Universal Standard Benefits Set

Advisory Committee Report

Recommendations Submitted to the
Commissioner, Minnesota Department of Health
in response to
1994 MinnesotaCare Health Care Reform Legislation

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December 30, 1994

Mary Jo O'Brien
Commissioner
Minnesota Department of Health
717 Delaware Street South East
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Minneapolis, Minnesota 55440-9441

Dear Commissioner O'Brien:

As chair of the Universal Standard Benefits Set (USBS) Advisory Committee, I am proud to present you with a report of the committee's recommendations. Committee members held six half-day meetings and one full-day meeting, and spent many more hours reviewing materials for these meetings. The recommendations in this report represent hours of debate and discussion. The high level of commitment to the process that committee members displayed was exemplary. Members also graciously agreed to be available for additional meetings should there be a need to make further recommendations.

Benefit set cost and funding issues were not part of the committee's legislative charge, and therefore the committee did not take them up. However, it was the strong opinion of the entire committee that benefit set decisions should be made in light of cost and funding information.

The USBS Advisory Committee composition was unique to the many advisory committees currently meeting to work on health care reform issues. It was unique because there was substantial representation from the health care practitioner community. This strong health practitioner representation may explain the very comprehensive nature of the USBS the committee recommends. But this "cross fertilization," as one member put it, of the practitioner community was a vital and necessary process. The resulting information represented here will serve as a valuable multidiciplinary tool in understanding where benefit set design should move in the years ahead.

While the time line for the committee's work was short, members considered carefully the items recommended here. The USBS is a health care reform policy that should and will remain dynamic as it responds to changes in health care delivery and technology. The work of this committee developed a firm and detailed base on which to enact legislation and refine the USBS for the years to come.

On behalf of all the USBS Advisory Committee members, thank you for the opportunity to serve on this committee, and for considering the recommendations of this report.

Sincerely,

Lowell Anderson, Chair
Universal Standard Benefits Set Advisory Committee

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Overview

1994 MinnesotaCare legislation directed the Commissioner to appoint an advisory committee to develop recommendations for the Universal Standard Benefits Set (USBS). There were 38 committee members representing a wide variety of health disciplines and interest groups, including statutorily mandated representatives of health care providers, purchasers, consumers, health plan companies, and counties. Appendix A contains a list of the committee members. The USBS Advisory Committee held six half-day meetings and one full-day meeting between September 8th and November 17th 1994. The committee was initially chaired by member Ann Christ. Ms. Christ resigned due to a move out of state and member Lowell Anderson took over as chair.

Over 200 people applied to serve on the USBS Advisory Committee. The high level of interest in the process was also evident from the large volume of materials distributed by both committee members and the public at the USBS meetings. Audience attendance averaged about 50 people per meeting.

The committee used parliamentary procedure and adopted positions using a majority vote. The committee was initially presented with two benchmark benefit sets, one representing a current HMO plan and one a current indemnity plan, which served as a base of information about current benefit sets as the committee developed new ones. The members developed a set of guiding principles, a definition of appropriate and necessary care, a set of exclusions to be used with a benefit set, and two potential benefit sets, one of which they recommended. There was considerable debate on these issues and sometimes the division of votes was very close.

The committee found it challenging to discuss benefit set options without the advantage of more knowledge about larger financing issues and without the immediate ability to know the cost impact of benefits they were discussing so that they could decide accordingly. The members stated that it was important to make benefit design decisions in light of the cost impact. The cost information being developed simultaneously by the Health Care Commission and Department of Health staff was recognized as a significant factor in overall design of the USBS.

The Minnesota Department of Health contracted with Deloitte and Touche, an actuarial firm, to provide some discussion materials and price the benefit sets. The committee had several presentations from Deloitte and Touche and had some opportunity to inquire about the assumptions of the cost model. There were four levels of cost-sharing applied to the recommended benefits set. Committee members did not have time to modify them and therefore they do not represent the committee's work. The committee did not have sufficient time to react to or recommend levels of cost-sharing, nor did their legislative charge require it of them. The committee passed a resolution expressing their willingness to reconvene to further explore these issues and advise the Commissioner.

Charge in Legislation

The 1994 MinnesotaCare legislation establishes an advisory committee to make recommendations for a Universal Standard Benefits Set to the Commissioner of Health. Article 4 of the legislation reads as follows:

Sec. 7. **62Q.21 UNIVERSAL STANDARD BENEFITS SET.**

Subdivision 1. **MANDATORY OFFERING.**

Effective January 1,1996, each health plan company shall offer the universal standard benefits set to its enrollees.

Subd. 2. **STANDARD BENEFIT SET.**

Effective July 1, 1997, health plan companies shall offer, sell, issue, or renew only the universal standard benefits set and the cost-sharing and supplemental coverage options established in accordance with sections 62Q.25 and 62Q.27.

Subd. 3. **GENERAL DESCRIPTION.**

The universal standard benefits set must contain all appropriate and necessary health care services. Benefits necessary to meet public health goals, adequately serve high risk and special needs populations, facilitate the utilization of cost effective alternatives to traditional inpatient acute and extended health care delivery, or meet other objectives of health care reform shall be considered by the commissioner for inclusion in the universal standard benefits set. Appropriate and necessary dental services must be included.

Subd. 4. **BENEFIT SET RECOMMENDATIONS.**

The commissioner of health, in consultation with the Minnesota health care commission and the commissioners of human services and commerce, shall develop the universal standard benefits set and report these recommendations to the legislature by January 1, 1995. The commissioners shall include in this report a definition for appropriate and necessary care, in terms of type, frequency, level, setting, and duration of services which address the enrollee's mental and physical condition. In developing this definition, the commissioners shall consider that a benefit set that excludes genuinely appropriate and necessary services will not reduce or contain costs, but will only transfer those costs onto individuals and the public sector. Therefore, the definition of appropriate and necessary care must be sufficiently broad to address the needs of those with chronic conditions or disabilities, including those who need health services to improve their functioning, and those for whom maintenance of health may not be possible and those for whom preventing deterioration in their health conditions might not be achievable, and meet other health care reform objectives. In developing the universal standard benefits set, the commissioners shall take into account factors including, but not limited to:

(1) information regarding the benefits, risks, and cost-effectiveness of health care interventions;

(2) development of practice parameters;

(3) technology assessments;

(4) medical innovations;

(5) health status assessments;
(6) identification of unmet needs or particular barriers to access;
(7) public health goals;
(8) expenditure limits and available funding;
(9) cost savings resulting from the inclusion of a health care service that will decrease the utilization of other health care services in the benefit set;
(10) cost efficient and effective alternatives to inpatient health care services for acute or extended health care needs, such as home health care services; and
(11) the desirability of including coverage for all court-ordered mental health services for juveniles.

Subd. 5. **ADVISORY COMMITTEE ON THE UNIVERSAL BENEFITS SET.**
The commissioner shall appoint an advisory committee to develop recommendations regarding the services other than dental services to be included in the universal benefits set. The committee must include representatives of health care providers, purchasers, consumers, health plan companies, and counties. The health care provider representatives must include both physicians and allied independent health care providers representing both physical and mental health conditions. The committee shall report these recommendations to the commissioner by October 1, 1994.

Subd. 6. **ADVISORY COMMITTEE ON DENTAL SERVICES.**
The commissioner shall appoint an advisory committee to develop recommendations regarding the level of appropriate and necessary dental services to be included in the universal standard benefits set. The committee shall also develop recommendations on an appropriate system to deliver dental services. In its analysis the committee shall study the quality and cost-effectiveness of dental services delivered through capitated dental networks, discounted dental preferred provider organizations, and independent practice dentistry. The committee shall report these recommendations to the commissioner by October 1, 1994.

Subd. 7. **CHEMICAL DEPENDENCY SERVICES.**
If chemical dependency services are included in the universal standard benefits set, the commissioner shall consider the cost effectiveness of requiring health plan companies and chemical dependency facilities to use the assessment criteria in Minnesota Rules, parts 9530.6600 to 9530.6660.

Sec. 8. **62Q.23 GENERAL SERVICES.**

(a) Health plan companies shall comply with all continuation and conversion of coverage requirements applicable to health maintenance organizations under state or federal law.

(b) Health plan companies shall comply with sections 62A.047, 62A.27, and any other coverage required under chapter 62A of newborn infants, dependent children who do not reside with a covered person, handicapped children and dependents, and adopted children. A health plan company providing dependent coverage shall comply with section 62A.302.

(c) Health plan companies shall comply with the equal access requirements of section 62A.15.

Sec. 9. **62Q.25 SUPPLEMENTAL COVERAGE.**

Health plan companies may choose to offer separate supplemental coverage for services not covered under the universal benefits set. Health plan companies may offer any Medicare supplement, Medicare select, or other Medicare-related product otherwise permitted for any type of health plan company in this state. Each Medicare-related product may be offered
only in full compliance with the requirements in chapters 62A, 62D, and 62E that apply to that category of product.

Sec. 10. **62Q.27 ENROLLEE COST-SHARING.**

(a) The commissioner, as part of the implementation plan due January 1, 1995, shall present to the legislature recommendations and draft legislation to establish up to five standardized benefit plans which may be offered by each health plan company. The plans must vary only on the basis of enrollee cost sharing and encompass a range of cost-sharing options from (1) lower premium costs combined with higher enrollee cost-sharing, to (2) higher premium costs combined with lower enrollee cost-sharing. Each plan offered may include out-of-network coverage options.

(b) For purposes of this section, "enrollee cost-sharing" or "cost-sharing" means copayments, deductibles, coinsurance, and other out-of-pocket expenses paid by the individual consumer of health care services.

(c) The following principles must apply to cost-sharing:

(1) enrollees must have a choice of cost-sharing arrangements;

(2) enrollee cost-sharing must be administratively feasible and consistent with efforts to reduce the overall administrative burden on the health care system;

(3) cost-sharing for recipients of medical assistance, general assistance medical care, or the MinnesotaCare program must be determined by applicable law and rules governing these programs;

(4) cost-sharing must be capped at an annual limit determined by the commissioner to protect individuals and families from severe financial hardship and to protect individuals with substantial health care needs;

(5) cost-sharing must not be applied to preventive health services as defined in Minnesota Rules, part 4685.0801, subpart 8;

(6) the impact of enrollee cost-sharing requirements on appropriate utilization must be considered when cost-sharing requirements are developed;

(7) additional requirements may be established to assist enrollees for whom an inducement in addition to the elimination of cost-sharing is necessary in order to encourage them to use cost-effective preventive services. These requirements may include the provision of educational information, assistance or guidance, and opportunities for responsible decision making by enrollees that minimize potential out-of-pocket costs;

(8) a copayment may be no greater than 25 percent of the paid charges for the service or product;

(9) cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more

restrictive than those requirements and limitations for outpatient medical services; and

(10) cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6660, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) The commissioner shall consider whether a health plan company may return to the enrollee all or part of an enrollee's premium as an incentive for completing preventive care, and may return all or part of an enrollee's cost-sharing for participating in health education, improving health, or reducing health risks.

Sec. 11. **62Q.29 STATE-ADMINISTERED PUBLIC PROGRAMS.**

Public agencies, in conjunction with the department of health and the department of human services, on behalf of eligible recipients enrolled in public programs such as medical assistance, general assistance medical care, and MinnesotaCare, may contract with health plan companies to provide services included in these programs, but not included in the universal standard benefits set.

Guiding Principles

USBS Advisory Committee members developed a set of principles to guide all subsequent committee work and to identify areas of majority opinion:

Universal Standard Benefits Set Advisory Committee Guiding Principles

Preamble -
These guiding principles apply to all Minnesotans without regard to age, race, gender, family composition, geographic location, income, employment status, citizenship status, diagnosis or functional status. The standard benefits set must include those who need health services to improve their functioning, those for whom maintenance of health may not be possible and those for whom preventing deterioration in their health conditions might not be achievable. Services should reflect a broad continuum of care. Benefits should be delivered in a developmentally appropriate manner and without regard to the site of service. Services must be culturally sensitive and appropriate. Cooperation and collaboration between the reformed health system, education, social services and economic security systems are essential.

1. Every Minnesotan is entitled to access to a comprehensive and affordable standard benefits set which includes appropriate and necessary health care services.

2. All Minnesotans, to the extent they are capable, share a responsibility for their health and well-being.

3. The USBS should promote and assure utilization of services that are effective and cost efficient. The focus must be on long-range outcomes and long-term cost effectiveness as opposed to short term expenditures.

4. The USBS is a key element in the broad effort to maximize the overall health of Minnesotans while reducing the rate of increase in health care costs. Cost projections must be considered within the overall context of health reform.

5. The USBS should be directly and indirectly affordable to the community.

6. The USBS should define a standard level of covered health services.

7. The USBS should encourage health promotion, wellness education, disease prevention and early detection, as well as other appropriate public health goals and objectives.

8. The USBS should encourage administrative simplification within its design, and should promote consumer understanding of its covered health care services.

9. The USBS should encourage improvement and innovation in patient care processes and in the health care delivery system.

Definition of Appropriate and Necessary Care

The USBS Advisory Committee developed the following definition of appropriate and necessary care to be used in concert with the benefit set they developed:

Appropriate and necessary care means primary, secondary and tertiary care services which address an individual's physical and mental condition as well as family health needs with sensitivity to cultural and developmental needs. It includes care that:

- is appropriate in terms of type, frequency, level, setting and duration to the individual's mental or physical condition as well as providing services in the least restrictive settings in that community; and

- is cost effective which means care that is the same or less costly, and at least as effective as alternative care in achieving a desired health care outcome, or, if more costly, its additional benefit warrants the cost. Cost effectiveness must be considered in the context of long term outcomes; and

- removes and/or reduces barriers to access to health care services; and

- is consistent with generally accepted principles of professional practice for licensed, registered or certified providers who manage the condition within the scope of their practice; and

- helps establish, improve, restore, maintain or prevent deterioration in the individual's physical or mental health condition, or helps to develop functional capacity in the individual's physical or mental health condition; and/or

- helps individuals with conditions that will inevitably deteriorate to minimize pain and suffering and to maintain a maximum level of dignity and independence; and/or

- is needed to detect an incipient problem or prevent the reasonable likely onset of a health problem.

Recommended USBS

The USBS Advisory Committee recommended a Universal Standard Benefits Set as follows:

SERVICES	COVERED
Preventive Care	
▪ routine examinations (e.g. physical, vision & hearing)	√
▪ employment/research exams	
▪ health education and counseling (e.g., smoking cessation, weight loss and parental and caregiver education and training for special needs clients)	√
▪ Well child care (e.g., physical, vision, hearing, and speech exams)	√
▪ child and adolescent screening to age 18 (educational and developmental)	√
▪ adult screening (e.g., blood pressure, pap tests, mammograms)	√
▪ immunizations	√
▪ family planning counseling	√
▪ prenatal and postnatal care	√
▪ pre and postnatal home visits to assess health of caregiver and child	√
Health Professional Services	
▪ office visits*	√
▪ conferences/counseling	√
▪ record maintenance and retrieval	
▪ hospital visits	√
▪ allergy injections	√
▪ therapeutic injections	√
▪ dialysis	√
▪ acupuncture	√
▪ obesity treatment	√
▪ assessment/diagnosis	√
▪ pharmaceutical care/medication management	√
▪ personal care services (associated with rehabilitation services only)	√

SERVICES	COVERED
Surgery	
▪ physician's office	√
▪ inpatient	√
▪ surgical center	√
▪ cosmetic surgery	
▪ reconstructive surgery (including birth defects)	√
▪ anesthesia services	√
Hospital	
▪ inpatient services	√
▪ medications	√
▪ intensive care	√
▪ private duty nursing	
▪ skilled nursing facility (associated with rehabilitation services only)	√
Prescription Drugs and Nondurable Equipment	
▪ name brand (34-day supply)	√
▪ generic (34-day supply)	√
▪ over the counter (when prescribed by provider)	√
▪ birth control pills (1 month supply)	√
▪ birth control devices	√
▪ injectables	√
▪ insulin and diabetic supplies	√
▪ allergy medications	√
▪ ostomy supplies	√
▪ blood & blood products	√
▪ biologicals	√
▪ smoking patches	√
Vision Care	
▪ routine exams (listed under preventive services)	√
▪ exams for treatment of injury or disease	√

SERVICES	COVERED
▪ eyeglasses	√
▪ contact lenses when necessary for treatment of disease or injury (other than solely for the correction of vision)	√
▪ radial keratotomy/refractive surgery	√ see exclusions
X-Ray/Lab Services	√
Hearing Care	
▪ routine exams (listed under preventive services)	√
▪ exams for treatment of injury or disease	√
▪ hearing aids	√
▪ hearing aid batteries	√
▪ repair and replacement of hearing aids due to normal wear and tear	√
Maternity and Reproductive Services	
▪ prenatal care and postnatal care (listed under preventative services/including covered dependents)	√
▪ delivery	√
▪ hospital services for newborn	√
▪ nurse midwife	√
▪ abortion services	√
▪ surrogate pregnancy (adoption)	
▪ in vitro fertilization	2 attempts /year
▪ contraceptive implants	√
▪ infertility treatment (maximum 6 cycles)	√
▪ voluntary sterilization	√
▪ genetic counseling	√
▪ sexually transmitted disease screening (for adolescents and adults)	√
▪ sterilization reversal	
▪ devices and equipment	√
Mental Health Care	

SERVICES	COVERED
▪ inpatient	√
▪ partial hospitalization	√
▪ outpatient	√
▪ day treatment and intensive non-residential services	√
▪ partner & family therapy	√
▪ case management	√
▪ medication management	√
▪ assessment/diagnosis/psychological testing	√
▪ crisis services	√
▪ psycho/social rehabilitation services	√
▪ court-ordered services	√
Chemical Dependency Care	
▪ inpatient (hospital and residential)	√
▪ partial hospitalization (applicable day limits apply in aggregate to inpatient and partial hospitalization)	√
▪ outpatient	130 hours/yr
▪ detoxification (medical stabilization as entering treatment)	√
▪ day treatment	√
▪ case management	√
▪ medication management	√
▪ assessment/diagnosis	√
▪ chemical dependency continuum of care	√
▪ after care	√
▪ extended care/halfway house (only after completion of primary treatment)	√
Chiropractic Care	
▪ office visits/manual manipulation*	√
▪ examinations, adjunct therapies*	√
▪ diagnosis/assessment*	√
Dental Services -- See separate dental advisory committee report	√

SERVICES	COVERED
Assistive Technology and Supplies	
▪ prosthetics, orthotics	√
▪ durable medical equipment (e.g., assistive technology, accessories and supplies) (does not include constructive modifications to home, vehicle, or workplace)	√
▪ rehabilitation engineering consultation (e.g., evaluation, selection, design, customization, fitting and adjustments)	√
▪ repair, maintenance and replacement	√
▪ disposable medical supplies	√
▪ personal comfort items (telephone, television, etc.)	
▪ daily living aids	
Organ/Tissue Transplants	
▪ kidney, cornea, bone marrow, heart, heart/lung, liver, lung, musculoskeletal (maximum 2 attempts and as deemed appropriate and necessary)	√
▪ all others	
Home Care	
▪ home hospice care	√
▪ medical day care costs (for preschool age children only)	√
▪ nursing	√
▪ therapy (e.g., speech, physical, occupational, respiratory, audiology and behavioral)	√
▪ personal care services (associated with rehabilitation services only)	√
▪ medical/social services	√
Rehabilitation/habilitation	
▪ physical, occupational, cognitive, speech, respiratory, chemo/radiation, behavioral & audiology therapy	√
▪ vocational rehabilitation	
▪ health clubs and spas	
▪ case management	√
▪ extended care/transitional rehabilitation	√
Hospice Care	

SERVICES	COVERED
▪ medical social services	√
▪ medical appliances and supplies	√
▪ physical therapy, occupational therapy, and speech/language pathology services	√
▪ short-term inpatient care including respite care	√
▪ physical and nursing services	√
▪ counseling including dietary counseling	√
▪ home health aid & homemaker services	√
▪ outpatient drugs for symptom management & pain relief	√
Nutritional Services	
▪ special nutritional supplements and formulas for the dietary treatment of metabolic disorders; high caloric density nutritional products and special nutritional supplements when prescribed or recommended by a physician	√
▪ nutritional counseling for treatment and long-term management of acute and chronic disease	√
▪ therapeutic nutritional counseling	√
Emergency Care	
▪ ER with hospital admission	√
▪ ER with no hospital admission	√
▪ outpatient/urgent care	√
▪ air or ground ambulance	√
▪ other emergency transportation	√
▪ intrafacility transportation	√
Implants	
▪ artificial joints, pacemakers	√
▪ intraocular lens	√
▪ cochlear	√
▪ ear tubes	√
▪ breast, penile	
Out of Area Services	

SERVICES	COVERED
▪ emergency care with hospital admission	√
▪ emergency care with no hospital admission	√
▪ urgent care	√
Public Health Nursing Services	
▪ assessment and diagnosis of:	√
▪ children and adolescents	√
▪ special needs populations	√
▪ family violence victims	√
▪ health education of:	√
▪ pregnancy for teens	√
▪ access to preventive health services	√
▪ health promotion/counseling	√
▪ nursing treatment	√
▪ medication management	√
▪ administration of injections	√
▪ nursing clinics (e.g., WIC, immunization, school and teen services)	√

This benefit set is represented as Benefit Set C on the benefit set worksheet which is Appendix E of this report.

Resolutions

The committee passed the following resolutions to state the limits of their work or briefly address issues they did not have time to discuss at the meetings in depth:

Resolution #1

"The USBS Advisory Committee acknowledges that, although the benefit set outlined is designed to be inclusive of reasonable health care coverage for all Minnesotans, this benefit set was developed without the committee having information related to costs. If the Commissioner of Health or the Legislature desires a re-analysis of this benefit set to determine whether costs could be reduced, the committee is fully willing to be reconvened to assume that responsibility."

Resolution #2

Though time did not permit the discussion of a means of updating the USBS once it was in place, the committee passed the following resolution:

"The committee recommends that a standing committee be formed to address changes in health care and to update the USBS."

Resolution #3

Though not asked specifically to address the issue of public programs, the committee passed the following resolution:

"Coverage for eyeglasses should be restricted to low-income people. The committee recommends further study by the Commissioner in regard to eyeglasses for children (for example, a benefit of a fixed amount toward eyeglasses for children)."

Resolution #4

"The USBS Advisory Committee acknowledges that some health services which may not be included in the recommended benefit set should be included at least for persons receiving coverage through public programs. The additional benefits for enrollees in public programs (Medical Assistance, General Assistance Medical Care and MinnesotaCare) should include but not be limited to:

- Eyeglasses;

- Dental services as currently covered by the Medical Assistance, Program for Medical Assistance and General Assistance Medical Care enrollees and for MinnesotaCare enrollees with cost sharing levels to be determined;

- Chemical dependency long-term and extended care, but only if the patient has completed primary inpatient or outpatient treatment,

- Persons with chronic conditions and disabilities should not have to become impoverished in order to receive needed ongoing home care services, thus these services should be offered on a sliding fee basis for persons over the Medical Assistance income eligibility limits.

- Access services, including transportation, interpreter services and outreach services should be in place for low-income people.

- The level of services in public programs should not be reduced."

Exclusions

The USBS Advisory Committee developed the following exclusions to be used in concert with the benefit set:

The following exclusions assume that coordination of benefit services occurs.

The following services are excluded from the benefit set:

a) Services for an illness that is covered by any Workers' Compensation law, occupational disease law, any motor vehicle coverage or coverage statutorily required to be contained in any motor vehicle or other liability insurance policy, equivalent self-insurance, or similar legislation;

b) Services or treatment for cosmetic purposes except reconstructive surgery or treatment when such a service is incidental to or follows surgery resulting from an injury, illness, congenital disease or congenital malformation;

c) The part of cost for services or articles which is in excess of the usual and customary charge;

d) Services or articles not within the scope of authorized practice of an institution or individual including services provided by unregistered, unlicensed or uncertified individuals if the individuals are subject to such requirements;

e) Contact lenses except for treatment of disease;

f) Refractive surgery except when medically necessary for treatment of disease which cannot be corrected by other means;

g) Treatment of a covered service outside of Minnesota, except for services which are: a) emergent or urgent, or b) services which are appropriate and necessary, and unavailable in Minnesota and provided upon referral of the plan, or c) are part of an identified service area;

h) Services of the clergy that are rendered during the course of their normal practice as a member of the clergy, and by any other provider that would not bill in the absence of insurance;

i) Surgery for gender reassignment, except reconstructive pediatric surgery for congenital disease or malformation;

j) Reversal of voluntary sterilization;

k) Services and items provided only for the convenience of the patient or the patient's physician;

l) Procedures and associated expenses which are experimental. Experimental procedures and associated expenses do not include devices and drugs which have received an FDA approved investigational exemption, when there is substantial evidence that the devices and drugs provide significant benefit;

m) Services prohibited by law or regulation, or illegal under the laws of the State of Minnesota;

n) Services incurred while this policy is not in force with respect to the person who incurred the services;

o) Services provided at a frequency other than that accepted by the health provider community;

p) Any weight loss program and related fees, dues, food, vitamins, and exercise therapy and all associated labs, physicians visits, and services related to such programs except when prescribed for a specific health condition, or as determined by the health plan;

q) Services by persons who are family members or share your legal residence, except as allowed by law under Minnesota Statutes 256B.0627, subd. 4(b)(7).

The committee withheld a decision on one item considered for exclusion, and determined that further study was needed before a decision could be made:

1. Exams, other evaluations and/or others services for employment, insurance, licensure, judicial or administrative proceedings or research, except as an emergency examination ordered by judicial authorities, as otherwise covered under the benefit set, or unless it is appropriate and necessary.

Appendices

A) List of committee members

B) Letters of variance from report, as sent in by members

C) List of all comments submitted

D) Meeting minutes

E) Benefit set worksheet

F) Cost of the Recommended USBS

Appendix A

Universal Standard Benefits Set Committee Members

Universal Standard Benefits Set Committee Members

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Appendix B

Letters of variance from the USBS Advisory Committee Report as submitted by USBS Advisory Committee members.

STATE OF MINNESOTA

Department of Commerce — *Office Memorandum*

TO: Kathleen Cota
Dept. of Human Services

Mary Kennedy
Health Care Delivery Policy Division
Dept. of Health

FROM: John Gross

DATE: December 15, 1994

SUBJECT: Universal Standard Benefit Set

==========

At our December 2, 1994 meeting, we concluded that a report must develop a benefit set that is responsible to the consumer's needs, both in benefits and costs.

Taking into consideration, the universal benefit set committee's recommended benefit set, and the actuarial study, we concluded that an affordable benefit set similar to an HMO plan should be recommended in the report.

JEG/lmm

cc: Pat Nelson
Chuck Ferguson

MINNESOTA CHAMBER OF COMMERCE

December 12, 1994

Mr. Lowell Anderson, Chair
Universal Standard Benefit Set Committee
c/o Ms. Mary Kennedy, Division Director
Health Care Delivery Systems
Minnesota Department of Health
121 E. 7th Place
St. Paul, Minnesota 55164-0975

Dear Lowell:

After reviewing our committee's draft report, we have concluded that we cannot support its recommendations. We are deeply troubled by not only the cost of the proposed benefit set, but also a fundamental inconsistency between our guiding principles and the final benefit set.

According to our committee's actuary, the recommended benefit set will cost between $133 and $194 per member per month (PMPM). When administrative and underwriting expenses are added, the maximum could grow to $233 PMPM while the minimum could be as high as $159 PMPM. At these rates, the benefit set is significantly more expensive than what most Minnesotans and their employers now pay for health care coverage. A significant number of individuals and businesses are struggling to afford their current coverage. If the committee's recommended benefit set was to become law, Minnesota's uninsured population would probably grow.

Minnesota's business community supports universal access to health care. We have done so since the beginning of this decade. We believe that making health care affordable and keeping it that way is the foundation for universal access.

Today, many employers are able to provide coverage for about $115 PMPM. The Health Care Commission's informal survey of plans showed that the average cost was about $140 PMPM. Our benefit set would increase these averages significantly. As a result, Minnesota's covered population would likely decline. The committee's recommendation is not only contrary to business' objective, but also to its own guiding principles. (Specifically, see guiding principles #1 and #4.)

The legislature asked our committee to develop a benefit set that was both comprehensive and affordable. That was (and is) a difficult challenge. Some people believe that the two objectives are incompatible. We believe that by linking coverage to outcomes it is possible to be both comprehensive and affordable. This is not a traditional approach to health care coverage. We were unable to convince our colleagues to try it. Instead, they chose to work toward a list of coverages, missing a major opportunity to

move our health care system toward one based on outcomes as opposed to procedures. The report is, in short, a missed opportunity.

Sincerely,

William A. Blazar
Vice President,
Minnesota Chamber of Commerce

Steve Wetzell
Executive Director,
Business Health Care
Action Group

Tom Ebert
President,
Employers Association

/nja

cc: Business representatives, Minnesota Health Care Commission
Regional Health Care Coordinating Boards

December 15, 1994

To: Commissioner Mary Jo O'Brien

From: USBS Advisory Members

Dr. Kerry Beebe	Ms. Gretchen Flynn	Dr. Christine Goertz
Dr. Seymour Gross	Ms. Anne Henry	Dr. James Jordan
Ms. Beth Krehbiel	Ms. Jane Legwold	Ms. Salimah Majeed
Mr. Mark Moilanen	Ms. Luanne Nyberg	Dr. Charles Oberg
Ms. Dee Richards	Ms. Donna Zimmerman	

Thank you for giving us the opportunity to participate on the USBS Advisory Committee. The Committee was a diverse group, representing the interests of a broad spectrum of Minnesotans, and our debates were often lively. Nevertheless, we were able to reach decisions on a number of very significant issues in a brief period of time. We strongly believe that the guiding principles, the definition of appropriate and necessary care, and the recommended benefits set (with exclusions) provide a strong foundation for a reformed health care system, and that they are consistent with the legislature's intent to ensure that the health care needs of *all* Minnesotans are met in a cost effective manner that avoids cost shifting.

We are very proud of what the Committee was able to accomplish, but are concerned about several issues that we simply did not have time to address. We, therefore, appreciate the opportunity to comment on these unfinished matters and would welcome the opportunity to reconvene in order to complete these tasks.

Estimating the costs of the USBS

We are concerned that methods used to estimate the costs of the recommended USBS are not in keeping with the Committee's intent, nor with the legislature's intent. In applying traditional actuarial models, there is an assumption that a comprehensive benefits set such as the one we have recommended will result in over utilization and hence, in greatly increased costs. This assumption is based on past history with fee-for-service and HMO models. It fails to recognize the benefits set in the context of managed care as it will be delivered under the ISN/RAPO model in Minnesota.

Under the reformed system, both ISN and RAPO health plans will have great incentives to control costs and promote quality outcomes. In addition, there will be universal coverage and risk adjustment which will eliminate most adverse selection. Requiring health plan companies to offer a broader benefits set will not automatically drive up costs; rather, it will give health care providers and plans a broader array of tools to use in choosing the type of care that is truly most appropriate, necessary, and cost effective for an individual. Many items in the benefits set will allow the health plans to avoid more expensive care alternatives.

As indicated in the 1994 MNCare Act, cost estimates for the benefits set must also consider the expenditures in other parts of the State budget that will be offset by providing a broader benefits set. (For example: elimination of the need for MCHA; enabling more people to get off of Medical Assistance; and the prevention of long term problems that otherwise lead to expenditures in the State's long term care, education, social service, criminal justice and other programs.)

It is, therefore, critical that the methodology used to estimate the costs of the recommended USBS take into account the impact that including a particular health benefit has in reducing the utilization and "per member per month" costs of other health services. (This directive was given by the legislature in the 1994 MNCare Act, Article 4, Section 7, Subd. 4, #9 and 10.) The analysis should either:

- reflect cost savings that arise from the decreased use of other health care, criminal justice or social services in estimates of the cost of an additional or new service. (This analysis may give some services a *negative* cost.) or

- show the reduced costs of core hospital or clinic benefits (including public sector costs) when services are provided that have substantial effects in preventing the need for expenditures for traditional hospital or clinic services.

The firm of Deloitte and Touche indicated that they had little access to data about potential cost offsets resulting from the inclusion of various services in the benefits set. We strongly recommend that efforts be undertaken to gather this type of information so that accurate cost projections can be made. If the costs of the recommended USBS are still too high, we would like the opportunity to make the hard decisions about where the recommended USBS should be pared back. The extensive discussions we have had as a committee place us in a unique position to make such decisions in an informed manner.

Cost Sharing Provisions

We would also like the opportunity to reconvene in order to complete our discussions on cost sharing options as relate to the USBS. We are very concerned that certain types of cost sharing arrangements (deductibles and high co-pays, in particular) will have a negative impact in that they will discourage appropriate utilization and result in further cost shifting. If cost sharing provisions impose serious limits in accessing certain types of services, it's as if those services were not part of the USBS at all. Cost sharing arrangements that discourage prevention efforts and lead to delayed care or poor follow through on a plan of care are counterproductive to the goals of a reformed health care system that is attempting to emphasize quality and cost effectiveness. We, therefore, believe that the issue of cost sharing is directly tied to that of the USBS, and would appreciate having the chance to have more input on this important subject before a final recommendation is made to the legislature.

Glossary of Terms

During the Committee's deliberations, members had extensive discussions about the meanings of terms used as part of the recommended USBS. Background documents containing term definitions were often referenced in preparation for votes on the inclusion of the various types of benefits. Staff from Deloitte and Touche indicated that they also understood the Committee's intent relating to each type of service in the recommended USBS. Nevertheless, the Committee did not have time to compile and approve a glossary of terms to accompany this report. We would appreciate the opportunity to reconvene in order to complete this task so that the Committee's intent will be clear to the Commissioner, the legislature and members of the public who will be using this report as a basis for future decision making.

Clarifications to the Recommended USBS

We have attached several clarifications and a couple of additions to the recommended USBS, which we believe are consistent with the Committee's intent, but which the Committee simply did not get time to fully discuss.

Thank you again for the opportunity to participate in the USBS Advisory Committee. Please don't hesitate to call on us if we can be of further assistance.

CLARIFICATIONS/SUGGESTED ADDITIONS TO THE USBS

HOME-BASED TREATMENT

We wish to clarify that it was the committee's intent that home-based treatment should be covered for all services in the USBS, whenever the home is an appropriate setting. This was specifically discussed in relation to home-based mental health and psychosocial rehabilitation services. It was determined that it would not be necessary to explicitly list home-based services, since the definition of appropriate and necessary care allows all services in the USBS to be covered as appropriate without regard to setting.

VISION

Radial keratotomy/refractive surgery - While we agree with the general exclusion of radial keratotomy/refractive surgery, we strongly believe that it should be considered a legitimate benefit under the USBS in cases where it is medically necessary and no other appropriate treatment is effective for the individual. This point is addressed in the "Exclusions" section of our report, but is not reflected in the recommended benefits set itself.

MENTAL HEALTH

Assessment/diagnostic evaluation/psychological testing - We wish to clarify that psychological testing would not be necessary as part of the assessment in every case. Rather, it is an additional tool that should be accessed as appropriate. Similarly, collateral interviews may or may not be a necessary part of the assessment, depending on the case.

Psychosocial rehabilitation services - It was our intent to see the arbitrary, 60-day limit on psychosocial rehabilitation services removed, but the committee never had time to take a formal vote on this point. The definition of appropriate and necessary care and the managed care model will provide sufficient controls to ensure that such services are used only as appropriate and cost effective in each case.

Specialized treatment and evaluation for dual diagnoses (e.g., MI/CD) should be included in the USBS to more effectively address the complex needs of an increasing number of individuals with dual diagnoses. Although a formal vote was never taken, this point was brought up in our discussions and met with general agreement by the group.

CHEMICAL DEPENDENCY CARE

Outpatient chemical dependency - During the discussion, members expressed their intent to make chemical dependency services consistent with mental health and physical health services, and to emphasize outpatient services as a cheaper alternative to inpatient care. In keeping with these goals, we believe that the arbitrary, 130 hour per year limit on outpatient chemical dependency should be eliminated. As stipulated above, the managed care model and the definition of appropriate and necessary care will guide the amount of service that will provide the best outcomes and be most cost effective in each case.

Rule 25 Assessment for Chemical Dependency

We respectfully suggest that your recommendation to the legislature include the provision that assessment criteria used in the State's Consolidated Chemical Dependency Treatment Fund under DHS Rule 25 be used in determining the level and type of placement for individuals needing chemical dependency treatment. As you know, the 1994 MinnesotaCare Act requires that Rule 25 criteria be used by CISN's and that the cost effectiveness of those criteria be considered in developing the USBS. The Rule 25 criteria are used to place patients most appropriately according to type, level, setting and duration of services.

Rule 25 assessment criteria has proven to be enormously cost effective, with the Consolidated Fund recouping 80% of its expenditures in one year alone. This kind of front-end management has proven to be more cost effective and efficacious than relying on benefit caps. Using the Rule 25 system throughout the state will guarantee that there is only one system for assessment and will facilitate apples-to-apples comparisons of outcome and cost data. While we are all strongly in favor of health care reform, the aspects of our current chemical dependency system that work should not be abandoned. Standardized assessment and diagnosis is something that other health fields are exploring, so it seems counterproductive to regress in the field of chemical dependency.

The USBS committee had a very hurried discussion of Rule 25 criteria at our last meeting, and some of us voted against the inclusion of Rule 25 solely because we did not think it should be listed in Section 7 which details the USBS. Nevertheless, we do believe it is vital to preserve the Rule 25 standard assessment process as part of a reformed health system, and urge you to include it as part of your recommendations to the legislature.

DENTAL SERVICES

We understand that recommendations on dental benefits have been addressed by a separate dental advisory committee, but we strongly recommend that dental services for low income individuals continue to be covered as under the current system. This recommendation is consistent with the resolution adopted by the USBS Advisory Committee that is included in the body of our report.

IMPLANTS - BREAST AND PENILE IMPLANTS

In the committee's discussion of exclusions, we specified that reconstructive surgery or treatment should be covered when related to an injury, illness, congenital disease or congenital malformation. Breast and penile implants should also be covered in such circumstances.

PUBLIC HEALTH NURSING SERVICES

We wish to clarify our understanding that the services listed under the public health section of the recommended USBS may be provided, not only by county public health nurses, but also by a variety of other professionals (e.g., non-government public health nurses, health educators and others), in a variety of settings.

EXCLUSIONS

As indicated in the "Exclusions" section of the report, the committee agreed that further study was needed before deciding if services by persons who are family members or share the patient's legal residence, should be excluded. It should be noted, however, that current law does allow for certain family members to provide personal assistance services under MN Statutes 256B.0627, subd. 4(b)(7). This is an important and cost effective provision of the law, which should be maintained.

December 13, 1994

Minnesota Department of Health
121 East Seventh Place
St. Paul, MN 55164-0975

The Universal Standards Benefits Set Advisory Committee was very clear in discussions that we were defining a set of benefits that Minnesotans would be able to access. We did not specifically list items such as foot or podiatric care, but rather chose to have them included in areas such as preventive, health professional services, surgery, hospital, etc. The driving factor in determining if a service such as foot care is covered will be if it meets the definition of appropriate and necessary. It was also the opinion of the committee that we not mention any particular health care professional provider group, but rather allow the defined benefits to be delivered by providers licensed or register and acting within the scope of their practice.

It is with this background in mind that I would like the record to state that it was my impression that foot care delivered by podiatric, medical, or osteopathic physicians as well as any other licensed health care professional acting within the scope of their practice be a part of the benefit set when appropriate and necessary.

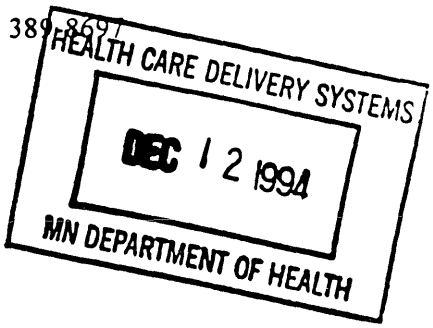
Respectfully Submitted,

Kerry L. Beebe, O.D.

Representative of eye care and allied health providers

Quality Health Alliance

P.O. Box 8674, Mankato, MN 56002-8674 (507) 389-8691



December 7, 1994

Mary Kennedy
Division Director
Health Care Delivery Systems
Minnesota Department of Health
P.O. Box 64975
St. Paul, MN 55164-0975

Dear Ms Kennedy:

I appreciate the opportunity to submit this letter of variance as an appendix to the universal standard benefit set advisory committee report. I have highlighted in a brief format my concerns or issues.

1. *Definitions of services covered within the benefit set have not been thoroughly discussed and documented. This is particularly true for services that have not been routinely been covered in a benefit set in the past. Examples include such things as: personal care services, psycho-social rehabilitation services, adjunct therapies, case management, etc.*

2. *I do not believe there are enough incentive differentials in the benefit set between in-patient and out-patient services. This will require more administrative oversight by health plans to direct patients to the most appropriate service in the most appropriate setting versus incenting the patient through higher in-patient deductibles/coinsurance so that patients would self select the least costly setting to receive medical services.*

3. *Although the committee did not have time, nor was it part of their charge, I would suggest that a cross analysis be conducted between the licensing laws for health care practitioners in the state of Minnesota to determine the level of benefit with who could perform the service (or "under the direction of") in the standard benefit set.*

4. *The out-patient emergency room deductible, where there is no hospital admission, is discriminatory to rural patients where there may not be options of physician offices or urgent care centers during certain days or times of the day. In many*

out-state communities, the only option for routine nonemergent after hours care is the hospital emergency room.

5. *Lastly, this benefit set option of Plan C greatly increases the level and breath of benefits provided. I would prefer a more incremental approach to adding benefits after a thorough/cost benefit analysis can be conducted for each new benefit to be added.*

I appreciate the opportunity to serve on this committee and to provide these comments.

Sincerely,

Robert Stevens
Executive Director

RS:db

RIVER REGION COMMUNITY SERVICES
RIVER REGION HOME HEALTH
RED WING HOSPICE
434 West Fourth Street • Suite 200 • Red Wing, Minnesota • (612) 385-3410 • FAX (612) 385-3414

December 8, 1994

Mary Kennedy
Division Director, Health Care Delivery Systems
Minnesota Department of Health
121 East Seventh Place
P.O. Box 64975
St. Paul, MN 55164-0975

Dear Ms. Kennedy,

Please find enclosed the requested corrections to the USBS draft.

In the benefit set listing:

Home Care:

The committee agreed to remove the limit on medical social services.

Public Health:

The committee agreed that public health services were adequately covered under prevention, home care and health professional services with the exception of health clinics. The committee decided to list under public health services: nursing and health clinics (e.g. WIC, immunization, school and teen services) This item is listed but was not checked as a covered service in Plan C.

Hospice:

The committee agreed to define hospice services as follows:

Hospice care (as described under Hospice Medicare Benefit)

* Physician and nursing services, medical appliances and supplies, out-patient drugs, short-term inpatient care (including respite care), home health aide and homemaker services, physical, occupational and speech/language therapies, Medical social services, dietary and other counseling.

Covered services : 100%

Cost-sharing: Copays - drugs 5% up to $5.00

- Inpatient respite $5.00 per day

Exclusions

In the exclusion listing (item n):

While recognizing the legitimate attempt to exclude "frivolous care", the committee decided the phrase "personal comfort" may exclude very legitimate care to alleviate pain and suffering such as hospice care and/or maximize dignity and independence. Item k adequately addresses the issue of excluding frivolous care.

Cost sharing

Although the committee did not address cost sharing options I want to reiterate MN HomeCare's position that individuals who need medical care should not be inappropriately discouraged from using services that could reduce the risk of need for more costly institutional care. A copay requirement for home care would create strong barriers for those in need of health care.

On behalf of the Minnesota HomeCare Association, I would like to thank you and your department for the opportunity to serve on this committee.

Sincerely,

Beth Krehbiel

Beth Krehbiel, PHN, MBA
Government Affairs Committee
Minnesota HomeCare Association

MINNESOTA COUNCIL OF HMOs

2550 University Ave. W.
Suite 330 North
St. Paul, Minnesota 55114

December 12, 1994

Ms. Barbara Nerness
Assistant Commissioner
Minnesota Department of Health
Health Care Delivery Systems Division
P.O. Box 64975
St. Paul, MN 55164

Dear Ms. Nerness,

Thank you for giving us the opportunity to comment on the final report of the Universal Standard Benefit Set Committee.

The Minnesota Council of HMOs believes that in the context of wanting to expand coverage and to increase affordability, the HMO benefit set currently in law (set "A") is most appropriate to be used as the standard benefit set. It is comprehensive and includes preventive services which makes it appropriate for most Minnesotans. Additionally, it allows more flexibility in meeting the wide range of additional needs that exist in our state.

The proposed standard benefit set "C" is more inclusive than necessary to assure a basic level of quality health care for all Minnesotans. If enacted into law, we will see two undesirable results: inappropriate use of certain services and large increases in cost of coverage for those currently insured. This will lead to more people dropping their coverage or moving to self-insurance.

The proposed standard benefit set "C" also includes many public health functions that are currently the responsibility of public entities. We would ask that the ramifications of redirecting responsibility for these public health functions be given more consideration and discussion than in the context of this universal benefit set determination.

The proposed definition of "appropriate and necessary" is much too broad to allow for clarity in how coverage decisions are made. Because the language is open to several different interpretations and does not clearly state who is ultimately responsible for coverage decisions, we anticipate that this definition is ambiguous enough to prompt an increase in litigation.

The term "providing services in the least restrictive settings," can be interpreted to mean that plans could no longer manage referrals or limit the network of providers with whom they contract. This will lead to serious increases in health care costs, especially for those who currently choose a more limited access network for the increased quality measurement and cost savings they can realize. Requiring coverage of services that "detect an incipient problem or prevent the reasonable likely onset of a health problem" is problematic. With the myriad of health conditions that can occur, one would have to include every test or service available at all times, with no clear responsibility for determination of whether these services are appropriate and necessary. We would suggest clarifying the definition by stating that the health plan responsible for providing the care is also given the responsibility, in consultation with its providers, for determining what the specific parameters by which appropriate and necessary determinations are made.

The USBS committee proposed creating a list of exclusions that would be put into law. Our greatest concern with the exclusions list as ratified by the committee is that it removes the ability of health plans to make the determinations of what is appropriate and necessary care. This is one of the basic tools of managed care organizations in assuring high quality and efficient use of resources.

Since exclusions are contractual issues, it is unclear as to how this list is to be used by the plans. If these are to be the only exclusions allowed by law, it does not take into account the speed with which new technologies and treatments, some effective and some not, are being developed. It will eliminate the ability of plans to be as clear as possible with their members as to what their coverage includes.

We appreciate being given the opportunity to participate in the important work of this committee. We believe that cost and quality considerations are not mutually exclusive. They can be balanced to assure a benefit design that allows for flexibility to meet a variety of needs and controls costs to allow affordability for everyone.

It is obvious to us from the outcome of the Universal Standard Benefit Set Committee meetings that we are all committed to the same thing, meeting the health care needs of Minnesotans. We hope that the work of this committee will serve as the continuation of a constructive dialogue between all who want to reach that goal.

Sincerely,

Deborah Glass

Deborah Glass
Vice President, Government Programs
Blue Cross Blue Shield of Minnesota

Patti Warden (cgj)

Patti Warden
Director of Finance
Medica/Allina Health Systems

Ghita Worcester (cgj)

Ghita Worcester
Director of Development and Marketing
UCare Minnesota

Members, Minnesota Council of HMOs

Minnesota
Department of
Employee
Relations

Leadership and partnership in human resource management

TO: Barbara Nerness, Assistant Commissioner
Minnesota Department of Health

FROM: Kathleen P. Burek, Manager
Employee Insurance Division

DATE: December 9, 1994

SUBJ: Variance Letter to the Universal Benefits Set Advisory Committee Report

As an agency member of the Health Care Commission and the Minnesota Health Data Institute, the Department of Employee Relations (DOER) has been actively involved, and supportive of, Minnesota's health care reform efforts. We have been a nationally recognized leader in providing comprehensive benefits to our employees at the lowest possible prices. We share the concern of many of the members of the Universal Standard Benefits Set (USBS) Advisory Committee about the needs of populations who are underserved by conventional insurance programs and by the sometimes perverse incentives created for publicly financed programs. It with regret then, that DOER cannot concur with the recommendations of the USBS Advisory Committee.

The USBS Benefits Set C would nearly double the costs for health insurance for those employers who offer indemnity plans. This is an unacceptable increase in costs for Minnesota businesses. The increase in costs will significantly erode employer-provided insurance among private, small employers, increasing the numbers of uninsured who will then need assistance through Minnesota Care. Despite the best of intentions, the USBS Committee has proposed a system that may actually worsen access to health services for low income persons and special needs populations.

Costs to the State for our employee benefits program will increase by approximately 50%, an unacceptable burden on Minnesota taxpayers. Further, the expanded benefits set constitutes an unfunded mandate on local units of government. Local units of government would be required to fund the additional benefits with no assistance from the state.

This memo re-states and expands on comments I made early in the deliberations of the USBS Committee.

There was much discussion at the committee meetings about "shifting" costs "back" to the private sector. However, we must remember that public programs are funded by the private sector through the tax system. The tax system has the advantage of being mandatory, hence, broad based. It is also reasonably progressive. The expanded benefits set substitutes the insurance system for the tax system. In contrast to the tax system, employer-sponsored insurance is voluntary, and thus narrowly based. While it is true that we are already paying for these services, a shift in the payment system allows some to escape their share of the payments, while others will assume an additional burden.

As long as ERISA pre-empts the state from mandating employer-sponsored health insurance, an expanded benefit set has two impacts in the private sector. The first is that large and medium-sized employers will increasingly self-insure, and not cover the additional benefits. Their employees and dependents will continue to rely on the public sector for access to the uncovered services.

The second impact is on small employers, increased numbers of whom will drop insurance if they already provide it. Those small employers who do not now provide insurance benefits will find health coverage priced even further beyond their reach. According to data presented to the Health Care Commission, the very smallest businesses, with the lowest payrolls, are those least likely to offer insurance coverage now. If small businesses cannot afford health insurance at current prices, they will not be able to afford the benefits set recommended by the advisory committee.

Individuals who currently purchase their own insurance will also be disadvantaged; many of these are low income people. Children are typically uninsured because their parents are not insured. Any erosion in privately sponsored insurance will harm one of the populations about which we are most concerned.

The Health Care Commission is developing its recommendations for financing universal coverage based on the assumption of a benefits set costing between $140 and $160 per member per month (pmpm). The Benefit Set C included in the USBS Committee's recommendation has an estimated pmpm cost of $197. The Health Care Commission would need to completely re-examine its financing options in order to raise the additional revenue needed to fund the proposed benefit set for Minnesota Care recipients. The Commission's preliminary targets for tax increases have been negatively received by legislative leaders. A larger set of tax increases would appear to have little chance of enactment.

The State and local units of government, unlike private businesses, do not have the option of ignoring legislative benefits mandates. Most public insurance is offered through fully-insured products, which will need to meet the requirements of the new benefits set. The increased costs associated with the expanded benefits set would therefore constitute an unfunded mandate on counties, cities, and school districts which provide employee insurance. Local units of government will be faced with the choice of raising taxes, cutting programs and services, or attempting to negotiate salary reductions with public employee unions in order to pay for the enhanced benefits, which labor has not sought at the bargaining table.

A conservative estimate of the additional cost to the State of Minnesota Employees Group Insurance Program (SEGIP) is over $100,000,000 per year. Almost all of this cost would be borne by the taxpayers, given current employer contribution levels. Some costs will be borne by employees, since employees pay 10% of the cost of family medical insurance if they choose the low-cost plan, and pay the difference between the low-cost plan and the higher-priced plans for single and family coverage.

Currently, services provided to low-income and special needs populations are funded by federal and state dollars. The theory behind the shift to the insurance system is that costs to the public sector for these programs will be reduced. Given the potential increase in the number of those seeking coverage through Minnesota Care due to erosion of employer-sponsored coverage, the continued need for public programs by employees and dependents of large, self-insured businesses, and increases in public employee benefits costs, the promised savings may be minimal at best.

The information available to the USBS Advisory Committee did not lend itself to the kind of balancing of costs and value which are needed in developing a benefits set within budget constraints. When DOER or any other employer considers a new benefit, a change in copayments, or expansion of existing coverage, we look at the incremental, per member per month (pmpm) cost of that benefit. The USBS did not have pmpm information on the individual services to be added to typical commercial products. We only received a global cost estimate of the entire package from the actuaries. We did not have the opportunity to make trade-offs or to assign priorities among services that would have been necessary to keep the cost of the USBS within established budget targets.

There is no doubt that some populations have not been well served in traditional insurance plans, and that eligibility standards for public programs often contain perverse incentives. We at DOER agree that it makes no sense to require people who could work to impoverish themselves in order to obtain needed health care services. It is possible to solve these problems in a more targeted fashion than to create a universal, standard

benefit set based on the highly specialized needs the population served by public programs.

The USBS Committee spent many hours to come as far as we did. It is clear from the resulting recommendations that much more work needs to be done. On behalf of DOER, I wish to express my appreciation for the work of the committee and of Department of Health staff. Again, I regret that DOER cannot support the Committee's recommendations.

Appendix C

Materials Submitted to the USBS Advisory Committee

Materials Submitted to the USBS Advisory Committee

The following materials were submitted to the USBS Advisory Committee from a variety of sources.

Document	Organization	Author	Date
Letter re: Model Comprehensive Health Care Model		Paul Sollie, Intake Social Worker	10/6/94
USBS Actuarial Costing Model (Presentation)		Deloitte & Touche	9/28/94
Report to MN Department of Human Services, Study of a Uniform Benefits Package		Deloitte & Touche	6/94
USBS Initial Cost Estimates -- Presentation		Deloitte and Touche	11/7/94
BellSouth Inc., Mental Health Care Facts			10/4/94
Proposed Benefit Set D -- Draft		Mark Moilanen	10/24/94
Letter		John W. Tomlin, VP of Finance,Gillette Children's Hospital	9/13/94
Draft Definition of Appropriate & Necessary Care ss1833b			
Guiding Principles for the Universal Standard Benefits Set (USBS)		Mark Moilanen, Courage Center	9/28/94
Cost Sharing Common Terminology			9/28/94
Definition of Appropriate and Necessary Care		Mark Moilanen, Courage Center	10/4/94
Position Statement	Accessible Space, Inc.		9/16/94
Letter	Ad Hoc Group of USBS Advisory Committee Members		
Recommendations and Comments on Exclusions	Ad Hoc Group of USBS Advisory Committee Members		11/10/94
Suggested Definition of Appropriate and Necessary Care	Ad Hoc Group of USBS Advisory Committee Members		
Recommendations and Comments on Exclusions	Ad Hoc Group of USBS Advisory Committee Members		11/10/94
Additional Actuarial Assumptions	Ad Hoc Group of USBS Committee Members		

Document	Organization	Author	Date
Technical Assistance Monograph #5, State Efforts to Define Standard Health Benefits Packages	Alpha Center	Rebecca R. Paul & Daniel M. Campion	8/24/93
Position Statement	American Diabetes Association, MN Affiliate		9/19/94
Standard Benefits in Health Care Reform -- The Impact and Cost	American Academy of Actuaries		5/93
Letter	American Diabetes Association	Ron Soskin & Dace Trence	11/11/94
Letter	American Physical Therapy Assoc.	Joanne Bohmert and Peter Polga	10/17/94
Rx for Health: the Family Physicians' Access Plan	American Academy of Family Physicians		10/92
Suggestions on Vision Care Benefits and Cost Sharing	Brainerd Eyecare Center	Kerry Beebe	11/8/94
Suggested Changes to Benefits Set C	Courage Center	Mark Moilanen	
Mental Health Services Basic Benefit Set Considerations	Hamm Clinic		
Psychotherapy Needs of Patients With Mental Disorders (The)	Hamm Clinic/Washington Psychiatric Society		
Mental Health Services Basic Benefit Set C	Hamm Clinic		
Mental Health Service Basic Benefit Considerations	Hamm Clinic		
How to Manage CD in the USBS for Optimum Outcomes and Cost Effectiveness	Hazelden Foundation		10/21/94
DSM-IV Classification	Jane Legwold, Park Psychotherapy & Consulting Inc.		
Position Statement	League of Women Voters		11/3/94
Statewide Goals for Community Health Services	MDH/CHS/Section of Public Health Nursing		1/93
Letter	Medical Alley	James Stice	11/10/94
Statement of Principles	Medical Alley		9/26/94
Letter Re: Input Regarding Exclusions	Medical Alley		11/10/94
Recommendations for the Mental Health Component of the USBS	Mental Health Assoc of MN and MN Psychological Association		9/27/94

Document	Organization	Author	Date
Designing a State Subsidy Program, Questions and Broad Policy Options (Discussion draft -- not approved by the MHCC)	Minnesota Health Care Commission		9/21/94
Principals [sic] in Designing the Universal Benefit Set	Minnesotans for Affordable Health Care		
Letter	MN Disability Law Center	Anne Henry	10/12/94
Position Statement	MN Mental Health Professional Coalition		
Examples of Current Contract Features -- Discussion Draft	MN Department of Health		10/27/94
Eye Care Component of USBS	MN Optometric Assoc and MN Academy of Ophthalmology		9/26/94
Cost-Sharing Discussion Outline ss1930b	MN Department of Health	Deloitte and Touche	11/7/94
Hospice: Managed Care for the Terminally Ill	MN Hospice Organization		
1994 MinnesotaCare Act -- Summary	MN Department of Health		5/94
1992 MinnesotaCare Act -- Summary	MN Department of Health		1/93
Memo re: The Home Care Benefit	MN HomeCare Association	Beth Kriebel	10/25/94
Universal Benefits Set Recommendations	MN Council of HMOs		
1994 SHP Benefits which Differ from the DHS Uniform Benefit Package Chart	MN Department of Employee Relations	Kathleen P. Burek	9/27/94
Memo re: The Hospice Medicare Benefit	MN Hospice Organization	Daniel Holst, Director	10/24/94
Improving Health and Reducing Health Care Costs in Minnesota	MN Dietetic Association		5/93
Letter re: How Hospice Benefit is Defined in the benefit set	MN Hospice Organization	Daniel Holst, Director	9/9/94
Children's Benefit Set and the USBS	MN Department of Health	Barbara Nerness, Asst. Commissioner	9/30/94
Position Statement on the USBS	MN Consortium for Citizens with Disabilities		9/2/94
1993 MinnesotaCare Act -- Summary	MN Department of Health		5/93
Position Statement	MN Academy of Audiology		10/20/94
The Hospice Medicare Benefit	MN Hospice Organization		10/24/94

Document	Organization	Author	Date
Position Statement on the USBS	MN Independent Health Care Provider Coalition		10/5/94
Position Statement on the Definition of Appropriate and Necessary Care	MN Hospital Association		10/6/94
USBS Guiding Principles -- Discussion Draft ss1837	MN Department of Health	Deloitte and Touche	
Letter re: USBS committee Issues	MN Disability Law Center	Anne Henry	10/3/94
Position Statement	MN Assoc of Home Care Social Workers		9/18/94
Standard Benefit Set Discussion -- Draft ss1783	MN Department of Health		
Universal Coverage Report Summary	MN Health Care Commission		2/1/94
USBS Model C and Children's Benefits Recommendations	MN Department of Health/Division of Family Health		11/9/94
USBS Enabling Legislation	MN Department of Health		5/23/94
Home Care in the USBS	MN HomeCare Association		10/1/94
Letter	MN Nurses Association	Eileen Weber	11/14/94
Letter, The Nutrition Document	MN Dietetic Association	Julie Ann Seiber	11/14/94
Position Paper on Chiropractic Coverage in the USBS	MN Chiropractic Association		10/5/94
Letter	MN Disability Law Center	Anne L. Henry	11/10/94
Position Paper	MN Occupational Therapy Association		9/28/94
Foot Care Component of USBS	MN Podiatric Medical Association		10/5/94
Contract Exclusions	MN Department of Commerce		11/7/94
Long Term Care Benefits	MN Long Term Care Campaign		9/27/94
Cost-Sharing Worksheet ss1892	MN Department of Health	Deloitte and Touche	10/94
Chemical Dependency Coverage in Basic Benefit Set	MN Department of Human Services	Cindy Turnure, Dir., Chemical Dependency	9/1/94
Guaranteed Benefits Set Task Force Report 1994	MN Medical Association		9/94
Costs of Failing to Provide Appropriate Mental Health Care (The)	MN Psychological Association		
Memo re: Cost Estimates - USBS	MN Chamber of Commerce	Bill Blazar	11/16/94

Document	Organization	Author	Date
Position Paper on Behalf of MN Farmers Union	MN Farmers Union	Winona Zimmerman	9/26/94
Proposed Changes and Additions to Plan C	MN Dietetic Association	Julie Ann Seiber & Phyllis Nickels	11/17/94
Letter	MN Psychological Association	Sy Gross, President	10/6/94
Improving Health and Reducing Health Care Costs in Minnesota	MN Dietetic Association		
Medical Benefits Task Force Reports, 1991 and 1994	MN Medical Association		8/29/94
Position Paper	MN Air Medical Council		9/29/94
Request to Add Health Services and Clarification to Benefit Set C	MN Disability Law Center		11/10/94
Home Health Care Benefits	MN HomeCare Association		
MN Universal Benefit Set: Recommendations for Mental Health Coverage: Type, Frequency, Level, Setting and Duration	MN Mental Health Professional Coalition		9/94
Minnesota's Health Care Programs -- A summary of medical programs ...	MN Department of Human Services		5/94
MN Universal Benefit Set: Recommendations for Mental Health Coverage: Type, Frequency, Level, Setting and Duration Draft	MN Mental Health Professional Coalition		8/94
MN Health Care Commission -- Presentation re: Financing Strategy and Categories of Savings to Offset the Cost of Universal Coverage	MN Health Care Commission		9/15/94
Notes on Standard Benefit Set (10/11/94)	MN Association of Community Mental Health Programs, Inc.		10/24/94
Newspaper Articles	MN Multiple Sclerosis Society	Doug Grow, *Star Tribune*	9/2/94
Letter	MN Pharmacists Association	Lowell J. Anderson	10/6/94
USBS for Children: Recommendations	Natl Assoc of Pediatric Nurse Associates & Practitioners		
Letter	North Memorial Home Health and Hospice	Rosemary Moneta, Director	10/4/94
Scope of Health Care Benefits for Infants, Children, and Adolescents Through Age 21 Years	PEDIATRICS Vol. 91 No. 2	Committee on Child Health Financing	2/93

Document	Organization	Author	Date
Pharmaceutical Coverage, Access and Benefit Design for the MN USBS Advisory Committee -- Key Issues	Pharmaceutical Research and Manufacturers of America		9/15/94
Letter	Social Work Public Policy Action Group	Tony Bibus, Chair	10/4/94
Final Report to the Legislature	The MN Health Care Access Commission		1/91
Guiding Principles Excerpted from the Background Reading Material	Universal Coverage Summary Alpha Center Report MMA Medical Benefits Task Force 2/91		

Appendix D

Meeting Minutes

September 8, 1994

September 28, 1994

October 7, 1994

October 12, 1994

October 20, 1994

November 7, 1994

November 17, 1994

Meeting Minutes

Note: To obtain attachments mentioned in USBS Advisory Committee meeting minutes, please contact the Minnesota Department of Health at (612) 282-3842 and request the specific attachments you would like to receive.

Universal Standard Benefits Set (USBS) Advisory Committee
Summary Minutes for September 8, 1994

I. Introduction

The meeting was called to order by Ann Christ, Chair. Each member of the committee introduced themselves.

Mary Kennedy, Acting Division Director for the Health Care Delivery Policy Division, indicated that while the committee will not receive a per diem, the members are eligible for reimbursement of travel expenses.

II. Charge of the Committee

Barbara Nerness, Assistant Commissioner, described the legislative charge and elaborated on the statutory requirements that go along with the charge.

USBS Committee Charge

> To develop recommendations regarding the services, other than dental services, to be included in the universal benefits set which address the enrollee's mental and physical condition.
>
> The universal standard benefits set must contain all appropriate and necessary health care services. Benefits necessary to meet public health goals, adequately serve high risk and special needs populations, facilitate the utilization of cost effective alternatives to traditional inpatient acute and extended health care delivery, or meet other objectives of health care reform shall be considered by the USBS Advisory Committee and the commissioner for inclusion in the universal standard benefits set. Appropriate and necessary dental services must also be included.
>
> Laws of Minnesota, Chapter 625, Article 4, Section 7.

These recommendations will be made to the Commissioner of Health who will be working in consultation with the Minnesota Health Care Commission, the Commissioner of Human Services and the Commissioner of Commerce.

The Legislature's expectation is that the USBS be comprehensive in nature as opposed to minimum or basic. The committee must also be aware that there will always be a need for supplemental services and benefits in order to assure that certain populations, especially those with special needs, receive all necessary services. Although it is not the responsibility of the USBS Advisory Committee to deal directly with the financing issues relevant to the USBS, the committee must consider the financial implication of various benefits as it develops the package of various health services to be provided. Actuarial information will be available to ensure the committee is continuously cognizant of financial issues.

Barb Nerness further explained that in developing the USBS, the legislature directed the commissioners to take into account factors including, but not limited to the following:

Factors for Consideration

(1) information regarding the benefits, risks, and cost-effectiveness of health care interventions;
(2) development of practice parameters;
(3) technology assessments;
(4) medical innovations;
(5) health status assessments;
(6) identification of unmet needs or particular barriers to access;
(7) public health goals;
(8) expenditure limits and available funding;
(9) cost savings resulting from the inclusion of a health care service that will decrease the utilization of other health care services in the benefit set;
(10) cost efficient and effective alternatives to inpatient health care services for acute or extended health care needs, such as home health care services; and
(11) the desirability of including coverage for all court-ordered mental health services for juveniles.

The recommendations of the advisory committee will be taken to the public through various existing forums and committees including Regional Coordinating Boards, State Community Health Services Advisory Committee, Maternal and Child Health Advisory Task Force, Emergency Medical Services Advisory Committee as well as other possible forums.

The Committee asked for a copy of the public health goals. The Department will provide them for the next meeting.

III. Meeting Protocol

The meetings will be taped. In order to facilitate this, please state your name before speaking. The meetings are open to the public. Although the public cannot provide testimony at these meetings, written comments are encouraged.

IV. Roles

Minnesota Department of Health: Review the USBS Advisory Committee report and make a recommendation to the legislature in January.

Departments of Human Services and Commerce: The Commissioner of Health must consult with these agencies on the USBS.

Contractor: Deloitte & Touche will provide technical assistance concerning the benefit sets and additional assistance on determining cost sharing and the affordability study.

Advisory Committee: The role of this committee is to make specific recommendations on benefits to be included in a USBS to the Commissioner of Health. The Commissioner of Health will submit a report to the Legislature in January 1995.

V. Review of Background Information

The material was reviewed briefly.

VI. Preliminary benefit sets

The department of health presented two standard benefit sets for discussion purposes. During the ensuing presentation and general discussion several points arose about the relationship of the USBS Committee's role and the role of the Minnesota Health Care Commission in the financing study.

VII. Committee Discussion

Based on the general discussion of the benefit set options, the committee developed a list of issues that need to be considered and a list of draft guiding principles for consideration.

Issues (Listed, but not prioritized)

Some plans will not pay for prescriptions written by a nurse practitioner.

Nutritional services.

Transportation: emergency and non-emergency.

Catastrophic cases currently go to another system. Can we alleviate the barriers?

What should be in the public sector or public health sector or the USBS?

Are we getting to a discussion of 24-hour coverage; workers comp; lifetime (is this beyond the scope of the group?)

Need a definition of case management.

Transplant services: medically necessary v. experimental -- these issues need clarification.

Should be a broader category of reproductive services be considered preventive services?

Treatment of mental health services:
- Court ordered mental health services (may not now be provided except in the public sector)
- School Psychologist services (talk to Dept of Education)
- Chronically Mentally ill -- Community Mental Health Centers (What are the components of care)?

Continue capitated system for Hospice services.

Efficacy v. effectiveness: scientific research v. research in practice setting; efficacy may not be effective.

How does prevention fit into benefit set?
- Periodic v. routine exams
- Time based cost shifting, e.g. Nicotine patch v. cardiac care later.

While developing the USBS, need to consider that the delivery system trend is moving from fee-for-service to managed care.

Add "assistive technology" to Durable Medical Equipment category.

Add "examination and adjunct therapies" to Chiropractic category.

Home health -- should not have a day limit.

Guiding Principles for Consideration
Outcomes measurements.

Moral responsibility.

Cost to society in other areas:
- Juvenile
- People afraid to leave public programs because they will lose their medical benefits
- Effect on local property taxes.

Special Populations:
- Different services for different populations, e.g. adolescents, high risk pregnant women.

Promote cost sharing, not cost shifting:
- Any subsidy is a shift
- Cost sharing is explicit, cost shifting is not
- Account for hidden costs in plans if shifts occur to public programs.

Accessibility of services, especially rural Minnesota.

Incentives:
- We do not want to create incentives to "dump" patients into another system.
- Include incentives to keep patients in "primary tier" before "dumping" to second tier.
- Incentives to do the "right thing".
- Create incentives to promote independence; avoid institutions.

Define benefits by what we are trying to achieve.

Shifting cost to providers.

In addition to these mentioned, consider ones that other places used that are in the background reading material (see attached):
- Universal Coverage Summary, A Vision for the Future (p. 2)
- Alpha Center Report, Pages 8-9, 20-21
- MMA Medical Benefits Task Force, 2/91, Values and Principles (pp.3-4).

VIII. Next Steps

The Health Department will take the lists of issues and guiding principles to Deloitte and Touche for consideration as they develop additional standard benefit set options.

At the next meeting, the advisory committee will refine the list of guiding principles.

The following information will be available at the next meeting:

- The list of state mandated health benefits
- Preliminary cost estimates on the two standard benefit sets that were presented at today's meeting
- Three additional benefit sets
- Draft definition of appropriate and necessary
- Affordability information

Chair Christ adjourned the meeting.

Universal Standard Benefit Set Committee
Summary Meeting Minutes for September 28, 1994

I. Opening Remarks

The meeting was called to order by Ann Christ, Chair. She reminded the committee of their very full schedule for the afternoon and the need to move through the agenda aggressively.

Assistant Commissioner Barbara Nerness made several comments.

She appreciated that some committee members were able to attend the Legislative Oversight Committee Meeting earlier today.

She said that the Health Care Commission is extremely interested in being kept informed of the work this committee is doing and that this committee should also be cognizant of the work the commission is doing concerning global financing of the benefit package. She further stated that it is important for this group to work through what the benefit package should be, but also important to be cognizant of the financial issues that relate to the services. The committee needs to keep in mind that actuarial services will price out that package. Asst. Commissioner Nerness reported that the commission will be sending a staff person to discuss the cost sharing options and financing structure.

Asst. Commissioner Nerness reported that some of the deliverables on cost estimates from Deloitte and Touche probably will not be available until after the last scheduled meeting. Therefore, there may need to be another meeting to make sure the committee is able to have some discussions about that information.

Committee members commented that looking at cost may limit the benefit package in a way that continues to shift costs onto public programs, that comprehensiveness may in some instances be a cost saving mechanism, and that providing some services provides cost offsets in other areas.

Assistant Commissioner Nerness acknowledged that considering cost should not be done to the exclusion of these points and to give the Department of Health any data members may have on those issues.

II. Discussion of Guiding Principles

The Committee broke into four small groups: providers, purchasers/government, consumers, and health plan companies to discuss what the guiding principles of this committee should be. Principles are numbered where edited from the original Deloitte and Touche draft (attached), and listed as new if developed by the group. The summary of each groups comments are as follows:

The Government/Purchasers group:

1. Every Minnesotan should have access to a standard benefit set.
2. as is on draft

new The SBS maximizes the health of the population as a whole.
new The SBS is cost effective and results oriented.
new The SBS takes on a holistic systems approach that's broader than the medical model.
new The SBS approaches the benefit set design from an exclusionary angle and include broad categories of services with discretion to adapt to changing technology and innovations.
new The SBS incents providers to keep people healthy.

The Health Plan Companies group worked from the draft as follows:

1. Every Minnesotan is entitled to an affordable standard benefit set which defines appropriate and necessary health care services.
2. All Minnesotans share a responsibility for their health and well-being. (then incorporating part of #9) The SBS should encourage health promotion, wellness education, disease prevention and early detection.
3. deleted
4. The SBS should promote utilization of services that are clinically effective and cost efficient.
5. The SBS is a key element in the broad effort to improve the overall health of Minnesotans while controlling the rate of increase in health care costs.

6.-8. deleted

10. The SBS should encourage administrative consistency within its design, and should promote consumer understanding of its covered health care services.

new In designing the SBS we must balance the benefits included with the most of that coverage.

The Provider Group:

1. Every Minnesotan is entitled to increased access to health care.
2. All Minnesotans, to the extent they are capable, share a responsibility for their health and well-being.
3. The SBS should be comprehensive and include all appropriate and necessary health care services.
4. The SBS should promote utilization of services that are clinically effective so that they include services for those who need health services to improve their functioning, and those for whom maintenance of health may not be possible, and those for whom preventing deterioration in their health conditions might not be achievable. The focus of the benefit set must be on long range outcomes and long term cost effectiveness as opposed to short term expenditures.
5. no changes
6 The direct and indirect costs of the SBS should be affordable to the community.
7 no changes
8. The SBS should define a standard level of covered health services.
9. Add sentence. Services should reflect a continuum of care that goes beyond the narrow medical model.
10. no change

Add the following concepts:

- Must look at effects of cost off-sets.
- Services must be geographically available.
- Do not cost shift to other aspects of society.
- Do not narrow current benefits to high risk patients.
- Encourage innovation and improvement.

The Consumer group, working from the draft, made the following changes:

1. Every Minnesotan has a right to access to a standard benefit set without regard to age, race, gender family composition, geographic location, income, employment status, citizenship status, diagnosis or functional status. No one should have fewer appropriate and necessary health services than they had in 1994.
2. okay as is.
3. The SBS should include all appropriate and necessary health services which must be broadened to include "those for whom maintenance of health may not be possible and those for whom preventing deterioration in their health conditions might not be achievable".

Services should reflect a continuum of care that goes beyond a narrow medical model.
Benefits should be delivered in a developmentally appropriate manner and without regard to the site of service. Services must be culturally sensitive and appropriate. Cooperation and collaboration between the reformed health system, education, social services and economic security systems are essential.

4. The SBS should promote and assure utilization of services that are clinically effective and cost efficient. The focus must be on long-range outcomes and long-term cost effectiveness as opposed to short term expenditures.
5. (Add) Cost projections must be considered within the overall context of health reform.
6-8. okay as is.
9. The SBS should include health promotion, wellness education, disease and injury prevention and early detection. Emphasis should be placed on early intervention and prevention, but the definition of those terms must be broadened to include services that can reduce expenditures and other parts of the health system.

Chair Ann Christ indicated that the Department staff will take these comments and incorporate them into one document to be available at the next Committee meeting.

III. Discussion of Draft Definition of Appropriate and Necessary

Jim Scearcy of Deloitte and Touche presented on their research of various current definitions of appropriate and necessary from health carriers, consumer groups and in Minnesota statute. This background information provided a historical perspective from which to work when creating a new definition.

Committee comments and questions on this topic included:

- Who will determine how definition is applied: a qualified/certified provider? And who would decide that - the plan? the state?
- The law discusses broadening the definition to include helping improve or slow deterioration this was not included in list.
- Are there numbers on savings from not cost shifting, more preventive medicine, and early intervention?

- How will fee-for-service, versus managed care, impact health care education?
- How do you determine costs without knowing what's going to happen with ERISA?
- How many people will be affected by process if Medicare and Medicaid, Veterans Administration, Bureau of Indian Affairs, self-insureds, are not affected by this benefit set. 40 percent?

Mr. Scearcy cautioned that as you move from broad definitions into addressing the needs of particular groups one must be very cognizant of what that does to the general population which in turn will affect the total cost of the program. He stated that some coverage issues can be addressed in the benefit set as opposed to in the broad sweeping definitions. He noted that many of the questions, while important, did fall outside of the scope of the work Deloitte and Touche did on this topic.

Chair Ann Christ indicated that there was not enough time to break into groups, but members should individually fax in comments to the Department of Health. Staff will develop a draft to reflect the comments. She said if members do not respond, it will be taken to mean that they are comfortable with what was presented.

Additional Committee comments included:

- Feeling uncomfortable about not spending more time on this issue.
- Suggesting breaking into small groups that allow members to cross fertilize.
- We are trying to do too much at once. We need more depth.
- Everything the health care community could conceive of is appropriate and necessary for some patient in some situation but not for every patient every time. Not sure how to go from this to a patient situation.

Chair Ann Christ acknowledged the comments and said that Department of Health Staff will re-evaluate this process and find ways to address this issue. Assistant Commissioner Nerness explained that the reason staff asked for faxed comments was so committee members could bring it back to colleagues, have time to respond, in order that the committee could have a more discussion at next meeting. This was only to provide a spring board from which to develop specifics on legislative intent and other issues.

IV. Discussion of the model to be used for cost estimates

Mr. Scearcy presented the model that Deloitte and Touche will be using to do cost estimates on the benefit sets this committee works on. They will be working to keep the relative numbers very representative. The model didn't exclude self-insureds when pricing relative benefit sets because its difficult to separate them out from the general population. It was pointed out that the uninsured numbers were from 1990. The Department will supply newer numbers to Deloitte and Touche. The cost numbers the committee gets will be useful for comparison and for deciding what should be in and out of the benefit set, i.e., one service costs Y cents per member per month to compare to another service which costs X amount.

Committee member questions and comments included:

- If a benefit isn't represented in the set, is that cost considered? If something isn't covered, will the benefit set appear very cost effective because a cost isn't there but somewhere else?
- The state will have to address difference between public and private expenditures.
- Does the Deloitte and Touche model assume more managed care in 1997 and the savings from it?
- Do data sources used address medical cost offset issues and look at the cost efficiencies of providing services in a broader context than they had in the past to capture the cost savings of going beyond the medical model?
- A group of consumer committee members discussed some additional assumptions which they would like Deloitte and Touche to consider, including looking at cost savings in the long and well as short term, and to explicitly state where they do and don't know the what the long term cost savings will be or whether there will be any.

Mr. Scearcy said the model will not represent some changes in the delivery system that may happen as a result of systems change. Questions about the impact of an individual service changing in a certain manner can be answered. The impact of various provisions on the cost of the program can be detailed. The model will reflect if a service is being paid for by the individual or rolled back into the system elsewhere. He said that costs will be direct costs of the benefit set, if something is limited or not covered, it's costs will not be included.

Mary Kennedy, Health Care Delivery Policy, Minnesota Department of Health explained that some of the questions being asked are related this group, while others are broader and refer to what will be the end product brought to the legislature which will have a number of inputs on broader financing. Deloitte and Touche is under contract to look at benefit design. She asked that they remember this committee is the only committee looking specifically at benefit design.

Mr. Scearcy explained that the Deloitte and Touche model assumes the 1997 market environment including guarantee issue, no preexisting condition exclusions, individual mandate, community rating, more managed care, and an ISN, CISN and RAPO market. The model only trends the costs, however, to 1995. While cognizant of the subsidy issue it is not currently addressed because the model assumes that everyone is included, all their health conditions are covered, and that they are all accessing medical care. The model is not excluding any services for lack of ability to pay right now because cost sharing is not represented yet.

Mr. Scearcy cautioned that the number will not look like what you see today for a individual premium cost. They are using global projections and numbers. The number members will see is presented as per member per month cost which is not the same as an individual premium rate. Commercial products don't price on the individual member basis, so there will have difficulty tying these number to current experience. Dental care is also in this model which is not typically seen.

Mr. Scearcy said that they are assuming that 95% of the services are not in dispute. Administrative costs not reflected here. Social services not included in benefit set A or B because they were only asked to show current models for sake of reference as a starting point.

V. Discussion of different cost sharing options

Department of Health staff distributed a sheet of definitions of some of the currently used cost sharing options. Most of the groups came back saying they had too little information to address this issue and would like a definition of appropriate and necessary and more complete benefit set design before addressing the cost sharing issues. The provider group recommended that all services in a recommended plan of care be covered with no copay or deductible.

VI. Closing Comments

Chair Ann Christ said the committee has a very aggressive agenda for the next scheduled meetings. She requested feedback on how much or how little we can accomplish in the time we have available, and a reminded the committee that we are an advisory group to the Commissioner of Health and we have five opportunities to advise the Department of Health on these various issues. The potential does exist to schedule another meeting, however, time is very limited. The Committee needs to look at the most time effective way of getting information forth. There has been frustration today with the process. She gave her phone number (627-4301) and asked that committee members call her to talk and that she would like to take suggestions on how the committee could better proceed. She gave an overview of the next meeting agenda.

Committee members offered the following comments on how to better the process:

- Would like to be able to read materials before coming, maybe even 1/2 hour before the meeting.
- Doesn't feel some of the legislative intent has been represented in the work done so far.
- Not enough time for thorough discussion of what committee members think.
- Seem to be discussing re-engineering of the system for employed populations only.

Universal Standard Benefit Set Committee
Summary Meeting Minutes for October 7, 1994

Opening Remarks

Chair Ann Christ said that given the frustrations expressed at the last meeting, the first order of business was to discuss the Committee's role, what we've done, and what some of the frustrations were. Barbara Nerness will lead that discussion.

Assistant Commissioner Barbara Nerness thanked members who took the time to talk with her on the phone. The suggestions and comments were helpful because this has never been done before. She asked that committee members continue to give her feedback. She said the Department of Health does not have a grand scheme or plan, so its very important to work together because everyone is working toward the same goal - a good product to give to the legislature. She said the written comments received have been extremely helpful, especially those containing data which the actuaries can use. Department of Health staff met with Committee Chair Ann Christ last Friday to change the meeting plans to reflect concerns raised at the last meeting so hopefully this meeting will be more responsive to your needs. She stressed that people on the committee come from very divergent backgrounds and that some committee members had expressed concern about being able to do what was necessary in order to be effective. It was for that reason that the historical information from Deloitte and Touche on Appropriate and Necessary definitions and benefit sets A and B were presented. She said the committee should, however, work from the statutory directives to proceed. If committee members feel the need for additional time on topics, or time is not being spent wisely, it is important to know so the agenda can be revised.

Assistant Commissioner Barbara Nerness said she had talked with Commissioner O'Brien and she and Mary Kennedy had met with Representative Greenfield and Senator Berglin to get additional information on expectations. The Commissioner said she hopes to receive from the Committee some guiding information in writing on what the definition of appropriate and necessary should look like and the criteria and process to be used in framing a benefit package. She said the Commissioner realizes, however, that with a diverse 37 member Committee she is not predisposing that they will reach consensus, but she is interested in the Committee's opinions. She informed the Committee of another scheduled meeting, Nov. 17th, 8:30 - 12:00, with the room reserved until 4:00 if the committee feels they need more time.

Chair Ann Christ asked for comments on the proposed agenda containing two major discussion issues - guiding principles and discussion of appropriate and necessary In addition Dave Haugen is scheduled to update the committee on the Health Care Commission's financing study at 11:30.

Committee members discussed how to arrive at a report and agreed that some sort of voting process would be necessary. Several members commented that while complete consensus was unlikely a good articulation of opinions would be valuable to the Commissioner.

Chair Ann Christ suggested that the group move into discussing guiding principles as a way of testing out how the Committee will proceed with the ongoing discussion of how they would like to proceed on a given agenda item.

Mary Kennedy, Director of the Division of Health Care Delivery Systems, Department of Health noted that the handout members have is the first compilation of guiding principles that came from each small group's work at the last meeting. She offered the group a range of options in proceeding and asked for suggestions as well. The Committee decided that the guiding principles were key to their work and to discuss them as a large group. Committee members voted and agreed to use the parliamentary process for this discussion.

Working from the summary document of the small group work (attached) the following discussion occurred and guiding principles were determined by the committee:

#1. Every Minnesotan is entitled to access to an affordable standard benefit set which defines appropriate and necessary health care services.

Discussion:
Members agreed that the entitlement should be to access and not to the standard benefit set itself. Some members expressed concern that there was no inclusion of diverse populations in the language and it was agreed to address that in later principles. The Committee decided against the blanket statement that no one should have less than they had in 1994 because current benefit sets vary so widely. Members discussed whether or not all the needs of special needs populations should be included in the basic benefit set. Concerns that the medicaid benefit package would be eroded were expressed. It was mentioned that changing the funding streams for health care may have unintended effects. DHS's position is that there should be a supplemental package to address their needs so that the benefit package is not priced out of the market and so that the entitlements and mandated services for these populations can continue to

exist regardless of what the benefit package looks like. It was mentioned that copays are outlawed in MA so they can not be part of the cost sharing options that are developed. Questions arose about whether or not the general population would be able to "buy up" to those services and, if so, how would it be underwritten, does not that plan already assume lots of cost shifting to government programs, and could not their services rather be included in the benefit set but have some kind of gatekeeper mechanism to keep down pricing of the package. There was confusion about the committee's charge with respect to special populations. Mary Kennedy clarified that the Department interpreted the law to say that in the short term there would be exceptions made in public programs. The law states that public programs will be able to buy additional services, which is a clear indication that SBS would not meet everything covered in public programs. Committee members said that the law says to do more than we do now in considering the needs of people with chronic conditions and disabilities and recognize that cost shifting to public systems does happen. Members discussed the need for change in requiring people to live in poverty to cover their health care costs, and the need for society to bear the cost of this very random and unpredictable situation so that people can work and live independently. Committee members expressed confusion about what should be included while looking at public health goals. Assistant Commissioner Nerness said the Department has been looking at this question for about a year and a half and a report is due to the legislature from the State Community Health Service Advisory Committee (SHSAC) in February 1995. The Department certainly envisions providing core public health functions like food born outbreaks, nursing home inspections, clean water, etc. The Committee will be provided with a copy of last year's report. There is ongoing discussion of how plans will meet public health goals for their individual clients. Committee members said there are three things consumers want from this process - a health plan that is understandable so that they can read the document, that it is consistent from plan to plan, and that it allows for some financial comparison between plans. A Committee member said that if this is viewed as an incremental process over many years, some of these other issues can be addressed that way. It was mentioned that cost shifting occurs in two directions, both by shifting special needs populations to public programs and also through depressed reimbursement rates from public programs, that then must be made up by charging private customers more. Mary Kennedy said that there are a number of processes going on simultaneously in the Department and it probably won't be until the legislative session that they can be linked together.

Guiding Principle number 1 was adopted by a 18 to 8 vote.

#2 All Minnesotans, to the extent they are capable, share a responsibility for their health and well being.

Discussion revolved around whether or not "capable" included financially capable. A committee member said that the original concern was for children and adults incapacitated from making their own decisions. Some concern was expressed that the wording was too broad, but was left as is.

Guiding Principle number 2 was adopted by a 29 to 1 vote.

#3 The SBS should promote and assure utilization of services that are effective and cost efficient. The focus must be on long-range outcomes and long-term cost effectiveness as opposed to short term expenditures.

Committee members expressed concern that diversity was not reflected in an explicit manner, nor special needs language and that if cultural sensitivity is not spelled out it is forgotten. Some members were not comfortable with what the words meant. The Committee moved to use the method of making a preamble taking language from 1 and 3 which are inclusive.
Guiding Principle number 3 was adopted by a 29 to 0 to 1 vote.

#4 The SBS should promote and assure utilization of services that are effective and cost efficient. The focus must be on long-range outcomes and long-term cost effectiveness as opposed to short term expenditures.

Committee members omitted the term "clinically" from effective as it appeared too narrowly focused on the medical model and against putting "proven" into the language because many things for the disabled population have no opportunity to be proven but are necessary.
Guiding Principle number 4 was adopted by a 26 to 3 to 1 vote.

#5 The SBS is a key element in the broad effort to maximize the overall health of Minnesotans while reducing the rate of increase in health care costs. Cost projections must be considered within the overall context of health reform.

Committee members discussed the definition of community health and the difference between community health and individual health. Wording was changed from "controlling the rate of increase in health care costs" to "reducing the rate of increase in health care costs" to reflect statutory language. Language substituting "improve" for "maximize" did not pass.

Guiding Principle number 5 was adopted by a 30 to 0 vote.

#6 The SBS should be directly and indirectly affordable to the community.

Committee members discussed the role of this committee related to cost issues as opposed the Health Care Commission's role and the need to take cost into consideration when looking at a benefit set. Members pointed out that they are charged with looking at the relative cost of including certain benefits, though not to look at global financing issues. Committee members discussed what "direct" and "indirect" means. Committee members voted on several variations of omitting guiding principle 6 and/or 7 in their entirety. Mary Kennedy explained that "direct" tends to mean what you pay for in premiums and out of pocket, while "indirect" tends to mean what a person is paying in taxes and other forms of support.
Guiding Principle number 6 was adopted by a 20 to 8 to 2 vote.

#7 Guiding Principle number 7 was deleted as redundant by a 28 to 1 to 1 vote.

#8 The SBS should define a standard level of covered health services.

Committee members discussed whether or not it was redundant. The committee discussed whether or not the benefit set should be defined by exclusions. A number of variations on an amendment were offered focused on whether or not the benefit set should define specific services or broad categories of services. It was mentioned that sometimes broad categories are used to deny specific services. No amendments passed. The motion to delete #8 in its entirety did not pass. There was discussion about whether "standard" should be changed to "floor" or "minimum", but no changes passed. Mary Kennedy offered clarification that the Department envisions that the benefit set would be comprehensive enough to cover most people, with some buying additional coverage, rather than something so minimal that almost everyone needed to buy additional coverage.
Guiding Principle number 8 was adopted by a 17 to 10 vote.

#9 The SBS should encourage health promotion, wellness education, disease prevention and early detection, as well as other appropriate public health goals and objectives.

Concern was expressed that the terms used were not goals but rather processes and goals would be preferable. Language was offered as an amendment that said "encourage health, wellness and disease prevention" with no second so it was not discussed.

Guiding Principle number 9 was adopted by a 29 to 2 vote.

#10 The SBS should encourage administrative simplification within its design, and should promote consumer understanding of its covered healthcare services.

Committee members expressed concern that cost offset measures were not mentioned here or elsewhere in the principles.
Guiding Principle number 10 was adopted by a 26 to 0 to 1 vote.

The preamble combined pieces of guiding principles 1and 4. Lines through text indicate deletions and underlined text indicates additions.

These guiding principles apply to all Minnesotans without regard to age, race, gender, family composition, geographic location, income, employment status, citizenship status, diagnosis or functional status. ~~No one should have fewer appropriate and necessary services than they had in 1994.~~ The standard benefit set must ~~be broadened to~~ include those who need health services to improve their functioning, those for whom maintenance of health may not be possible and those for whom preventing deterioration in their health conditions might not be achievable. Services should reflect a continuum of care that complements ~~goes beyond a narrow~~ a medical model. Benefits should be delivered in a developmentally appropriate manner and without regard to the site of service. Services must be culturally sensitive and appropriate. Cooperation and collaboration between the reformed health system, education, social services and economic security systems are essential.

Discussion:
Some committee members said the preamble was much broader than they expected. Some members were concerned with the term "narrow medical model" and the group voted to amend as indicated. Concern was expressed that the wording mandates services to a group of people not currently getting services from the health plan. It was explained that the current verbs health plans use now are set up to leave out people with congenital disabilities because they never had a certain functioning level to begin with. For example, If a child is born without an ability, restoring something leaves them outside the scope of the health plan because they are custodial, they are not rehabilitative. The same is true of people who need help to maintain their functioning but this is what the legislative language says should be addressed.

Concern was expressed that this would mean all long term care should be covered. A member pointed out that the same problem exists for more minor care for people being denied physical therapy for an injury so they can continue to work. Once their condition worsens so that they can not work, then the treatment is no longer maintenance but rehabilitative and so they can obtain treatment again but the injury is prolonged and work time is lost. The preamble passed. The committee decided to wait on discussing the definition of appropriate and necessary until the next meeting in order to hear Dave Haugen's presentation.

Dave Haugen, Health Care Commission, presented background information on financing study currently underway. (handouts attached.) The Commission's charge to conduct the financing study to develop a stable financing plan grew out of the universal coverage report published last year which in turn grew out of the initial vision of the health care reform to achieve cost containment so that universal coverage could become affordable. He explained that the numbers of uninsured used in their model show that all the hard work in Minnesota has meant stabilizing the uninsured number while nationally the number of uninsured people is rising. Two actuarial firms have been hired to help with this study. The Commission will be selecting a per member per month number to estimate of these costs in developing their model, but is looking forward to the estimate this group will arrive at in its costing models. He said that the USBS is the only group looking at benefit design and the Commission will rely heavily on the information developed . An example of the kinds of issues the Commission is grappling with is if we allow a subsidy of coverage for everyone, whether they need it or not, or an approach that says we need to retain as much of an employer based coverage as we can and just help those who don't have that employer based coverage. He said one of the next steps is to identify the savings or money in the system that can be redirected to finance universal coverage; where it is and how we can account for it.

Mary Kennedy explained that what members have in their packets today is the compilation of the key phrases in current definitions of appropriate and necessary. They are to look at that before Wednesday's, meeting. There will be no additional mailings between now and then. She said that most people who responded favored the last definition as found in the Deloitte and Touch product but since then other possibilities have come in and information from other sources was handed out today. She said that after the group finishes reviewing the definition of appropriate and necessary, we can begin to develop a model benefit set. She mentioned that the Washington state information was just for their information because Washington is a bit ahead of our process. She emphasized that the Department is not endorsing this for the Committee but some will recognize some of the same issues being raised.

Universal Standard Benefit Set Committee
Summary Meeting Minutes for October 12, 1994

Opening Remarks

Chair Ann Christ outlined the agenda for the meeting: to revisit the Committee's work on guiding principles, and to begin work on the definition of appropriate and necessary, with benefit set C handed out at the end for members to read and work on for the next meeting. She said feedback from last meeting was positive and members indicated that they liked the democratic process. She said that some members had expressed concern about the time it took to accomplish the process. She indicated that she would take direction from the Committee on how quickly or slowly to pace the meeting.

Guiding Principles Draft Discussion (see attached)

Discussion: A Committee member asked that language in the preamble be modified to eliminate "that complement the medical model" and insert "broad" before "continuum of care". The member said that while historically using the terms "medical model" may have been appropriate, the goal here is for a broader perspective of health care. This amendment to the preamble passed by a 22 to 4 vote.

A Committee member asked for clarification between the first and third principles, one referring to a "standard" and one to a "comprehensive" benefit set because "comprehensive" means a very rich benefit package. Members explained that in the medical jargon comprehensive means covering a broad array of services.

It was suggested that the third principle and the first principle be put together by adding "affordable" to the first principle and deleting the third. The amendment to guiding principle numbers 1 and 3 passed by a 25 to 0 vote.

A Committee member submitted an additional principle for consideration: "The SBS should encourage improvement and innovation in patient care processes and in the health care delivery system." This additional guiding principle passed by a 26 to 0 vote.

Appropriate and Necessary Definition discussion (see attached)

Mary Kennedy, Director, Health Care Delivery Systems at the Department of Health, commented on how the 1994 MinnesotaCare statute guides the USBS work. She pointed out that the language charges the Committee to work solely on benefits. She said the language in one paragraph says that the Commissioners are to develop an appropriate and necessary definition that considers a broad range of issues, and in a second paragraph, which discusses the benefit set, the language says it must be sufficiently broad to address the needs of those with chronic conditions or disabilities. Mary said therefore there are two tasks, first to work on the appropriate and necessary definition which will guide what kind of health care coverage is sold in the state and second to develop a benefit set which reflects that same appropriate and necessary discussion.

The Committee agreed to work from one of the definitions submitted by members. (see attached)

Discussion: Mary Kennedy explained that the first bullet, although it repeats the statute, is not duplicitive in that this phrase will be used as part of the contract or law in guiding provider and health plan interaction.

A Committee member proposed adding to the end of the first sentence the phrase "as well as services required to access or effectively utilize family, community, health or health related services" as health occurs within the context of the family and the community. Some members felt that statement got into public health types of services. Some members felt that the language was too broad and said that a payer won't know what to do with it.

On the second bullet, a member said that the sentences lacked the concept of health results justifying the amount spent. Assistant Commissioner Barb Nerness pointed out that some of the issues of cost containment do arise here, which are by nature subjective, and she would welcome Committee members thoughts. She said that ambiguity has to be named and understood and is part of the patient/doctor relationship in determining together what they would like the outcome to be. A Committee member asked if cost effectiveness belongs in the definition of appropriate and necessary. Mary Kennedy said that she believed since this request is in legislation the purpose is to have a definition that will substitute for the standard definition for all of the medically necessary language used now in the health care industry. She pointed out that most of those definitions have some kind of language related to cost in analyzing a service. She said

it is a standard used to give guidance when there is a question or dispute, so members should be aware that omitting it would be a dramatic departure from current practice. Assistant Commissioner Barbara Nerness pointed out that it would also be a departure from the cost-effectiveness goals of MinnesotaCare reform as well. Members discussed and clarified what was meant by "least restrictive setting" and that it does not refer to in or out of a managed care network but to what kind of clinical setting should be used. On the third bullet point, the Committee discussed how to distinguish between people facing a barrier to care and those who might take advantage of services, like transportation for convenience only. Some members said they felt it would be fairly simple to distinguish between the two. It was mentioned that any kind of regulation will be open to abuse, but there are barriers to care, and it should be up to the judgement of the provider to perform the "gatekeeping" kind of decision that they have to make all the time. The Medica example of Provide a Ride was cited and the Committee member from Medica indicated that most of the people who call for a ride usually need it and requests are rarely denied. A member suggested that the language could specify vulnerable populations. It was noted that removing these barriers are cost effective measures that bring down the rate of no-show clients and improve the rate of preventive care delivered that may otherwise end up in the emergency room.

A Committee member pointed out that in the fourth bullet, "licensure" is not the only form of accepted professional credentialing and should include "registered" as well.

The last three items were briefly mentioned as being linked to one another by and/or phrases. A Committee member objected that they were duplicative.

Mary Kennedy offered a few pieces of background information for Committee members to keep in mind: First, she said that the definition of appropriate and necessary is meant to replace all the different kinds of definitions currently used in health plans that tend to be called medically necessary, so it would be a universal definition, consistent from plan to plan. She said it would be in the context of standard benefits, and so it need not repeat what is in the benefit set because they would be paired. She said it would be what becomes the basis in writing contracts or purchasing services and in resolving disputes and so plays a very important role in what the benefits are. Second, she asked Committee members to think about which issues need to be addressed here versus elsewhere - what are delivery system issues and network issues that would vary from plan to plan or personal situation to situation. She said it is assumed that there will be

variation across plans in price and delivery system. A Committee member pointed out that most services currently denied are based on the appropriate and necessary definition and this is true even though the standard benefit set includes that service.

The Committee next dealt with specific language changes. The committee decided not to vote on individual language changes but instead to vote the entire definition up or down.

The first sentence was amended to include the phrase "as well as family health needs after "an individual's physical mental health condition" and before "with sensitivity to cultural and developmental needs".

The third bullet was replaced by the language "removes and/or reduces barriers to access to health care services". Committee members expressed concern that this language should not limit the possibility of managed care systems limiting their provider networks, to remain viable, and should not limit the managed care processes. A Committee member said that if it is stated too broadly there is no basis for denial.
The second bullet language was offered which read: "Cost effective means care that is the same or less costly, and at least as effective as alternative care in achieving a desired health care outcome, or, if more costly, its additional benefit warrants the cost. Cost effectiveness must be considered in the context of long term outcomes." An additional phrase was attached to the end of the first bullet which read: "..as well as providing services in the least restrictive settings in that community." "Community" was added to address the fact not all forms of care are available in all areas of Minnesota. Committee members discussed "least restrictive" and if it meant that the service would have to be the most cost effective to be delivered in the least restrictive setting. It was mentioned that, for example, dumping people in regional treatment centers might be less costly but was not the least restrictive. A Committee member pointed out the need for some kind of uniform responsibility in deciding what is cost effective. A Committee member pointed out that it is still possible for a plan to find it more cost effective not to care for the patient in some situations. A member asked whether a more effective service brings you into a different comparison of services, or is it already implied in the first sentence and if a new therapy is more costly and more effective would that it would not be judged against cheaper therapies? A Committee member said that there is no way to define the desired outcome but broadly, so it must err in that direction because there are too many variables that can't be predicted or controlled. A member expressed concerns that if decisions are subjective, things will go to court, but other members said that here is no way to avoid litigation.

A Committee member said that there was nothing written to address the acceptability of care by the patient, and it is often a negotiation process to with the patient to arrive at care that is acceptable to the individual. A member asked if a patient does not accept the treatment plan, is the patient accepting the responsibility of paying for that treatment?

The definition of appropriate and necessary, with the above changes, passed by a 16 to 12 vote.

Several Committee members said they would like more discussion on the definition as voted on and that the Committee didn't get to discuss how the different issues combined with each other. Some members expressed the desire to have the Committee work toward more consensus on the definition. Chair Ann Christ said the Committee may want to work on the definition further at the next meeting.

Benefit Set C

Benefit set C was distributed for discussion with the understanding that members could read it and be prepared for more in-depth discussion at the next meeting.

Mary Kennedy told the Committee that it was important to remember benefit sets A and B were meant to be the beginning of the discussion. She explained that starting with those two as a base will allow Committee members to see what the cost differences would be given health care reform issues like guarantee issue, universal coverage, etc.separately from changes to the benefit design. She said that the goal is to discuss covered benefits, then cost sharing, and then the Committee will look at standardized cost sharing options.

Discussion: A Committee member pointed out the need to address how health care services provided at correctional facilities and school services fit into the process. A Committee member asked if the staff could do a brief summary of the cost sharing utilization literature and the fact that certain populations don't use services if there is cost sharing. It was mentioned that benefit set C could be the fullest benefit set, and then benefit sets D & E could be more modest. A Committee member asked if the pricing of these benefit sets was based on pure claim costs because if not, HMO and indemnity experience would distort the information the Committee gets. The member was concerned that the information is based on past experience but in the future all plans will be managing their product as ISNs. The member said it would be easier to look at pure claim costs, and easier to obtain pure

claim costs to see the relative worth of the plans in terms of benefits provided. Mary Kennedy said they are assuming managed care in a limited network and anticipating a 1997 market place and the Department will get members a definition on that, but it is true that there will still be additional differences. Assistant Commissioner Barbara Nerness said it is helpful to have this kind of input from members, i.e., how do we need to look at this, what are the limitations on it. She further stated that it is not possible to have a perfect model, it will have certain constraints, qualifications and assumptions, but what the Committee can do is look at the methodology that was used and then take that information and use it in a manner that is most appropriate.

Next Steps

Mary Kennedy said that the Committee could begin a discussion at the next meeting about exclusions and if there should be a list of not-covered services. Chair Ann Christ said that the Committee would go over benefit set C and make modifications, and possibly talk about what sets D and E might look like if there is time. She asked for ideas from the group about possible next steps or information they would like. Comments included:
- do Sets A & B as is plus definition of appropriate and necessary worked in.
- use the maternal and child benefit set modified to include adults
- consider certain types of coverage only for certain segments of the population

Chair Christ adjourned the meeting.

Universal Standard Benefit Set Committee
Summary Meeting Minutes for October 20, 1994

Chair Ann Christ opened the meeting at approximately 8:30 a.m.

Dr. George Winn, Chair of the Dental Advisory Committee gave a short summary of the Committee's work. Dr. Winn said that the Dental Advisory Committee's charge was to determine dental health care benefits that are appropriate and necessary and to make recommendations about the delivery system for those benefits. He said the Committee has been receiving a good deal of input, both written and oral, and has been operating by consensus thus far. A first draft of their report was reviewed and another will be out soon. He said the Committee's report consists of five sections: delivery system, benefits, medical/dental services, special needs, and relevant issues - pros and cons. He said they have not received any cost information yet from the actuaries. Dr. Winn explained that medical/dental services include care for problems such as congenital dental anomalies, issues that are both medical and dental in nature. He said that the Dental Advisory Committee has done a good job of getting the issues out on the table and discussing all the pros and cons so the Commissioner will know the issues.

Chair Ann Christ introduced Joseph Harten from the Deloitte and Touche actuary firm who was there to answer questions on Benefit Set C. Committee members discussed the lack of specificity or generality of the benefit set as listed. MDH staff said that work was not being done at a CPT code level because it would not allow for innovation.

Discussion of the benefit set work sheet raised some general questions. Preventive care discussion focused on smoking cession, gambling treatment and weight loss programs. Committee members felt these services may contribute to major cost savings for society. Some of these services are currently covered by health plans but many are not. The committee decided to consider smoking cessation and weight loss covered under education and counseling, and gambling under mental health. The committee next discussed how the definition of appropriate and necessary services will fit into the level of detail in the recommended benefit set. A committee member suggested that once they start listing individual services, there will be things not included that should be included. It was suggested that the provider be relied on to use a body of knowledge to determine what is appropriate and necessary in an individual situation.

The discussion moved on to physicians services. It was noted that there was not much difference across plans in this area. Discussion topics included: lengthy phone conversations; therapeutic injections; acupuncture; definition of physician; how much of the counseling would be going on in the primary care context before being referred; custodial care covered here and not in home health care category; and services currently provided in schools, juvenile detention centers.

Public health nursing services were discussed next. Questions asked were: Why is it included? Are the plans going to vendor this out? How is it administered? and if public health is assimilated into the different categories, doesn't that inflate the package? Mary Kennedy, MDH, stated that public health nursing services now provided are often services that health plans also currently provide, as opposed to core public health functions. She agreed that this is mixing a list of services with a category of providers. A member stated that public health nursing services may not fit the traditional categories of coding of services, but should be included in the separate category and in preventive care. In regard to the question about public health services being assimilated into the different categories and inflating the package, Mr. Harten, actuary, said that they were looking at this as a special population that may not have otherwise been reached, so this was a population expansion not a service expansion. The committee gave general consensus to the suggestion that the category be eliminated and not address types of providers but services.

It was suggested that the committee change physician services to health professional services to reflect that the types of services that may be delivered by a number of professionals. The committee agreed to stay away from that level of specificity because it ties the hands of the community and ISNs as they try to put services together.

The committee voted to distribute the public health services through the categories and to change physicians services to health professionals category: 29 to 0

Ms. Kennedy asked the committee to discuss limits for Benefit Set C so that the actuaries could move ahead with costing out Benefit Set C. She also asked for discussion on Benefit Sets D and E. The committee agreed that Benefit Set C was seen as a richer enhancement of current services listed in A and B. Discussion included comments on: chemical health assessment not specifically included (suggested using rule 25); under chiropractic services diagnostic procedures, x-rays and acupuncture need to be included; under vision care (when optometrists and ophthalmologists were recommending less than what is here) not include refractive surgery (radial keratotomy) and

eyeglasses should be covered for children below a certain income level; cover all injectables (including insulin), nicotine patches, and pharmaceutical care; update durable medical equipment and therapy language; and include psycho/social rehabilitation.

The committee agreed that Benefit Set D would then cover all services (including long term care) in which people are covered on a broad base of services where almost all of the care is currently paid through public money. Long term chemical dependency care, pancreas transplants and invitro fertilization, private duty custodial care, nursing services expanded to include nonprofessional services, personal attendant care services, mental health services not traditionally included, and all home health services would be included. All services should be delivered in the least restrictive setting and could require all appropriate services to be delivered in people's home. One of the members pointed out that putting those services in now will "crash" this benefit set.

The committee reviewed the MCHA appeals process. For the 30 to 40 disputes per year that can not be settled between the administrator (Blue Cross/Blue Shield) and the patient, a committee made up of an MCHA enrollee, one from the administrator and one person from the public examines the dispute.

The exemptions for MCHA were discussed by Charles Ferguson, MN Department of Commerce (see attached). He stated that most exemptions were straight forward and do not require additional comment. Some comments for specific excluded services include:

m) custodial care -care designed chiefly to assist a person to meet activities of daily living. The care is of a nature that does not require the services or supervision of trained medical or paramedical personnel. Examples of custodial care include, help in walking and getting in and out of bed, assistance in bathing, dressing, feeding and using the toilet, preparation of special diets and the administration of medication that usually can be self administered.

y) & z) transplants- much of the language used is the result of court cases. If the policy has not specifically excluded a given transplant, it is probably covered.

Ms. Kennedy asked about other exclusions that are not listed in the MCHA list. A member stated that it was a fairly standard list. However, other members added the following services generally not covered: v-code diagnoses (domestic violence, marriage counseling); compulsive overeating; and

educational services. A member stated that exclusions cannot be based on a diagnosis or disability.

The committee next discussed specific exclusions that may be include in the USBS. Comments on cosmetic surgery included: breast reconstruction after surgery would not be excluded because generally reconstructive surgery after an "injury" from surgery is included. Mr. Ferguson stated that there is a definition in law about what reconstructive surgery is and it is very broad. Issues regarding mental health needs for cosmetic surgery were raised. Mr. Ferguson stated that in 62A, unless mental health reasons were specifically excluded, the service would be covered. A member stated that in the children's benefit set, reconstructive surgery or treatment when such a service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, it is covered. The committee agreed that the intent is to not to cover cosmetic surgery except to treat an injury which could result from trauma, illness or congenital condition. The committee also discussed gender reassignment surgery. Members expressed concerns about surgery for mental health reasons as well as concerns about congenital corrections. A discussion continued about personal responsibility for paying for this service for reasons other than congenital corrections. Kathleen Cota, MN Department of Human Services expressed concerned that if these services are not included in the standard benefit set, there will then be a justification for dropping them from the Medical Assistance benefit set as well. The committee also discussed if artificial insemination should be excluded.

A member stated and the committee agreed that there are exclusions that are very standard and asked the department to put something in writing for both an exclusion list and a Benefit Set C list, and give the committee something to react to rather than to continue discussion on each listed exclusion.

Committee members set another meeting for November 7, 8:30 a.m. - 12:00 p.m. Chair Ann Christ stated that if members would like further input on mental health and chemical dependency benefits, and the weighing of different benefits, they should get comments and input to staff by Tues. Oct. 25.

MDH staff will send to members: staff recommendations for exclusions, a rework of Benefit Set C, staff recommendations on limits, Mark Moilanen's language on DME and therapies, and MDH version of cost sharing options.

Universal Standard Benefit Set Advisory Committee
Summary Meeting Notes for November 7, 1994

Barbara Nerness, MDH Assistant Commissioner, announced that Ann Christ, prior chair of this committee, has resigned because of a change in positions with UCare. Lowell Anderson has been appointed the new chair of this committee.

Chair Anderson introduced new members, Ghita Worcester from UCare, and Craig Endsley with the Independent Business Association of Minnesota. Anderson stated that he was going to change the voting procedure. Instead of counting votes as has occurred in previous meetings, he will call for a voice vote and make a decision on the vote. If a division is called, votes will be counted. The committee agreed to this new procedure.

The agenda was set as follows: discussion of definition of Appropriate and Necessary Services; discussion of exclusions for USBS; Benefit Set C limits; and costing information on Benefit Sets A, B and C.

Chair Anderson asked if anyone wanted to make any changes to the draft copy of the definition of Appropriate and Necessary Services as it was distributed in today's meeting notes. No one indicated any changes. Anderson directed staff to remove the DRAFT stamp from the document.

Chair Anderson asked if there were any deletions/additions or changes to the list of exclusions distributed in today's meeting notes. Two members indicated some proposed changes. Chair Anderson suggested that in order to allow all members a chance to review the proposed changes, they should be distributed in the mailing for the November 17 meeting. He directed members to submit any other proposed changes to MDH by November 10 for discussion on November 17.

Mary Kennedy, Division Director of Health Care Delivery Policy, initiated the discussion on costing for Benefit Sets A, B and C. James Scearcy, Project Manager from Deloitte and Touche, was there to answer technical questions about the costing model.

Mr. Scearcy had several overheads (attached) to help explain the costing model. He stated that the PMPM (per member per month) figures in the costing models were NOT benefit set premiums, or single or family rates. The PMPM does not reflect administrative costs or risk adjustments. He indicated that administrative costs and risk adjustment may add between 10% to 20% costs.

On overhead #3, Mr. Scearcy indicated that Plan A and Plan B costs were very similar before applying cost sharing options. In the Assumptions section, with regard to the 1997 market environment, Mr. Scearcy stated that a major assumption is that Universal Coverage "works" and that no additional migration to self-insured status occurs. He also indicated that Medicare populations are excluded from the model. The model assumes a 1997 mature reformed health care market. Public health cost were not included in Benefit Set C because Deloitte & Touche is still working to obtain good estimates on current expenditures.

In overhead #4, Populations Estimates, Mr. Scearcy explained that with the exclusion of Medicare and self-insured populations, approximately 2.8 million Minnesotans were left as potentially affected by the USBS. Kathleen Cota, DHS, pointed out that the Medicaid numbers have increased to 510,000 from the listed 475,000.

In overhead #5, Mr. Scearcy explained how the Gross PMPM was determined. The 1993 insured population (Medicare and self-insured out and Medicaid in) was applied to the 1997 market (managed care environment plus addition of current uninsured market). Next the benefit enhancements from Benefit Set C (at approximately $10) and Dental Services (at $26.36) were added. Then the trend data (total of utilization plus medical inflation) was added to obtain a Gross PMPM of $197. Ms. Kennedy pointed out that the Trend data used the maximum medical growth limits and therefore represents the worst case scenario. In addition, the dental services were at the maximum rate because no copays or deductibles were applied.

In overhead #6, Mr. Scearcy stated that if Medicaid populations were excluded, the Gross PMPM would be reduced about $32. One of the members pointed out that Medicaid populations varied greatly in their use of medical services from the AFDC populations to the blind and disabled populations.

Overhead #7 shows that Benefit Set A with limited cost sharing, projects a Net PMPM of $180.02. The cost-sharing is: limited copayments and generally 100% coverage with out-of-pocket expenses not to exceed $500/person, $1,500/family. See attached Cost-Sharing Discussion Outline for more details.

In overhead #8, it shows that Benefit Set B with greater cost-sharing, projects a Net PMPM of $139.84. The cost-sharing is: $1,000 calendar year deductible and generally 80% coverage with out-of-pocket expenses not to exceed $3,000/person, $5,000/family.

In Benefit Set C Option 1 (overhead #9) using a modified copay model, the Net PMPM is $185.56. In Option 2 (overhead #10) using a modified co-insurance model, the Net PMPM is $146.57.

The final overhead #11 shows that Covered PMPMs are very similar and the cost-sharing options (copays or co-insurance together with deductibles) make the greatest difference in the Net PMPM.

Ms. Kennedy asked the committee to consider other cost sharing options. The committee asked MDH staff to develop two more cost-sharing models. Discussion surrounding cost-sharing included comments on use of deductibles to provide economic incentives to achieve appropriate use of services. No action was taken.

There was a discussion on out-of-network use of providers with no action taken.

There was discussion but no action taken on current legislative language on limits on cost-sharing to 25% of cost of service.

A proposed Benefit Set D was handed out. MDH staff was asked to format it like the other benefit sets. There will be a report on cost information for Benefit Set D at next meeting.

The meeting was adjourned at approximately 12:00.

Universal Standard Benefits Set Committee
Summary Meeting Minutes for November 17, 1994

Correction to meeting minutes from October 20th:

Committee member Chuck Ferguson from the Department of Commerce corrected information on page three, the fourth paragraph. The minutes should read: Mr. Ferguson stated that in statute 62A, according to the committee's definition of appropriate and necessary, unless mental health reasons were specifically excluded, the service would be covered.

Chair Lowell Anderson opened the meeting at approximately 8:30 a.m. The proposed meeting agenda was accepted. Chair Anderson pointed out that, as this was the last advisory committee meeting, the group should discuss how to complete their work by the end of the day. The committee discussed the report that would represent their work. They agreed on the format and that subjective narrative should be kept to a minimum. An appendix allowing for inclusion of the varying opinions of committee members was discussed. The committee agreed to include those comments written by members, and discussed the need for brevity so as not to subsume the report with the comments section.

The committee took up the discussion of exclusions. Committee members worked from a handout of written comments submitted by committee members and interested parties to the Department of Health, arranged by issue. In many cases the votes cast to include or exclude a specific item were close. Members discussed whether or not some items belonged in the health plan contract versus the exclusions list. See attached list of exclusions as passed.

Jim Scearcy from the Deloitte and Touche actuarial firm presented cost information on two additional cost sharing options that had been developed, as well as the cost of Benefit Set D as submitted by committee member Mark Moilanen. See attached cost information. Mr. Scearcy explained that the two new cost sharing options, III and IV had higher consumer out-of-pocket cost sharing and therefore lower net PMPM (per member per month) costs. Mr. Scearcy revisited the issue of the cost of the public health section of Benefit Set C. He indicated that the costs of the public health section would add approximately 1.5% to the total cost, or about $150-$160 million for the state. Mr. Scearcy estimated that the cost of Benefit Set D would be about 10%-20% more than the current projected costs of Benefit Set C, prior to changes made at the meeting that day. He also explained that his confidence

level on the percentage difference was wide, as Benefit Set D included many services for which Deloitte and Touche did not have good cost information since they are not available in the current marketplace (e.g., child care while a parent attends a health care appointment).

Benefit Set C was then discussed and changes were made. The committee worked from a handout of written comments submitted by committee members and interested parties to the Department of Health, arranged by issue. See attached revision of Benefit Set C.

The committee decided not to discuss the issue of cost sharing for a couple of reasons. The committee acknowledged that, while they had received some cost information, they would not have the chance to see the impact of the changes made that day on the cost of Benefit Set C. Furthermore, they acknowledged that their charge did not include making cost sharing recommendations.

The committee passed the following resolutions to state the limits of their work or briefly address issues they did not have time to discuss in depth:

Resolution #1

The USBS Advisory Committee acknowledges that, although the Benefits Set outlined is designed to be inclusive of reasonable health care coverage for all Minnesotans, this Benefits Set was developed without the committee having information related to costs. If the Commissioner of Health or the Legislature desires a reanalysis of this Benefit Set to determine whether costs could be reduced, the committee is fully willing to be reconvened to assume that responsibility.

Resolution #2

Though time did not permit the discussion of a means of updating the USBS once in place, the committee passed the following recommendation:

The committee recommends that a standing committee be formed to address changes in health care and to update the USBS.

Resolution #3

Though not asked specifically to address the issue of public programs, the committee passed the following resolution:

Coverage for eyeglasses should be restricted to low-income people. The committee recommends further study by the Commissioner in regard to eyeglasses for children (for example, a benefit of a fixed dollar amount toward eyeglasses for children).

Resolution #4

The USBS Advisory Committee acknowledges that some health services which may not be included in the recommended Benefits Set should be included at least for persons receiving coverage through public programs. The additional benefits for enrollees in public programs (MA, GAMC and MinnesotaCare) should include but not be limited to:

- eyeglasses;
- Dental services as currently covered by the Medical Assistance Program for MA/GAMC enrollees and for MinnesotaCare enrollees with cost sharing levels to be determined;
- Chemical dependency long-term and extended care, but only if the patient has completed primary inpatient or outpatient treatment;
- Persons with chronic conditions and disabilities should not have to become impoverished in order to receive needed ongoing home care services, thus these services should be offered on a sliding fee basis for persons over the Medical Assistance income eligibility limits;
- Access services, including transportation, interpreter services and outreach services should be in place for low-income people;
- The level of services in public programs should not be reduced;

Committee members agreed to review a staff drafted USBS Advisory Committee Report to be mailed out and they would return it with corrections and any comments to be attached. The timeline laid out for production of the committee report was: Draft by Dec. 1st, one week for committee members to review the draft and submit corrections and comments, and report to be released in mid-December.

The meeting was adjourned at approximately 4:00 p.m.

Appendix E

Benefit Set Worksheet

Plan A
In-network only

Limited copayments and generally 100% coverage

Out-of-Pocket Limit: $500/person, $1,500/family

Plan B
All providers

$1,000 calendar year deductible and generally 80% coverage

Out-of-Pocket Limit: $3,000/person, $5,000/family

Plan C

Cost-sharing option I: Limited copayments and generally 100% coverage; *out-of-pocket limit*: $500/person, $1,500/family

Cost-sharing option II: $1,000 calendar year deductible and generally 80% coverage; *out-of-pocket limit:* $3,000/person, $5,000/family

Cost-sharing option III: Additional copayments followed by 100% coverage; *out-of-pocket limit*: $750/person, $2,250/family

Cost-sharing option IV: $2,000 calendar year deductible and generally 80% coverage; *out-of-pocket limit:* $5,000/person, $10,000/family

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
Preventive Care									
▪ routine examinations (e.g. physical, vision & hearing)	√	-0-			√	-0-	-0-	-0-	-0-
▪ employment/research exams									
▪ health education and counseling (e.g., smoking cessation, weight loss and parental and caregiver education and training for special needs clients)					√	-0-	-0-	-0-	-0-

 Note: "e.g." indicates examples, not a complete list Note: ✓ indicates services covered

Covered Benefit and Cost-Sharing Outline

Appendix E

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
▪ Well child care (e.g., physical, vision, hearing, and speech exams)	√	-0-	√ To age 6	-0-	√	-0-	-0-	-0-	-0-
▪ child and adolescent screening to age 18 (educational and developmental)					√	-0-	-0-	-0-	-0-
▪ adult screening (e.g., blood pressure, pap tests, mammograms)	√	-0-	√	-0-	√	-0-	-0-	-0-	-0-
▪ immunizations	√	-0-	√ To age 6	-0-	√	-0-	-0-	-0-	-0-
▪ family planning counseling	√	-0-	√	-0-	√	-0-	-0-	-0-	-0-
▪ prenatal and postnatal care	√	-0-	√	-0-	√	-0-	-0-	-0-	-0-
▪ pre and postnatal home visits to assess health of caregiver and child					√	-0-	-0-	-0-	-0-
Health Professional Services									
▪ office visits*	√	$10 copay	√	20%	√	$10 copay	20%	$10 copay	20%
▪ conferences/counseling					√	$10 copay	20%	$10 copay	20%
▪ record maintenance and retrieval									
▪ hospital visits	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ allergy injections	√		√	20%	√	-0-	20%	-0-	20%
▪ therapeutic injections					√	-0-	20%	-0-	20%

* If the office visit copay is applied, any additional services pertaining to that office visit are not subject to another copayment.

Covered Benefit and Cost-Sharing Outline

Appendix E

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
▪ dialysis	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ acupuncture					√	$10 copay	20%	$10 copay	20%
▪ obesity treatment					√	$10 copay	20%	$10 copay	20%
▪ assessment/diagnosis	√	$10 copay	√	20%	√	$10 copay	20%	$10 copay	20%
▪ pharmaceutical care/medication management	√	$10 copay	√	20%	√	$10 copay	20%	$10 copay	20%
▪ personal care services (associated with rehabilitation services only)	√	$10 copay	√	20%	√	$10 copay	20%	$10 copay	20%
Surgery									
▪ physician's office	√	$10 copay	√	20%	√	$10 copay	20%	$10 copay	20%
▪ inpatient	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ surgical center	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ cosmetic surgery									
▪ reconstructive surgery (including birth defects)	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ anesthesia services	√	-0-	√	20%	√	-0-	20%	-0-	20%

* If the office visit copay is applied, any additional services pertaining to that office visit are not subject to another copayment.

Covered Benefit and Cost-Sharing Outline

Appendix E

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
Hospital									
▪ inpatient services	√	-0-	√	20%	√	-0-	20%	$100/ confinement	20%
▪ medications	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ intensive care	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ private duty nursing									
▪ skilled nursing facility (associated with rehabilitation services only)	√	-0-	√	20%	√	-0-	20%	-0-	20%
Prescription Drugs and Nondurable Equipment									
▪ name brand (34-day supply)	√	$10 copay	√	20%	√	$10 copay	20%	$12 copay	20%
▪ generic (34-day supply)	√	$5 copay	√	20%	√	$5 copay	20%	$7 copay	20%
▪ over the counter (when prescribed by provider)					√	100% copay	100% copay	100% copay	100% copay
▪ birth control pills (1 month supply)	√	$10 copay	√	20%	√	$10 copay	20%	$12 copay	20%
▪ birth control devices					√	-0-	20%	-0-	20%
▪ injectables	√	$10/5 copay	√	20%	√	$10/5 copay	20%	$12/7 copay	20%
▪ insulin and diabetic supplies	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ allergy medications	√	$10/% copay	√	20%	√	$10/5 copay	20%	$12/7 copay	20%
▪ ostomy supplies	√	-0-	√	20%	√	-0-	-0-	-0-	-0-

Covered Benefit and Cost-Sharing Outline

Appendix E

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
▪ blood & blood products	√		√		√	-0-	20%	$10 copay	20%
▪ biologicals	√		√		√	-0-	20%	$10 copay	20%
▪ smoking patches					√	100% copay*	100% copay*	100% copay*	100% copay*
Vision Care									
▪ routine exams (listed under preventive services)	√	$10 copay			√	-0-	-0-	-0-	-0-
▪ exams for treatment of injury or disease	√	$10 copay	√	20%	√	$10 copay	20%	$10 copay	20%
▪ eyeglasses					√	100% copay	100% copay	100% copay	100% copay
▪ contact lenses when necessary for treatment of disease or injury (other than solely for the correction of vision)	√		√		√	-0-	20%	$20	20%
▪ radial keratotomy/refractive surgery	√ see exclusions		√ see exclusions		√ see exclusions	Covered as a surgery	Covered as a surgery	Covered as a surgery	Covered as a surgery
X-Ray/Lab Services	√	-0-	√	20%	√	-0-	20%	-0-	20%
Hearing Care									
▪ routine exams (listed under preventive services)	√	$10 copay			√	-0-	-0-	-0-	-0-
▪ exams for treatment of injury or disease	√	$10 copay	√	20%	√	$10 copay	20%	$10 copay	20%

* followed by 100% reimbursement if the plan determines smoking has stopped.

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
▪ hearing aids					√	-0-	20%	$30 copay	20%
▪ hearing aid batteries					√	100% copay	100% copay	100% copay	100% copay
▪ repair and replacement of hearing aids due to normal wear and tear					√	$10 copay	20%	$10 copay	20%
Maternity and Reproductive Services									
▪ prenatal care and postnatal care (listed under preventative services/including covered dependents)	√	-0-	√	-0-	√	-0-	-0-	-0-	-0-
▪ delivery	√	-0-	√	20%	√	-0-	20%	$100 per confinement	20%
▪ hospital services for newborn	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ nurse midwife	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ abortion services	√	-0-	√	20%	√	-0-	20%	100% copay	100% copay
▪ surrogate pregnancy (adoption)									
▪ in vitro fertilization					2 attempts /year	$10 copay	20%	$30 copay	20%
▪ contraceptive implants					√	-0-	20%	$10 copay	20%
▪ infertility treatment (maximum 6 cycles)	√	-0-	√	20%	√	-0-	20%	$30/per cycle	20%

Covered Benefit and Cost-Sharing Outline

Appendix E

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
▪ voluntary sterilization	√	$10 copay	√	20%	√	-0-	20%	-0-	20%
▪ genetic counseling	√		√		√	-0-	20%	$10 copay	20%
▪ sexually transmitted disease screening (for adolescents and adults)	√		√		√	-0-	20%	$10 copay	20%
▪ sterilization reversal									
▪ devices and equipment					√	-0-	20%	$10 copay	20%
Mental Health Care									
▪ inpatient	30 days/yr	$30 copay	30 days/yr	20%	√	-0-	20%	$100/confinement	20%
▪ partial hospitalization	30 days/yr	$30 copay	30 days/yr	20%	√	-0-	20%	$100/confinement	20%
▪ outpatient	40 sessions/ year	$10 copay	40 hrs/yr	20%	√	-0-	20%	$10 copay/office visit	20%
▪ day treatment and intensive non-residential services	60 days/yr	-0-	60 days/yr	20%	√	-0-	20%	-0-	20%
▪ partner & family therapy					√	-0-	20%	$10 copay	20%
▪ case management					√	-0-	20%	$10 copay	20%
▪ medication management	√	-0-			√	-0-	20%	-0-	20%
▪ assessment/diagnosis/psychological testing					√	-0-	-0-	-0-	20%
▪ crisis services	√		√		√	-0-	20%	-0-	20%

Covered Benefit and Cost-Sharing Outline

Appendix E

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
▪ court-ordered services					√	-0-	20%	$10 copay	20%
▪ psycho/social rehabilitation services					√	-0-	20%	$10 copay	20%
Chemical Dependency Care									
▪ inpatient (hospital and residential)	28 days/yr	$30 copay	73 days/yr	20%	√	-0-	20%	$100/ confinement	20%
▪ partial hospitalization (applicable day limits apply in aggregate to inpatient and partial hospitalization)	30 days/yr	$30 copay	73 days/yr	20%	√	-0-	20%	$100/ confinement	20%
▪ outpatient	20 - 40 hours/yr	$10 copay	130 hours/yr	20%	130 hours/yr	-0-	20%	-0-	20%
▪ detoxification (medical stabilization as entering treatment)					√	-0-	20%	$20/day	20%
▪ day treatment	√	-0-	√	20%	√	-0-	20%	$5/day	20%
▪ case management					√	-0-	20%	-0-	20%
▪ medication management	√	-0-			√	-0-	20%	-0-	20%
▪ assessment/diagnosis					√	-0-	-0-	-0-	-0-

*If the office visit copay is applied, any additional services pertaining to that office visit are not subject to another copayment.

Covered Benefit and Cost-Sharing Outline

Appendix E

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
▪ chemical dependency continuum of care					√	-0-	-0-	-0-	-0-
▪ after care					√	-0-	20%	-0-	20%
▪ extended care/halfway house (only after completion of primary treatment)					√	-0-	20%	$5/day	20%
Chiropractic Care									
▪ office visits/manual manipulation*	√	$10 copay	√	20%	√	$10 copay	20%	$10 copay	20%
▪ examinations, adjunct therapies*	√	$10 copay	√	20%	√	$10 copay	20%	$10 copay	20%
▪ diagnosis/assessment*	√	$10 copay	√	20%	√	$10 copay	20%	$10 copay	20%
Dental Services -- See separate dental advisory committee report	√		√		√				
Assistive Technology and Supplies									
▪ prosthetics, orthotics	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ durable medical equipment (e.g., assistive technology, accessories and supplies) (does not include constructive modifications to home, vehicle, or workplace)	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ rehabilitation engineering consultation (e.g., evaluation, selection, design, customization, fitting and adjustments)					√	-0-	20%	-0-	20%
▪ repair, maintenance and replacement	√	-0-	√	20%	√	-0-	20%	-0-	20%

* If the office visit copay is applied, any additional services pertaining to that office visit are not subject to another copay.

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
▪ disposable medical supplies	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ personal comfort items (telephone, television, etc.)									
▪ daily living aids									
Organ/Tissue Transplants									
▪ kidney, cornea, bone marrow, heart, heart/lung, liver, lung, musculoskeletal (maximum 2 attempts and as deemed appropriate and necessary)	√	-0-	√	20%	√	-0-	20%	$100/ confinement	20%
▪ all others									
Home Care									
▪ home hospice care					√	-0-	20%	-0-	20%
▪ medical day care costs (for preschool age children only)					√	-0-	20%	-0-	20%
▪ nursing	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ therapy (e.g., speech, physical, occupational, respiratory, audiology and behavioral)	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ personal care services (associated with rehabilitation services only)	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ medical/social services	√	-0-	√	20%	√	-0-	20%	-0-	20%

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
Rehabilitation/habilitation									
▪ physical, occupational, cognitive, speech, respiratory, chemo/radiation, behavioral & audiology therapy	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ vocational rehabilitation									
▪ health clubs and spas									
▪ case management	√	-0-			√	-0-	20%	-0-	20%
▪ extended care/transitional rehabilitation	√				√	-0-	20%	-0-	20%
Hospice Care									
▪ medical social services					√	-0-	20%	-0-	20%
▪ medical appliances and supplies					√	-0-	20%	-0-	20%
▪ physical therapy, occupational therapy, and speech/language pathology services	√				√	-0-	20%	-0-	20%
▪ short-term inpatient care including respite care	√				√	-0-	20%	-0-	20%
▪ physical and nursing services	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ counseling including dietary counseling	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ home health aid & homemaker services	√				√	-0-	20%	-0-	20%
▪ outpatient drugs for symptom management & pain relief	√				√	-0-	20%	-0-	20%

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
Nutritional Services									
▪ special nutritional supplements and formulas for the dietary treatment of metabolic disorders; high caloric density nutritional products and special nutritional supplements when prescribed or recommended by a physician					√	$10/week	20%	$30/week	20%
▪ nutritional counseling for treatment and long-term management of acute and chronic disease					√	-0-	20%	-0-	20%
▪ therapeutic nutritional counseling					√	-0-	20%	-0-	20%
Emergency Care									
▪ ER with hospital admission	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ ER with no hospital admission	√	$35 copay	√	20%	√	$35 copay	20%	$75 copay*	20%
▪ outpatient/urgent care	√	$10 copay	√	20%	√	$10 copay	20%	$20 copay	20%
▪ air or ground ambulance	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ other emergency transportation	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ intrafacility transportation					√	-0-	20%	-0-	20%

* Urgent care cost-sharing applies to emergency room use when urgent care services are not available.

Covered Benefit and Cost-Sharing Outline

Appendix E

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
Implants									
▪ artificial joints, pacemakers	√	-0-	√	20%	√	-0-	20%	$100/ confinement	20%
▪ intraocular lens					√	-0-	20%	$100/ confinement	20%
▪ cochlear					√	-0-	20%	$100/ confinement	20%
▪ ear tubes	√	-0-	√	20%	√	-0-	20%	$100/ confinement	20%
▪ breast, penile									
Out of Area Services									
▪ emergency care with hospital admission	√	-0-	√	20%	√	-0-	20%	-0-	20%
▪ emergency care with no hospital admission	√	20%	√	20%	√	$35 copay	20%	$75 copay*	20%
▪ urgent care	√	20%	√	20%	√	$20 copay	20%	$30 copay	20%

* Urgent care cost-sharing applies to emergency room use when urgent care services are not available.

	Plan A		Plan B		Plan C				
	Services	Cost-Sharing	Services	Cost-Sharing	Services	Cost-Sharing Option I	Cost-Sharing Option II	Cost-Sharing Option III	Cost-Sharing Option IV
Public Health Nursing Services									
▪ assessment and diagnosis of:					√				
- children and adolescents					√				
- special needs populations					√				
- family violence victims					√				
▪ health education of:					√				
- pregnancy for teens					√				
- access to preventive health services					√				
▪ health promotion/counseling					√				
▪ nursing treatment					√				
▪ medication management					√				
▪ administration of injections					√				
▪ nursing clinics (e.g., WIC, immunization, school and teen services)					√				

Standard Benefit Set--Plan D

Plan D is an expanded version of Plan C. Beyond the services listed for Plan C in the Cost Sharing Discussion Outline (December 1, 1994), the following additional services are covered under proposed Plan D. The services are grouped under the same broad headings which have been used to organize all prior plan options. Note that service sites were not generally listed under Plan C.

Preventive Care:	◆ no changes
Health Professional Services:	◆ therapeutic telephone consultations ◆ consultation with family, school officials, mental health providers
Surgery:	◆ no changes
Hospital:	◆ partial hospitalization (Plan C covered partial hospitalization only for mental health and chemical dependency)
Prescription Drugs and Nondurable Equipment:	◆ pharmaceutical supplies (beyond prescribed supplies and equipment)
Vision Care:	◆ repair/replacement (beyond normal wear)
X-Ray/Lab Services:	◆ no changes
Hearing Care:	◆ audiology services ◆ hearing aid dispensing fees ◆ ear molds and hearing aid accessories ◆ home visits

Maternity and Reproductive Services:	◆ prenatal pediatrician consultation ◆ pediatric specialty care
Mental Health Care:	◆ preventive care (clarification only; assumed to be covered as assessment) and early intervention ◆ counseling for adjustment to disability for disabled and family ◆ relationship counseling (in addition to marital and family counseling in Plan C) ◆ in-home therapy
Chemical Dependency Care:	◆ no changes
Chiropractic Care:	◆ no changes
Dental Services:	◆ no changes
Assistive Technology and Supplies:	◆ seating and positioning equipment ◆ daily living aids
Organ/Tissue Transplants:	◆ no changes
Home Care:	◆ home health aide services (clarification only; assumed to be covered as personal care services in Plan C) ◆ counseling for adjustment to disabilities ◆ orientation and mobility training ◆ health professional visits
Rehabilitation/Habilitation:	◆ behavior modification/management ◆ rehabilitation technology and engineering ◆ assessment/treatment of oral motor dysfunction

Hospice Care:	◆ no changes
Nutritional Services:	◆ no changes
Emergency Care:	◆ special transportation due to health conditions (other than intrafacility)
Implants:	◆ no changes
Out of Area Services:	◆ no changes
Public Health Nursing Services:	◆ no changes
Other Miscellaneous Services:	◆ care coordination, case management, and services coordination (beyond mental health, chemical dependency and rehabilitation/habilitation services) ◆ child supervision during clinic visits ◆ interpreter services ◆ written materials in Braille, large print, audio, and foreign languages ◆ medical day care (except under home care services) ◆ evaluation/treatment of physical and sexual abuse (generally covered under mental health and health professional categories) ◆ outreach services ◆ pain management (beyond hospice care and office visits) ◆ parent/caregiver education and training (except for special needs clients) ◆ risk assessment ◆ common carrier transportation ◆ transportation expense for services more than 30 miles away ◆ lodging and meal expense for services requiring overnight stay

Appendix F

Cost of the Recommended Universal Standard Benefits Set

Cost of the Recommended USBS

The costs of the recommended USBS were determined by Deloitte and Touche, the actuarial consultant. Since the actuary could not complete the determination of the final cost until the proposed benefit set was established at the last committee meeting, the members did not have an opportunity to react to the final contents or make further changes based on cost information. The committee did have several presentations from the actuary and had opportunities to ask about the assumptions made in costing the benefit set. Committee members did not always agree with the assumptions and conclusions of the actuary. Some members of the committee stated that the cost model did not sufficiently represent the cost offset savings by the benefit set design. The actuary was only able to include this information in the model where actual documentation was available.

Some committee members expressed concern that a traditional actuarial approach would not provide a complete picture of cost dynamics within the context of a reformed health care system. Committee members stated that the costs should be expressed in per citizen per month (PCPM) not per member per month (PMPM). They said that the costs should reflect a statewide population, which includes public program participants for whom health care costs are usually more expensive, and not just those for whom health plan premiums are paid for by individuals or employers.

In addition to not having an opportunity to examining the costs, the committee members do not have the opportunity to examine the cost sharing options nor the effect on the costs from the cost sharing options. The effect of the cost sharing options can be see in Chart 2.

The Cost Model

The Deloitte and Touche actuarial firm developed an actuarial costing model to determine the Gross Per Member Per Month (PMPM) dollar amount. The Gross PMPM dollar amount reflects the cost of providing services on a per member per month basis and includes the cost of providing all of the services listed in the benefit set before any exclusions, limitations, copays, deductibles or out-of-pocket maximums are applied to the benefits. PMPM is the dollar amount that reflects the cost of providing services on a per member per month (PMPM) basis. PMPM figures do not represent benefit set premiums because they do not include administrative costs, risk adjustment or other adjustments made when setting premiums. It is estimated that administrative costs and risk adjustment would add an additional 10% to 20% to the PMPM cost, depending on the health plan and the services included.

In developing the model, Deloitte and Touche identified the Minnesota populations that would be included or covered by the USBS. For the purposes of the costing model, the Medicare population was excluded because those benefits are defined in federal law and therefore will be unaffected by the USBS. People covered in the self-insured market were also excluded because the federal ERISA law exempts them from complying with state law.

Deloitte and Touche also made several assumptions about the market conditions under which the USBS would operate in 1997 which can be seen in Chart 1.

Determining The Gross PMPM (Chart 1)

Gross PMPM - the cost of providing all of the services listed in the benefit set before any exclusions, limitations, copays, deductibles or out-of-pocket maximums are applied to the benefits.

The Gross PMPM serves as a baseline to determine the Net PMPM which is amount after adjusting for non-covered services, coverage limitations and cost-sharing options (detailed in Chart 2).

In order to establish the Gross PMPM, the actuary went through several steps as represented in Chart 1 on the facing page.

Box 1

The Gross PMPM was determined by starting with 1993 actuarial information. The population used is the estimated 2.8 million Minnesotans to be covered by the USBS. It does not include those covered by Medicare and the self-insured population. It does includes all people enrolled in the public health care programs (i.e., Medical Assistance, General Assistance Medical Care and MinnesotaCare).

Box 2

The Gross PMPM in Box 1 is adjusted based on the planned changes in the 1997 health care market as outlined in current law. This includes all insurance reforms such as elimination of pre-existing condition exclusions, guarantee issue in place, ISN's, CISN's and RAPO in place (reflects a more managed care environment), and an individual mandate effectively implemented.

Box 3

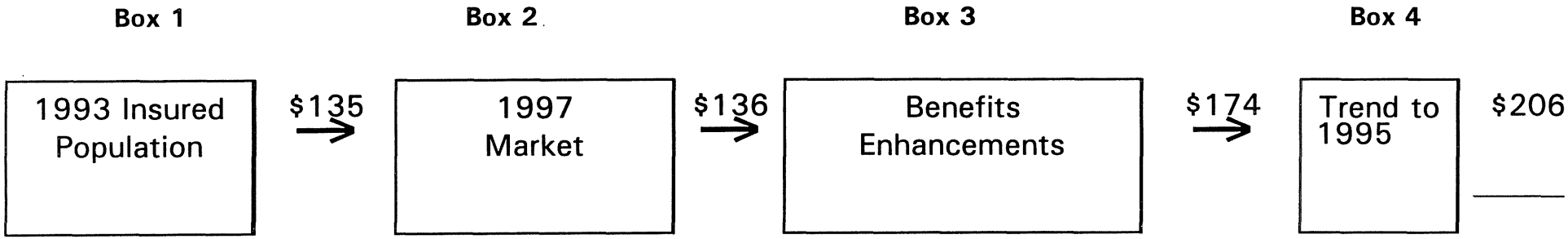
Box 3 represents the benefit set changes as the differ from what is currently on the market today. For example, dental services are added here, as well as the removal of some limits and exclusions and any added services which are not typically covered by most health plans today. The dental benefits add the greatest proportion -$26- to the increases.

Box 4 In Box 4 the dollars are trended forward to 1995 dollars, using the growth limits in law: 9.4% in 1994 and 8.3% in 1995. This results in the final Gross PMPM of $206.

D&T stated that if public health care program recipients were excluded, the Gross PMPM would be reduced by $32.

Chart 1

Gross PMPM Estimates



Assumptions:

- Medicare population not included
- Self-insured population not included
- ISN/RAPO environment in place
- Uninsured population now covered
- Dental benefits included
- Removal of some limits and exclusions
- Enhanced coverage
- '94 growth limits: 9.4%
- '95 growth limits: 8.3%

PMPM Summary - Chart 2

The following narrative explains in more detail the Chart 2 on the following page.

- **Gross PMPM** - the cost of providing all of the services listed in the benefit set before any exclusions, limitations, copays, deductibles or out-of-pocket maximums are applied to the benefits.

- **Non-Covered Services Reduction** - the exclusion of non-covered services (those listed but not checked).
- **PMPM** - the resulting PMPM amount, after the non-covered services reduction.

- **Coverage Limitations** - the impact of limitations on days, visits or age.
- **PMPM** - the resulting PMPM amount, after coverage limitations are applied.

- **Copays, Deductibles and Coinsurance** - the different types of cost-sharing and their impact on the use and therefore cost of benefits.

- **Net PMPM** - the resulting PMPM amount, after any cost sharing is applied.

Details of the four benefit sets and cost sharing options represented here can be found on the benefit set worksheet in Appendix E of this report.

Chart 2

PMPM Summary

	Gross PMPM	Non-Covered Services Reduction	PMPM	Coverage Limitations	PMPM	Copays, Deductibles, & Coins	Net PMPM
Set A	$206.00		$193.77		$192.82		$184.52
Set B	$206.00		$192.23		$191.32		$143.34
Set C, Cost Sharing Option I Limited Copay	$206.00		$203.06		$203.00		$193.19
Set C, Cost Sharing Option II $1,000 Deductible	$206.00		$203.06		$203.00		$152.72
Set C, Cost Sharing Option III Add'l Copay	$206.00		$203.06		$203.00		$188.53
Set C, Cost Sharing Option IV $2,000 Deductible	$206.00		$203.06		$203.00		$133.06

Benefit Set D (found in Appendix E of this report) costs are estimated at 10 - 15% above the costs of Benefit Set C.