MinnesotaCare expenditures only to the extent that they modify the behaviors of enrollees. This effect is expected to be small, and the resulting cost savings are expected to be minimal, especially in the short term. In addition, the discounted premiums, which will apply to the majority of MinnesotaCare enrollees, will probably attract more applicants and result in a small increase in the overall number of enrollees. The costs for these enrollees will offset any savings from positive

changes in behavior. Subsequently, these offsetting factors will most likely produce a budget-neutral effect on MinnesotaCare expenditures.

To implement the discount, the system eligibility and accounts receivables systems would require program modification. The cost would be $9,600. The Appendix details the programming cost.

The second goal of the wellness discount, which is health promotion and education, is important and must be taken into consideration, even though the results are not easily measured. Recognizing nonuse of tobacco and prenatal abstinence from alcohol sends a message to the public that these products are harmful and should be avoided. The wellness discount would, therefore, accomplish MinnesotaCare's goal of educating the public and encouraging healthy lifestyle behavior choices.

The Department recommends that in spite of minimal cost savings, the wellness discount be implemented in the interest of promoting healthy lifestyle behaviors.

Implementation Strategies and Timeline

Implementation of the premium discount is proposed for October 1, 1993. A promotional campaign would be launched informing MinnesotaCare enrollees of the future discount. During the campaign, enrollees would be encouraged to maintain nonuse of tobacco or to incorporate nonuse of tobacco in their lifestyle behaviors in order to qualify for the discount.

Current enrollees would be offered the discount through the monthly, ongoing premium notice mailings. One or two questions regarding nonuse of tobacco, pregnancy, etc., would be added to the premium discount notice. Enrollees' responses would be used to determine eligibility for the premium discount. New applicants would also be offered the premium discount through the standard application process. One or two additional questions would be incorporated into the MinnesotaCare application, and eligibility would be determined at the time of regular processing.

The October 1, 1993, implementation date would highlight the first anniversary of MinnesotaCare implementation. It would also provide substantial opportunity for enrollees to change lifestyle behavior before the discount ended on July 1, 1997, due to final phase out of rate bands. The phase out of rate bands is required by the HealthRight Act.

Monitoring Compliance

In many respects, the administration of CHP was based on the private insurance model. It was promoted as health insurance, and although minimal, there was a charge to the customers. This helped reduce the negative image that often accompanies public assistance programs, and greatly contributed to CHP's success.

Furthermore, the application process was streamlined and made as nonbureaucratic as possible.

Monitoring of MinnesotaCare enrollees who receive the wellness discount must be approached carefully so as not to revive the stigma of government involvement. At the same time, the wellness component provides government with an opportunity to provide leadership in advancing the public health concepts of health promotion and health education.

The private insurance industry has experience in this area, and what has been learned is valuable. Blue Cross Blue Shield of Minnesota (BCBS) has the largest market share of individual insurance products in the state, and has offered a premium discount for nonuse of tobacco to individual policy premium holders for the past several years. According to BCBS staff, monitoring is conducted through claims and medical record reviews. At the time of review, if evidence of pre-existing conditions or behaviors such as smoking is identified, the premium is increased or the policy is terminated. This is a labor-intensive process, and is justifiable for individual products such as those offered by BCBS because of the absence of community-based rating. For the purposes of the state-subsidized MinnesotaCare plan, however, a discount that would provide only minimal cost savings would not justify extensive monitoring.

Under the statute, quality control of eligibility determinations is provided for by requiring random audits to verify reported income and eligibility (Minnesota Session Laws 1992, Article 4, Section 6, Subdivision 3). This provision can be applied to verification of eligibility for the wellness premium discount. However, staffing resources to conduct review of medical claims on a random basis is not provided for in the budget. Therefore, the recommendation is that no verification be required at this time.

Conclusion

Both DHS and MDH are committed to encouraging healthy lifestyle behaviors. Offering a premium discount to MinnesotaCare enrollees who practice healthy lifestyle behaviors is one method to promote health in Minnesota. This initiative presents government with the chance to take a leadership role in advancing public health concepts. A budget neutral discount would minimize the financial risk to the taxpayers and at the same time demonstrate Minnesota's commitment to high quality of life standards for all its citizens.

Appendix

The cost estimates for the effect of the proposed discounts are based on the following assumptions:

70% of families will qualify for the nonsmoking discount; this will reduce premium revenues by 14%.

20% of families will qualify for the pregnant woman nondrinking discount of 5%; this will reduce premium revenues by 1%.

The total revenue reduction projected from the discounts is 15%. If the Legislature wishes to make the discounts budget-neutral, this can be accomplished by increasing the nondiscounted premiums by 17.65%.

The table below illustrates the effect of this change on premiums which MinnesotaCare enrollees are required to pay:

Corresponding Premiums with Cost-Neutral Discounts

Current Premium	No Discount	Nonsmoking Discount Only	Pregnant Woman Nondrinking Only	Both Discounts
$10	$12	$9	$11	$9
25	29	24	28	22
50	59	47	56	44
75	88	71	84	66
100	118	94	112	88
150	176	141	168	132
200	235	188	224	176

Systems programming costs are based on an estimated requirement of 6 weeks of analysis and programming at the cost of $40/hour (6 weeks X 40 hours/week X $40.00/hour = $9,600).

Bibliography

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5. Minnesota Department of Health: *Review and Cost of Alcohol Abuse in Minnesota,* Minneapolis, 1985.