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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

PROGRAM EVALUATION REPORT

State Employee Health Insurance

FEBRUARY 2002

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OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA • James Nobles, Legislative Auditor

February 20, 2002

Members
Legislative Audit Commission

In the last few years, health insurance premiums for the State of Minnesota and its employees have increased dramatically. In May 2001, the Legislative Audit Commission directed us to analyze the cost of health insurance for state employees and examine cost-saving alternatives that other employers have implemented. As we began the study, the state was in the midst of adopting a new employee health plan, the Minnesota Advantage Health Plan. Consequently, we focused our analysis on the new plan's cost-control features.

Overall, we found that the state has implemented many of the alternatives suggested by national experts to help control rising health insurance costs. In particular, Minnesota Advantage expands employee cost-sharing requirements and uses a purchasing strategy that should help control costs, although the extent of cost savings is uncertain. We recommend that the Department of Employee Relations monitor and evaluate Minnesota Advantage over the next two years, paying special attention to provider and employee incentives to control costs.

In conducting this study, we received the assistance of the Department of Employee Relations. This report was researched and written by Jo Vos (project manager), Valerie Bombach, and Stephanie Lenhart.

Sincerely,

/s/ James Nobles

James Nobles
Legislative Auditor

/s/ Roger Brooks

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Summary

The state's new health insurance plan, Minnesota Advantage, contains needed changes, but their impact on costs is uncertain.

Major Findings:

- A variety of factors have contributed to a general rise in health insurance costs, including an aging population, prescription drug use, technological advances, market consolidation, and a "backlash" against managed care (pp. 27-32).
- Despite using managed care and managed competition to help control the costs of its employee health insurance program, the State of Minnesota has seen its insurance premiums rise more rapidly than national averages in the late 1990s (pp. 10-16, 19).
- The state has paid a higher share of insurance premiums than most other employers and, until 2002, did not use employee co-pays, deductibles, and co-insurance as extensively as others (pp. 23-26).
- The state's new health plan, the Minnesota Advantage Health Plan, incorporates needed changes in the design of health benefits for state employees that should help reduce anticipated increases in health care costs, but the extent of cost savings from the new plan is uncertain (pp. 35-48, 50-51).

- The Department of Employee Relations relies too much on its consultant to provide certain basic information about its insurance program that should be maintained in department files and readily available to policy makers (p. 78).

Key Recommendations:

- The Department of Employee Relations should monitor and evaluate the Minnesota Advantage Health Plan over the next two years, paying special attention to employee and provider incentives to control costs (p. 51).
- The department should develop a more comprehensive description of consultant duties and required work products in its contracts, and document and retain evidence supporting key decisions pertinent to the insurance program in agency files (p. 79).

Report Summary

Concerned about rising health care costs, the State of Minnesota negotiated significant changes in the way state employee health insurance benefits are structured for 2002. Although the new plan, known as the Minnesota Advantage Health Plan, is still built around managed care and managed competition concepts, it introduces new cost-control incentives for health care providers and significantly expands cost-control incentives for state employees.

The State Must Negotiate Health Benefits With Its Public Employee Unions

State law requires that the state meet and negotiate with its public employee unions on the terms and conditions of employment, including health insurance benefits. Although each of the state's 17 bargaining units negotiates a different contract with the state, insurance benefits are generally the same. The Department of Employee Relations extends the same benefits to executive branch employees who are not represented by a union, and the legislative and judicial branches of government generally follow suit. The department estimates that it will cost approximately $316 million to administer and provide health insurance benefits to the state's 118,000 current and retired employees and their dependents in 2002.

A variety of factors that are difficult for employers to control have contributed to rising insurance premiums.

The State Has Used Managed Care and Managed Competition to Help Control Costs

Since 1990, all state employees have been enrolled in managed care health plans, most often in health maintenance organization (HMO) plans. Managed care plans typically have administrative mechanisms that monitor and authorize the use of services at both the member and provider levels.

Consistent with the principles of managed competition, the state has generally offered a choice of plans to state employees. From 1991 through 2001, the state offered five to seven plans each year, with each plan generally providing the same benefits. In addition, the state makes a fixed contribution toward insurance premiums that encourages employees to choose low-cost plans.

As With Most Employers, Insurance Premiums For State Government Began to Rise Sharply in 1998

Due to a variety of factors, including an aging population, increasing prescription drug use, technological advances, market consolidation, and a general "backlash" against managed care, health care premiums for state employees began to rise sharply in 1998, increasing 23 percent in 2000 and 18 percent in 2001. Employers both nationwide and statewide experienced a similar trend in premiums, although premiums for the State of Minnesota have generally increased at a faster rate than they have nationally.

The state appears to have been no more or less successful than other employers in controlling or addressing rising costs. But unlike other employers, the state has not previously passed rising costs on to employees either by increasing employees' shares of the premiums or by introducing additional cost-sharing mechanisms.

Minnesota Advantage introduces new cost-control incentives for providers and expands cost-control incentives for employees.

Minnesota Advantage Incorporates Some Needed Changes in How Health Insurance Benefits Are Structured

The Minnesota Advantage Health Plan introduces some significant changes that should help control rising costs. The new plan uses a well-known "risk adjustment" methodology that allows the department to examine how costs for treating the same type of patient varies across individual groups of providers. To encourage providers to compete with one another, the department classified providers into three levels using risk-adjusted costs. To encourage employees to select low-cost providers and to decrease unnecessary utilization, the state significantly expanded requirements for co-pays, deductibles, and co-insurance. Employees who choose providers in lower cost levels face lower out-of-pocket expenses than those who choose providers in higher levels. Finally, to allow employees the option of changing providers throughout the year, all health plans now have the same premiums for individual and family coverage respectively. The state continues to pay 100 percent of the premium for individual coverage and 90 percent for dependent coverage.

The Extent of Cost Savings From Minnesota Advantage Is Uncertain

The Department of Employee Relations estimates that Minnesota Advantage could reduce anticipated total health care costs by $25 million over the next two years—about 3 percent of total expenditures. The department estimates that the state could spend about $5 million less each year under Minnesota Advantage, while employees could spend about $1 million less in 2002 and $14 million less in 2003.

But there are several reasons why the extent of cost savings under the new plan is uncertain. First, the estimates depend on how accurately the department has projected what costs would have been had the state not changed its insurance program. Although the department assumed that 5 percent of employees would move to lower cost providers to save money under Minnesota Advantage, the department did not consider that some employees might have moved to lower cost health plans under the status quo.

Second, several factors may weaken the new plan's employee and provider incentives to control costs further. For example, state employees may not make up a large enough share of some providers' patient caseload to motivate price competition, and some areas of the state have only one provider or are dominated by a large provider. Also, about 69 percent of employees and 53 percent of providers are already in the lowest cost level. Finally, the department re-assigned many higher cost providers to the lowest level without changing their costs to ensure that employees have access to a low cost provider in all parts of the state.

Third, the department had problems providing accurate, reliable data concerning the state employee insurance program, and the department's estimates on cost savings have not been independently verified. The department needs to monitor and evaluate Minnesota Advantage over the next two years, paying special attention to issues related to provider and employee incentives to control costs.

The State Has Already Adopted Several Cost Control Mechanisms

While employers nationwide are searching for innovative plan designs, the available options are limited. Three commonly discussed options that the state has not already implemented—innovative co-pay tiering, contract "carve-outs," and certain types of defined contribution plans—do not appear to be feasible options for significant cost control at this time. The state has already implemented the most widely used defined contribution approaches: a fixed-dollar contribution and flexible spending accounts. The department should monitor other employers' experiences with various plan designs.

Likewise, the Department of Employee Relations has recently implemented various administrative tools that research suggests may be effective in helping to control health care costs. Some of these mechanisms are designed to help keep the state employee insurance fund solvent and health plan administrative costs low. Other mechanisms hold health plan carriers accountable for tracking costs and quality and reporting that information to the state. For example, administrative costs, including department expenses, were approximately $30.5 million in 2000—about 9 percent of employee premiums in 2000. Private consultant fees to help design Minnesota Advantage, explain how it works, maintain a data warehouse, and negotiate carrier contracts accounted for nearly $1 million of administrative costs.

Despite efforts by the state to implement many of the available alternatives to control costs, the state can anticipate sizable cost increases in future years. While the industry is beginning to explore new innovations to limit cost increases, many of the cost-control issues relate to broader health care policy considerations that cannot be addressed by the department in isolation. Significant innovation in the Minnesota market is likely to require a coalition representing the state's full purchasing power—including other publicly financed health care programs—and a willingness to consider policy reform.

Introduction

As with other employers nationwide, the cost of health insurance for Minnesota state employees has increased rapidly in recent years. Insurance premiums grew 23 percent in 2000 and 18 percent in 2001. The average annual cost of insurance premiums, including both the state and employee shares of the premium, ranged from $3,187 to $4,499 for individual coverage and from $7,969 to $11,248 for family coverage in 2001.

In May 2001, the Legislative Audit Commission directed us to examine the cost of health insurance for state employees, focusing particularly on cost-saving alternatives that other employers have implemented. Because the Department of Employee Relations was negotiating health insurance benefits with the state's public employee unions at the time, we delayed starting our study until late summer, expecting that benefit negotiations would be complete by then. As it turned out, contract negotiations between the state and its two largest public employee unions broke down over salary and health insurance benefits and a large percentage of state employees went on strike for two weeks in mid-October.

Disagreement over health insurance benefits was one of the reasons state employees went on strike in 2001.

Partly because the state was in the midst of adopting a new health care purchasing strategy as well as coping with the employee strike, the Department of Employee Relations had difficulty supplying us with reliable data in a timely way. As a result, our review was narrower and less definitive than we hoped. Despite these difficulties, we addressed the following questions:

- **How has the Department of Employee Relations' approach to health care purchasing changed over time? How does the state's new model for employee health insurance benefits, the Minnesota Advantage Health Plan, work?**

- **How do other public and large private employers structure their employee health insurance programs? How do their insurance premiums compare with state government's premiums?**

- **What factors affect health insurance premiums in Minnesota and for state government? Which factors are, at least partially, within the control of the Department of Employee Relations?**

- **In what ways could the State of Minnesota structure and administer its health insurance program to help control costs for state government or its employees?**

To answer these questions, we examined state laws, health plan contracts, and plan enrollment information. We obtained data from the Department of Employee Relations regarding health plan premiums and costs, enrollment, coverage, utilization, and market share. We also examined data related to health plans' administrative costs as well as the department's administrative costs. We talked with staff from several state agencies, including the departments of Employee Relations, Human Services, Health, and Commerce. We also met with representatives from the state's major health plans, health plan organizations, and employee unions. We reviewed state and national reports related to health benefits design and costs. Finally, we reviewed reports from other states, federal agencies, national health plan accrediting organizations, and the academic community to help us identify structural arrangements and administrative tools that might help control insurance costs.

Our study focused on health insurance coverage for current state employees and their families. The 2000 report of the Postretirement and Active Employee Health Care Task Force addressed the concerns of retirees, and we did not want to duplicate that effort.[1] Because the state has made major changes in its health care purchasing strategy, we focused on its new model, which went into effect in January 2002. Because it is too early to evaluate how well Minnesota Advantage actually contains costs, we examined its cost-control features.

The study focused on state-level activities and did not examine how health plans or care providers control costs. It also excluded other health-related benefits, such as dental insurance, life insurance, disability insurance, long-term care insurance, and pretax accounts. Finally, we did not evaluate the Department of Employee Relations' performance. Although we discuss whether the department has implemented certain administrative tools to help control costs, time limitations did not permit us to examine how effectively the department has used these tools.

This report is divided into five chapters. Chapter 1 discusses how the state's insurance program is administered, employee health benefits, and the number of employees covered by the state's program. Chapter 2 discusses how the state's overall strategy for purchasing health care for state employees has changed over time, trends in insurance premiums, comparisons with insurance programs of other employers, and the major factors that generally drive rising insurance premiums. Chapter 3 examines how the Minnesota Advantage Health Plan is designed to address rising health care costs. Chapter 4 examines other ways to structure or design insurance benefits to help control rising costs. Finally, Chapter 5 looks at various administrative tools to help control health care costs.

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1 Department of Employee Relations, *Report of the Postretirement and Active Employee Health Care Task Force* (St. Paul, December 15, 2000).

1 Background

SUMMARY

Minnesota statutes require that state government negotiate state employee health benefits with its public employee unions. Since 1986, the Department of Employee Relations, the state's lead agency on personnel matters, has worked with the Joint Labor Management Committee on Health Plans to explore various approaches to cost containment outside the formal bargaining environment. In December 2001, the Legislative Coordinating Commission Subcommittee on Employee Relations failed to approve or reject the current health benefits package that the department and employee unions negotiated, but the health benefits became effective in January 2002 anyway. The state's health insurance program, which covers about 118,000 current and former state employees and their dependents, must still be approved by the full Legislature in 2002.

Health insurance is designed to spread health risk broadly across a covered population, thereby protecting those insured from large financial losses due to illness, accident, or injury. Originally conceived as a tool to recruit and retain workers during World War II, health insurance has become an expected benefit in employee compensation packages. This chapter describes how insurance benefits for State of Minnesota employees are determined and how the insurance program is administered. It focuses on the following questions:

- **How is the state employee group health insurance program administered? How are insurance benefits determined?**
- **What health benefits do state employees have?**
- **Who is eligible for coverage, and how many employees participate?**

To answer these questions, we examined state laws, health plan contracts, and plan enrollment information. We also talked with staff at the Department of Employee Relations and representatives from the state's two largest public employee unions.

PROGRAM ADMINISTRATION

Since 1973, the Department of Employee Relations (formerly the Department of Personnel) has been responsible for designing and administering the state's insurance program. Through its Employee Insurance Division, the department is responsible for (a) purchasing and administering insurance coverage for state

employees, (b) enrolling employees in health plans, (c) collecting insurance premiums, (d) paying health care claims, and (e) resolving coverage and claims disputes.

To help perform these and related activities, the department employs about 40 full-time staff. In addition, the department contracts with a private consulting firm, Deloitte and Touche, for actuarial assistance in designing and carrying out the state's health care purchasing strategy. As we discuss in Chapter 5, department costs to administer the state's employee health insurance program totaled approximately $3.4 million in 2000, including nearly $1 million for Deloitte and Touche.

Unlike some other employers:

- **Minnesota statutes require that public employers, including state government, negotiate employee health benefits with their public employee unions.**

Health insurance is a negotiated benefit for most state employees.

The Public Employment Labor Relations Act, adopted in 1984, sets forth rules for collective bargaining between Minnesota public employers and their employees.[1] It requires that public employers meet and negotiate with elected representatives of public employee unions on "terms and conditions of employment," such as work hours, salaries, and benefits. The act also sets forth criteria for establishing the state's public employee bargaining units. In 2001, 17 occupationally-based bargaining units covered about 90 percent of state government's workforce. Eleven public employee unions represented these bargaining units.

The department created the Joint Labor Management Committee on Health Plans in 1986 to allow management and labor to explore various approaches to health care cost containment outside the environment of formal bargaining. The committee consists of representatives from each of the state's 17 bargaining units, the Department of Employee Relations, and, until 2002, the University of Minnesota.

Although each of the state's bargaining units meets separately and negotiates different contracts with the state, health insurance benefits are generally the same. Since 1989, the department has been using a "coalition bargaining" approach to negotiating health insurance benefits. State employee unions meet and develop one common proposal to present to management, which in turn provides a counter proposal to the union coalition. Additional counter proposals are then exchanged between the full coalition and the state. Items typically negotiated include health care provider networks, scope of coverage, and employer-employee shares of insurance premiums.

At the same time, however, the state and unions negotiate benefits as part of a "total compensation" package. During the 2002-03 biennial budget process, the Legislature built in a 3 percent increase over the previous biennium's spending for state employees' salaries and benefits, resulting in a total budget of approximately

1 *Minn. Stat.* (2000), §179A.

$3.5 billion for salaries and benefits.[2] The higher the share of this amount that is negotiated or allocated for salaries, the less that is available for benefits, and vice versa. If contract negotiations or state agency practices result in compensation packages that are greater than legislative appropriations, state agencies are generally expected to make up the shortfall by adjusting their budgets.

Once the state and each union reach a settlement, proposed contracts are forwarded to the Legislative Coordinating Commission Subcommittee on Employee Relations. The subcommittee approves or rejects the proposed contracts (it cannot modify them) and submits them to the full Legislature, which also must accept or reject the agreements without modification.

About 10 percent of the state's workforce is not represented by public employee unions. For example, legislative employees, Bureau of Mediation Services staff, and most judicial employees are not unionized. However, the Department of Employee Relations extends the health insurance benefits that are contained in union contracts to non-union employees in the executive branch through the *Commissioner's Plan* and the *Managerial Plan* and the legislative and judicial branches generally follow suit. The Legislative Coordinating Commission Subcommittee on Employee Relations must approve, reject, or modify the plans for non-union employees before it submits them to the full Legislature.

In addition to negotiating health benefits with public employee unions, the Department of Employee Relations negotiates contracts with health plan "carriers" or "claims administrators" to actually provide health-related services to state employees.[3] As shown in Table 1.1, health plan carriers typically provide (a) specified lists of health care providers, such as clinics, doctors, hospitals,

Table 1.1: Basic Definitions

Health Benefit Plans are sets of benefits that employers, in this case the Department of Employee Relations, have established for their employees.

Health Plan Carriers/Plan Administrators are companies that actually administer the state's health plans. The Department of Employee Relations contracts with carriers to (a) provide a network of providers, (b) process claims, and (c) provide other administrative services.

Provider Groups/Care Systems are organized networks of health care providers that carriers contract with to actually deliver health services to plan members. They may include doctors, hospitals, outpatient centers, mental health clinics, and other specialized services.

Primary Care Clinics are individual clinic sites within a provider group that act as members' entry point into a given provider group. Primary care clinics control plan members' access to some specialized services through the referral process.

SOURCE: Compiled by the Office of the Legislative Auditor.

2 Mr. George Deden, Department of Finance, interview by author, Telephone conversation, St. Paul, Minnesota, December 13, 2001. This estimate includes all funds, but excludes salaries and benefits for employees of the Minnesota State Colleges and Universities and the University of Minnesota.

3 *Minn. Stat.* (2000), §43A.22 requires that the department provide health insurance through carriers approved to do business in the state. The department cannot directly contract with health care providers for insurance-related services.

outpatient centers, and other specialized services, (b) claims processing, and (c) other administrative services. Currently the department contracts with three health plan carriers: BlueCross BlueShield of Minnesota, HealthPartners, and PreferredOne.

HEALTH PLAN BENEFITS

State health plans cover preventive care, including immunizations, pre-natal care, well-child care, allergy shots, routine physical and eye exams, and periodic screenings for cancer and other diseases. In addition, the plans provide comprehensive coverage for diagnosing and treating most illnesses and injuries.

Overall:

- **With few exceptions, the state's three health plans provide a uniform set of benefits to all state employees.**

The Department of Employee Relations has been working to align health plans so that coverage is the same across plans. Only a few differences exist, the most notable being limitations on fertility treatment.[4] However, health plan carriers differ in the way they administer benefits and reimburse providers and in the referral patterns of their primary care clinics. In Chapter 2, we discuss how important having standard plans across carriers has been to the department's overall health care purchasing strategy.

BlueCross BlueShield of Minnesota administers one of the state's health plans.

In addition to medical coverage, state employees have other health-related benefits that are beyond the scope of this study. State employees receive dental insurance, which provides comprehensive coverage for most conditions that require dental diagnosis and treatment, including orthodontia for children. It also covers a broad range of preventive services, including regular exams, x-rays, and teeth cleanings. Employees are also automatically enrolled in a basic life insurance policy, and additional insurance is available for employees, spouses, and children. The state also offers a number of optional programs,

4 In Chapter 3 we provide information about the specific benefits contained in the state's health plan for state employees.

including short- and long-term disability insurance, long-term care, and pretax accounts for medical and dental expenses and dependent child care. Finally, state employees earn sick leave based on their work hours and bargaining unit.

ELIGIBLE EMPLOYEES

The state's health insurance program covers all current permanent employees in the executive, legislative, and judicial branches of government, including employees of the Minnesota State Colleges and Universities.[5] Former employees may elect to continue insurance coverage at their own expense for 18 months or until they enroll in another group policy, and retired employees may continue coverage at their own cost indefinitely.

Most state employees enroll their dependents in the state's insurance program.

Employees may also elect to enroll their dependents in the state's health insurance program. Eligible dependents include spouses, unmarried children up to 19 years of age, unmarried children from 19 to 25 years of age who are full-time students, and physically or mentally handicapped children of any age.[6] Effective January 2002, the state employee insurance program extended dependent health care coverage to include most employees' same-sex domestic partners and their dependents.[7] Altogether:

- **In 2001, the State of Minnesota provided health insurance to more than 151,000 current and former state employees and their dependents.**

Employees with single coverage comprised 42 percent of the enrollment in the state's program in 2001 while employees opting for family coverage comprised 58 percent. The average family size for those employees choosing family coverage was 3.24 individuals. To provide this level of benefits, the state collected approximately $295.8 million in premiums for 2001.[8] As noted earlier, the University of Minnesota dropped out of the state's health insurance program effective January 1, 2002, which will reduce overall enrollment for 2002 by about 33,000 members.

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5 Concerned about rising costs and physician availability, the University of Minnesota withdrew from the state's medical insurance program, effective January 1, 2002.

6 Employees' spouses who work full time for employers with more than 100 employees and who choose to receive cash or credits in lieu of health insurance or in exchange for a health plan with a deductible of $750 or more are not considered eligible dependents for the state's insurance program.

7 Some state employee bargaining units did not enter into agreements that provide domestic partner benefits. Many legislators have expressed concern about these benefits and it is likely that the topic will be debated during the 2002 legislative session. The Department of Employee Relations initially estimated that same-sex domestic partner insurance benefits would cost the state about $1 million in 2002, but recently revised that estimate to $189,000 when fewer than 100 employees signed up for domestic partner benefits.

8 Department of Employee Relations, *Annual Premium Payments Summary* (St. Paul, July 2001). These figures do not include premiums collected for University of Minnesota employees and their dependents.

2 Insurance Trends and Comparisons

SUMMARY

Since the late 1980s, the State of Minnesota has shifted its employees to "managed care" health plans to help control costs. In addition, the state has built its insurance program on "managed competition" principles that are intended to provide incentives for health plans to compete with one another on cost and quality. But due to a variety of factors, including an aging population, prescription drug use, technological advances, market consolidation, and a "backlash" against managed care, health insurance premiums began to rise sharply in 1998. The State of Minnesota appears to have been no more or less successful than other employers in controlling or addressing these factors. Unlike the private sector and, to some extent, other government employers, the state has historically not passed rising costs on to employees either by increasing employees' share of insurance premiums or by introducing additional cost-sharing mechanisms.

As noted in the previous chapter, the Department of Employee Relations, in conjunction with the state's public employee unions, is responsible for developing the state's health insurance program. This chapter reviews how the state's overall strategy toward health care purchasing and the number and type of health plans available to state employees have changed over the last several years. It addresses the following questions:

- **How has the Department of Employee Relations' approach to health care purchasing changed over time?**
- **How do other public and private employers structure their employee health insurance programs? How do other employers' insurance premiums compare with state government's premiums?**
- **What are the factors affecting health insurance premiums for state government and other employers in Minnesota?**

To answer these questions, we obtained data from the Department of Employee Relations regarding health plan premiums and costs, enrollment, coverage, utilization, and market share. We also talked with staff from several state agencies, including the departments of Employee Relations, Human Services, Health, and Commerce, and met with representatives from the state's major health plans, health plan organizations, and employee unions. We also examined the

biennial reports that Minnesota statutes require the Department of Employee Relations to file with the Legislature.[1]

HEALTH CARE PURCHASING STRATEGY

From the early 1990s through 2001, the State of Minnesota's strategy for purchasing affordable health care coverage for state employees has involved two concepts: managed care and managed competition. In addition, the state over time self-insured all of its health plans.

Managed Care

The State of Minnesota has been offering health insurance to its employees since 1945. Like most employers who offered health insurance during the 1940s and 1950s, the state offered coverage through traditional indemnity plans. Under such plans, employees were generally free to choose their medical providers and services and the plans paid a fixed percentage of the cost of the services rendered.

The state switched to managed care plans to help control costs.

The state introduced the concept of "managed care" in 1963 when it began to offer health maintenance organization (HMO) coverage to state employees. As shown in Table 2.1, managed care plans typically have administrative mechanisms that monitor and authorize the use of medical services at both the member and provider level. They generally involve the following cost control features: (a) specified lists of providers, also known as "networks," with explicit criteria for selection; (b) reimbursement methods that have traditionally shifted some financial risk to providers; and (c) controls over member use of hospital and physician services. Managed care is based on the theory that such mechanisms will help control costs. In contrast, traditional indemnity plans impose few, if any, constraints on the choice of providers or service utilization.

Table 2.2 describes the different types of managed care plans that are available, including HMOs, point-of-service organizations (POSs), and preferred provider organizations (PPOs). These models vary in terms of how much control they exercise over members' choice of providers and utilization of services, with HMOs generally being the most restrictive and PPOs the least restrictive. The three plan types vary widely on how they select and pay providers and the kinds of incentives they give to providers and members.

By 1989, the state was offering its employees eight HMO plans and two conventional indemnity plans. However, despite the availability of several HMO plans, the majority of state employees were enrolled in indemnity plans. Because costs for the state's indemnity plans were higher than projected, the state replaced its indemnity plans with a new PPO plan in 1990 and, two years later, it modified the PPO plan to operate as a limited POS plan.

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1 Minn. Stat. (2000), §43A.31, subd. 2. Contrary to statutory requirements, we found that the department did not file a report for the 1998-99 biennium.

Table 2.1: Typical Managed Care Activities to Control Costs

Gatekeepers/Primary Care Physicians generally coordinate patient care and control patient access to specialists or out-of-network providers based on referral protocols. The intent is to improve quality of care and lower costs by reducing unnecessary visits to specialists and duplicative care by multiple physicians. For people with chronic or severe medical conditions, a primary care physician is particularly important for helping coordinate care among several physicians.

Utilization Review means reviewing the medical necessity, appropriateness, efficiency, or quality of health care services, supplies, or pharmaceutical treatment. Utilization review may occur before, during, or after treatment.

Preadmission Certification/Preauthorization requires a patient to receive carrier approval before receiving services, such as inpatient hospital care or drug therapy. The reviewer may determine the appropriateness of services and establish limits on care.

Concurrent Review evaluates ongoing care for a patient to determine whether care is appropriate and should continue or cease.

Retrospective Review/Prepayment Screens evaluate the appropriateness of care provided to patients after treatment is provided. The review may lead to denied reimbursement for services.

Physician Profiling/Focused Medical Review is used to identify providers whose practices deviate from accepted standards and to educate providers about the standards for cost-effective, appropriate care.

Second Opinions require patients faced with certain treatment options recommended by a physician, such as chemotherapy or surgery, to obtain the opinion of a second physician. The purpose is to reduce unnecessary treatments and to encourage nonsurgical alternatives whenever appropriate.

SOURCE: Compiled by the Office of the Legislative Auditor.

Since 1990, all state employees have been enrolled in managed care plans—mostly in HMO plans. Table 2.3 shows the various health plans that the state has offered since 1991 and the share of state employees enrolling in each managed care plan.

Overall:

- **State government's shift toward managed care is consistent with national and local trends.**

Nationally, enrollment in managed care plans increased from 27 percent in 1988 to 73 percent in 1996 and to 93 percent in 2001.[2] In the Twin Cities 11-county area, enrollment in employer-based coverage through managed care plans was high throughout most of the 1990s—82 percent in 1993 and 91 percent in 1997.[3]

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2 Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2001 Annual Survey* (Menlo Park, CA and Chicago IL, 2001), 75.

3 Minnesota Department of Health, *Employer-Based Health Insurance: Types and Choice of Plans* (St. Paul, April 2000), 2.

Table 2.2: Types of Managed Care Health Plans

Health Maintenance Organizations (HMO) Plans are the most tightly controlled type of managed care. *Staff model* HMOs hire their physicians directly while *group model* HMOs contract with one or more physician groups. *Independent practice association* (IPA) HMOs contract with one or more networks of individuals who, unlike other types of HMOs, also provide care to patients covered by other insurance. HMOs generally only cover health care when members receive it from a specified list or network of physicians or hospitals.

Point-of-Service (POS) Plans are considered "hybrids" in that they combine the cost-control mechanisms of HMOs with the provider choice options of PPOs. As with HMOs, POSs require members to use primary care physicians to control access to a specified network of physicians and hospitals, but, similar to PPOs, allow members to use physicians or hospitals not in the network, at a higher cost to the patient.

Preferred Provider Organization (PPO) Plans retain many of the elements of traditional indemnity plans, but provide members with a financial incentive to receive care from a "preferred" provider. Members can see physicians or hospitals not on the preferred list, but they pay more.

SOURCE: Compiled by the Office of the Legislative Auditor.

Table 2.3: Share of State Employee Enrollment in State Health Plans, 1991-2001

	Share of State Employee Enrollment[a]										
Health Plans	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
First Plan Select	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
HealthPartners	7	6	6	6	4	4	4	8	9	4	3
HealthPartners Classic[b]	32	34	35	36	29	28	25	26	25	22	24
Medica Premier	13	12	10	6	21	27	27	<1	N/A	N/A	N/A
Medica Primary	5	5	5	6	4	2	2	14	10	N/A	N/A
State Health Plan-POS	41	42	42	44	40	26	17	9	6	6	5
State Health Plan Select	N/A	N/A	N/A	N/A	N/A	11	23	42	47	57	56
PreferredOne	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	9	10
TOTAL[c]	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

[a]Data reflect share of employees only, including University of Minnesota employees, as of July 1 of each year. They do not include dependents who are enrolled in the state's program.

[b]HealthPartners Classic was known as Group Health until 1998.

[c]Percentages may not total 100 due to rounding.

SOURCE: Department of Employee Relations, *Annual Premium Payment Summaries*, 1991-2001.

In comparison, enrollment in managed care plans in Minnesota's other 76 counties increased from 37 to 87 percent, with most of the growth occurring in PPO or POS plans.

- **Nationally, enrollment growth in HMOs during the 1990s, long considered the hallmark of managed care, is often credited with controlling health care costs.**

For example, an analysis using data from a 1997 Robert Wood Johnson survey found that individual premiums for employers offering an HMO plan were about 6 to 10 percent lower than premiums for other plans.[4] A recent study of Fortune 500 companies from 1994 to 1999 identified three factors associated with lower premium cost increases: employer size, use of a regional purchasing strategy rather than relying on national carriers, and enrolling a greater percentage of employees in HMO or POS plans.[5] Another study found that, while there were no differences in the use of hospitals, emergency rooms, or surgery under HMO plans versus other types of health plans, they did reduce the use of more costly specialty services and increased the use of ambulatory care and preventive care.[6] According to one review of the literature, managed care typically reduces health care costs by 20 to 30 percent.[7] Other studies suggest that growth in enrollment in HMO plans has produced spillover benefits in the form of lower costs throughout the health care system.[8]

The amount of cost savings depend on the managed care strategies that are used.

It should be noted that managed care has changed significantly over time, which makes it difficult to measure its effectiveness in controlling costs. As discussed earlier, managed care models range from tightly structured staff-model HMOs to loosely organized PPOs, with each model varying considerably in how stringently they implement different cost controls. In addition, indemnity plans often come with PPO features, and PPO plans are often more similar to traditional indemnity plans than they are to HMO plans. For example, Segal Company surveys of state government health insurance programs classify health plans into two types: indemnity/PPO plans and HMO/POS plans.[9]

Managed Competition

Along with emphasizing managed care, the Department of Employee Relations implemented a "managed competition" approach to health care purchasing in the early 1990s. This approach attempts to contain health care costs by having health

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4 M. Susan Marquis and Stephan H. Long, "Trends in Managed Care and Managed Competition, 1993-1997," *Health Affairs* 18 (November/December 1999): 75-88.

5 National Health Care Purchasing Institute, *Corporate Health Care Purchasing Among the Fortune 500* (Washington, D.C., May 2001), 8.

6 U.S. General Accounting Office, *Managed Health Care: Employers' Costs Difficult to Measure* (Washington, D.C., 1993).

7 David Mechanic, *Mental Health and Social Policy: The Emergence of Managed Care* (Needham Heights, MA: Allyn & Bacon, 1999), 135.

8 Marquis and Long, "Trends in Managed Care and Managed Competition," 75-88.

9 Segal Company, *1999 Survey of State Employee Health Benefit Plans* (Washington, D.C., 2000), 6.

plan carriers compete with one another on cost and quality. A standard benefits package across plans is key to successfully implementing managed competition.

We found that:

- **Historically, the State of Minnesota has been more successful than most other large employers in implementing managed competition.**

Consistent with managed competition principles, the state has consistently offered a choice of plans and carriers to state employees. From 1991 through 2001, the state has offered five to seven plans each year, with each plan generally providing the same benefits. In addition, plan choices have included offerings from three or four carriers, thus providing competition among insurers.

Nationally, only 10 percent of public and private employers offered a choice of plans in 2001.[10] However, choice varies greatly by employer size. Of employers with more than 5,000 workers, 77 percent offered a choice of health plans in 2001, and the share of employees who had a choice of health plans increased from 82 percent in 1988 to 87 percent in 2001.

The state encourages plan carrier competition by contributing a fixed amount toward premiums.

Minnesota employers (other than the State of Minnesota) are less likely to offer a choice of health plans. In 1997, only 7 percent of Minnesota employers statewide offered more than one health plan, down from 16 percent in 1993.[11] This decline in choice was broad-based and occurred across all employer sizes, industries, and regions. However, a recent survey of 14 public employers and 8 private employers in the Twin Cities metropolitan area found that slightly more than one-half of the public employers offered more than one health plan while all of the private employers did so.[12]

In addition, the state has promoted managed competition by making a fixed contribution toward insurance premiums, thereby encouraging employees to choose low-cost plans. Implemented in 1989, the state contributes the entire premium of the low-cost plan in each county for individual coverage and 90 percent of the low-cost plan's premium for dependent coverage.[13] Because all of the state's health plans generally provide the same level of coverage, using the lowest-cost plan as the basis for employer contribution allows employees to see the relative costs of the various plans being offered, thereby providing financial incentives for them to enroll in the low-cost plan. For example, state employees in the Twin Cities metropolitan area paid anywhere from $0 to $110 per month for individual coverage and from $40 to $314 per month for family coverage in 2001, depending on the health plan that they chose. Regardless of the plan chosen, the

10 Kaiser Family Foundation, *Employer Health Benefits 2001*, 62-63.

11 Minnesota Department of Health, *Employer-Based Health Insurance*, 2.

12 Office of the Legislative Auditor's analysis of data in Deloitte and Touche, *Detailed Employee Benefit Survey Responses* (Minneapolis, unpublished document, 2001). The survey covered 8 private employers and 16 public employers, including the State of Minnesota and the University of Minnesota. For the purposes of our study, we excluded the responses from both the state and university.

13 Low-cost carriers are determined on a county-by-county basis. In 2001, State Health Plan Select was the low cost carrier in 43 counties, PreferredOne was low cost in 15 counties, State Health Plan in 14 counties, HealthPartners Classic in 12 counties, and First Plan Select in 3 counties.

state contributed $266 toward individual coverage and $626 toward family coverage.

PreferredOne became a health plan carrier for the state in 1990.

Managed competition has been successful in moving state employees to low-cost health plans. The majority of state employees have usually enrolled in the state's two lowest-cost plans. In 2001 HealthPartners Classic, the low-cost plan in the Twin Cities metropolitan area, enrolled 24 percent of employees statewide. State Health Plan Select, the low-cost health plan in most counties outside the Twin Cities metropolitan area, enrolled 56 percent of employees statewide. The remaining four health plans each enrolled 10 percent or less of state employees.

Few employers nationwide make a fixed contribution toward premiums.

Few employers provide strong financial incentives for their employees to choose a low-cost plan. In 1997, only 28 percent of all firms nationwide and 36 percent of firms with 500 or more employees contributed a fixed amount to all plans.[14] According to a 1995 survey, only 12 percent of businesses nationwide with 200 or more workers that offered a choice of health plans contributed a fixed dollar amount, as prescribed under managed competition.[15] In a recent survey of a small sample of Twin City metropolitan area employers, nearly all of the 14 public employers that offered more than one health plan contributed a fixed dollar amount toward each plan while most of the 8 private employers did not.[16]

- **Empirical research regarding the effectiveness of managed competition in controlling costs is mixed.**

Nationally, some studies of managed competition show savings, although mostly of a one-time nature followed by long-run growth rates.[17] Other studies show that where the employer contribution was fixed, annual premium growth has been lower.[18] But a recent analysis using data from a 1997 Robert Wood Johnson survey found no relationship between cost and offering a choice of plans.[19] Also, the average premium was not lower for employers offering strong financial

14 Marquis and Long, "Trends in Managed Care and Managed Competition," 84.

15 *Ibid.*, 77.

16 Office of the Legislative Auditor Office's analysis of data in Deloitte and Touche, *Detailed Employee Benefit Survey Responses*.

17 Marquis and Long, "Trends in Managed Care and Managed Competition," 77.

18 *Ibid.,*88.

19 *Ibid.,* 75-88.

incentives to employees to shop for lower-price plans than it was for other employers.

In addition, studies have consistently found that employees who are offered a choice of health plans prefer the lower-priced plans when they must pay out-of-pocket for the full price difference among plans.[20] But "adverse selection" was significant for a number of employers—enough to drive some plans out of the market. As Table 2.4 explains, adverse selection occurs when healthy employees, faced with a choice of plans, enroll in low-cost plans, leaving less healthy employees enrolled in high-cost health plans. This increases the cost of high-cost plans and eventually they become too expensive to remain a viable option for employees.

Table 2.4: Adverse Selection

Adverse Selection occurs when healthy employees, faced with a choice of health plans at varying cost to them, overwhelmingly enroll in low cost-plans, leaving less healthy employees enrolled in higher cost plans that, for various reasons, they may be reluctant to leave. This movement further drives up premiums for the higher cost plans. High cost plans eventually fall into a "death spiral' as they become too expensive to remain a viable option for employees.

SOURCE: Compiled by the Office of the Legislative Auditor.

As we discuss in Chapter 3, adverse selection concerns contributed to the Department of Employee Relations' decision to modify its purchasing strategy for 2002. For example, enrollment in HealthPartners dropped from 9 percent in 1999 to about 3 percent in 2001 while employees' share of the premium (in the Twin Cities metropolitan area) more than tripled. Enrollment in State Health Plan-POS has also fallen dramatically over the last several years—dropping from 26 percent in 1996 to about 5 percent in 2001. Twin Cities metropolitan area employees who enrolled for family coverage during this period saw their share of the premium more than triple.

Self-Insurance

Self-insurance involves greater risk but eliminates some costs.

Throughout the 1990s, the state offered one or two "self-insured" health plans administered by BlueCross BlueShield of Minnesota. As shown in Table 2.5, a self-insured plan is one in which the employer pays health insurance claims out of a fund retained internally. Thus, the employer essentially acts as its own insurance company and bears the financial risk of health care costs. In contrast, insurance companies rather than employers administer "fully-insured" plans and they pay claims out of the premiums collected from employers.

A major advantage of self-insurance is that it eliminates insurance company profit gained through "risk charges" that are built into premiums and allows the employer to retain any profits. Risk charges build financial reserves to protect

20 *Ibid.,* 77.

Table 2.5: Types of Insurance Plan Funding

Self-Insured Plans are plans where employers pay health insurance claims out of funds retained internally. Instead of paying premiums, employers collect "premium-equivalents" to fund their plans and pay claims. Federal law exempts self-insured plans from state regulation, including fund reserve requirements, mandated benefits, premium taxes, and consumer protection regulations.

Fully-Insured Plans are plans where employers pay premiums to insurance companies to administer their health plans and pay health claims. Employers are not responsible for health-related claims that exceed total premiums.

SOURCE: Compiled by the Office of the Legislative Auditor.

insurers against significant financial losses due to higher than expected claims. In addition, self-insurance gives employers a better opportunity to design and configure various plan elements to fit the unique needs of their employees.[21]

Effective January 2000:

- **The state self-insured all of its health plans, although employers are moving away from self-insurance nationwide.**

Being self-insured should make it easier for the state to collect and analyze comparable claims data across health plan carriers. This could help ensure that the state's health care purchasing strategy addresses the health needs of state employees. As we discuss in Chapter 3, the Department of Employee Relations used these data to help design the Minnesota Advantage Health Plan, the state's new health benefits model.

Even though state plans are self-insured, they must meet nearly all state mandates.

Self-insurance offers more potential for cost savings for private employers and other public employers than it does for the State of Minnesota. Federal law exempts self-insured health plans from state regulation, including state mandates as well as state taxes and assessments.[22] However, Minnesota statutes require that the state's health plans offer nearly all of the benefits that the Legislature mandates for fully-insured plans.[23] For example, state law requires that all fully-insured plans—and the State of Minnesota—provide coverage for some types of reconstructive surgery and lyme disease treatment.

Among the nation's largest employers (5,000 or more employees), the share of employees in self-insured indemnity plans remained relatively constant from 1996 to 2001 and the share of employees in self-insured HMOs increased.[24] But the share of employees in self-insured PPO and POS plans declined.

21 Chapter 5 discusses how the Department of Employee Relations monitors the success of Minnesota's self-insurance activities.

22 Employee Retirement Income Security Act (ERISA) of 1974.

23 *Minn. Stat.* (2000), §43A.23.

24 Kaiser Family Foundation, *Employer Health Benefits 2001*, 132-134.

Nationally, the percentage of covered workers in partially or completely self-insured plans declined from 56 percent in 1996 to 47 percent in 2001.[25] This trend was also seen among the largest employers, with a decline from 67 to 60 percent of covered workers in self-insured plans.

PREMIUM TRENDS

Table 2.6 shows insurance premiums for each of the health plans that the State of Minnesota has offered its employees since 1992.[26] Monthly premiums for

Table 2.6: Average Monthly Health Insurance Premiums by Plan, 1992-2001

Individual Coverage

Health Plans	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
First Plan Select	$147	$154	$164	$165	$165	$142	$162	$181	$222	$271
HealthPartners	151	154	171	173	160	168	185	207	294	375
HealthPartners Classic[a]	125	132	142	143	146	153	168	187	238	266
Medica Premier	154	174	176	132	135	156	N/A	N/A	N/A	N/A
Medica Primary	125	138	138	147	155	162	173	215	N/A	N/A
State Health Plan-POS	165	174	174	165	163	184	237	266	332	362
State Health Plan Select	N/A	N/A	N/A	N/A	137	145	162	181	222	271
PreferredOne	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	255	294
TOTAL AVERAGE WEIGHTED PREMIUM	$149	$158	$162	$153	$148	$158	$172	$193	$238	$279

Family Coverage

Health Plans	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
First Plan Select	$353	$370	$394	$395	$396	$356	$404	$453	$555	$678
HealthPartners	376	383	426	431	395	420	462	519	734	938
HealthPartners Classic[a]	308	326	350	353	359	383	421	466	594	664
Medica Premier	397	451	457	343	367	391	N/A	N/A	N/A	N/A
Medica Primary	323	355	357	379	399	405	432	539	N/A	N/A
State Health Plan-POS	371	391	396	398	406	459	593	664	830	904
State Health Plan Select	N/A	N/A	N/A	N/A	343	362	404	453	555	678
PreferredOne	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	639	736
TOTAL AVERAGE WEIGHTED PREMIUM	$353	$373	$383	$377	$375	$394	$429	$483	$592	$698

[a]HealthPartners Classic was known as Group Health until 1998.

SOURCE: Department of Employee Relations, *Annual Payment Premium Summaries*, 1991-2001.

25 Ibid., 132.

26 Because the state has been self insured since 2000, the state no longer pays insurance premiums. It does, however, calculate "premium-equivalents" to determine its budget and establish how costs will be shared between employer and employee. For the purposes of our report, we use the term premium to include premium-equivalents.

individual plans in 2001 ranged from $266 to $375 for individual coverage and from $664 to $938 for family coverage. Overall, average weighted monthly premiums were $279 for individual coverage and $698 for family coverage in 2001.[27]

Despite the adoption of managed care and managed competition principles:

- **Insurance premiums for state employees began to increase rapidly in the late 1990s.**

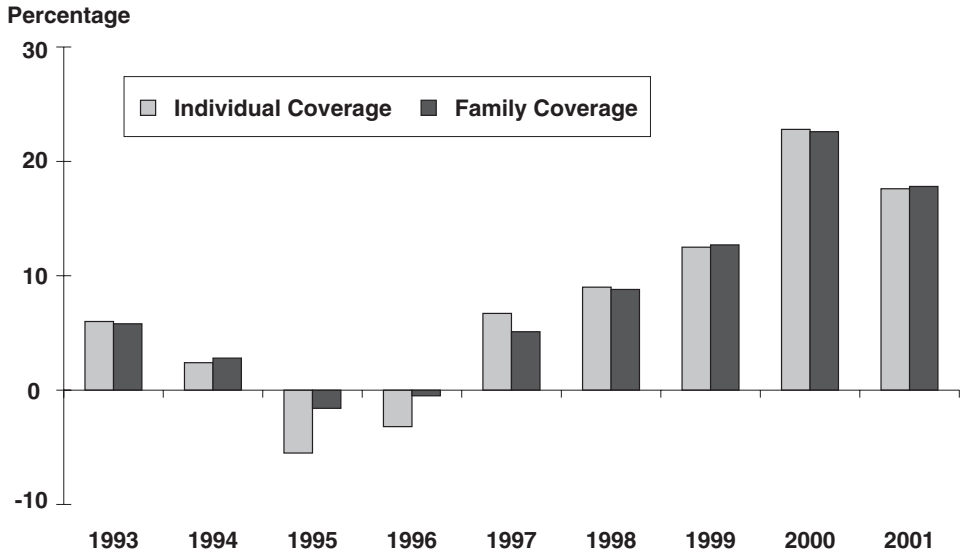
Figure 2.1 shows changes in average weighted premiums from 1992 through 2001. Average annual growth was low through the mid-1990s, actually declining in 1995 and 1996. But premiums began to rise sharply in 1998, increasing 9 percent over the previous year. Since that time, overall premiums for individual and family coverage have continued to grow, increasing 13 percent in 1999, 23 percent in 2000, and 18 percent in 2001.

Although it is difficult to compare premium growth across employers:

- **The rate at which insurance premiums increased for the State of Minnesota is generally consistent with national and state trends.**

Table 2.7 summarizes the results from four national employer surveys regarding health insurance premiums. Although specific results vary, the studies tend to

Figure 2.1: Annual Growth in Health Insurance Premiums for Minnesota State Employees, 1993-2001



SOURCE: Department of Employee Relations, *Annual Payment Premium Summaries*, 1993-2001.

27 Average weighted premiums are calculated by (1) multiplying the number of employees enrolled in each plan by the total premium, (2) summing these amounts, and (3) dividing the results by the total number of employees in the state's insurance program.

Table 2.7: Annual Growth Rates in Health Insurance Premiums Nationwide, 1991-2001

	(Percent Change from Previous Year)										
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Kaiser Family Foundation/ KPMG[a]	11.5%	10.9%	8.0%	4.8%	2.1%	0.5%	2.1%	3.3%	4.8%	8.3%	11.0%
Mercer/Foster Higgins[b]	12.1	10.1	7.9	-1.1	2.1	2.5	[c]	6.1	7.3	7.5	N/A
Towers Perrin	14.0	11.0	12.0	6.0	2.0	4.0	3.0	4.0	7.0	12.0	N/A
Bureau of Labor Statistics (unpublished estimates)	11.5	10.3	8.1	5.7	1.6	[c]	[c]	2.2	3.7	7.6	N/A

[a]Survey methodology changed in 1999 to include firms with fewer than 200 employees.

[b]Survey methodology changed in 1993.

[c]Growth/decline of 0.5% or less.

SOURCES: Minnesota Department of Health, *Health Insurance Premiums—An Update,* (St. Paul, August 2001); and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2001 Annual Survey* (Menlo Park, CA and Chicago, IL, 2001), 14.

Employers nationwide experienced premium increases in the late 1990s.

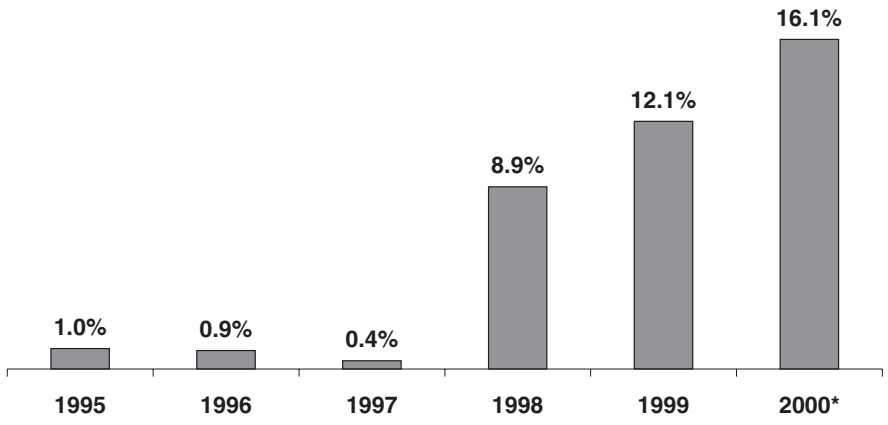
show that growth in health insurance premiums nationwide was low in the mid-1990s, but have accelerated in recent years—similar to the trend for Minnesota state government. For example, nationwide surveys by the Kaiser Family Foundation found that the average annual growth rate of insurance premiums decreased each year from 1991 through 1996. Annual growth rates have consistently increased since 1997, reaching 11 percent in 2001. In addition, in recent years, state and local governments nationwide have had the highest increase in premiums of any industry—10 percent in 2000 and 15 percent in 2001.[28] Previously, state and local government increases in premiums lagged the nation.

Premiums for Minnesota employers in general also began to increase sharply in 1998 after relatively small increases from 1995 to 1997. As shown in Figure 2.2, insurance premiums statewide jumped 16 percent in 2000, compared with a 23 percent increase in premiums for Minnesota state government employees.

It should be noted that insurance premiums measure the cost of offering health care coverage to employees; they do not measure the actual cost of employee health care. In addition, overall premiums may not be a good indicator of actual health care costs in any given year because insurance companies set their premiums using historical and projected claims data. This results in "premium cycles" where insurers keep premiums low following years of lower than expected costs to gain or keep market share, followed by years in which premiums exceed actual costs to make up for past losses. Although the state has addressed this volatility by self-insuring all of its health plans, it makes comparisons across employers (some of whom may not be self-insured) more difficult.

28 Kaiser Family Foundation, *Employer Health Benefits 2001,* 23.

Figure 2.2: Annual Growth Rates of Health Insurance Premiums for Minnesota Health Plans, 1995-2000



[a]Data for 2000 are preliminary.

SOURCE: Minnesota Department of Health, *Health Insurance Premiums--An Update* (St. Paul, August 2001).

STATE AND NATIONAL COMPARISONS

Using the results of existing research, we compared the State of Minnesota's insurance program in 2000 and 2001 with other employers' programs on a variety of measures, including premiums, the employer share of premiums, the use of cost-sharing mechanisms, and health insurance benefits as a percentage of employee compensation.

Premiums

A number of factors affect employers' insurance premiums, including employer size, type of industry, the location and concentration of their employees, local market conditions, the average age of their employees, and the benefit levels provided. As shown in Table 2.8:

- **Insurance premiums for Minnesota state employees were higher than national averages in 2001.**

Health insurance premiums for Minnesota state employees averaged $279 per month for individual coverage and $698 for family coverage in 2001—higher than most national measures. According to a 2001 study by the Kaiser Family Foundation, monthly insurance premiums for large employers (5,000 or more employees) nationwide averaged $213 for individual coverage and $600 for family coverage. Monthly premiums for state and local government nationwide averaged $217 for individual coverage and $615 for family coverage in 2001.

Table 2.8: Average Monthly Health Insurance Premiums for Minnesota State Government and the Nation, 2000-2001

	Average Weighted Premiums			
	Individual Coverage		Family Coverage	
Employers	2000	2001	2000	2001
State of Minnesota	$238	$279	$592	$698
Employers with 5,000 or more employees	196	213	523	600
Employers offering HMO plans	181	200	487	545
State and local government	211	217	520	615
State and local government offering HMO plans	196	217	503	545

SOURCES: Minnesota Department of Employee Relations, *Annual Premium Payment Summaries*, 2000 and 2001; and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2001 Annual Summary* (Menlo Park, and Chicago, IL, 2001).

Average monthly premiums for employers offering HMO plans were lower—$200 for individual coverage and $545 for family coverage.

In addition, a 2000 survey by Workplace Economics asked state governments about insurance premiums for the health plan that covered the largest number of employees.[29] Results showed that the average cost for individual coverage for state employees nationwide was about $247 in 2000 and the average cost for family coverage was about $484. Premiums for Minnesota's largest health plan for 2000 were lower than the national average for individual coverage ($222), but higher for family coverage ($555).

We also looked at premiums for each of the plans offered by the state and other employers. As noted previously, the State of Minnesota offers several health plans to its employees and the state makes a fixed dollar contribution to each. As Table 2.9 shows:

- **In 2001, insurance premiums for Minnesota's lowest-cost plan were generally higher than low-cost options offered by the federal government and a small sample of Twin Cities metropolitan area employers.**

In 2001, monthly premiums for individual plans that the state offered ranged from $266 to $375 for individual coverage and from $664 to $938 for family coverage. In comparison, overall premiums for HMO plans that the federal government offered its employees living in Minnesota ranged from approximately $237 to $315 for individual coverage in 2001, and from $568 to $755 for family coverage.

Also, individual coverage under the state's low-cost plan ($266) was more expensive than individual coverage in all but two of the plans offered by a small sample of private employers in the Twin Cities metropolitan area. Family coverage under the state's low-cost plan ($664) was higher than family coverage

29 Workplace Economics, *2000 State Employee Benefit Survey* (Washington, D.C., 2000).

Table 2.9: Range of Monthly Insurance Premiums for Plans Offered by Minnesota Employers, 2001

	Health Plan Premiums	
Employers	Individual Coverage	Family Coverage
State of Minnesota	$266-375	$664-938
Federal government	237-315	568-755
Public employers in the Twin Cities metropolitan area	147-342	514-861
Private employers in the Twin Cities metropolitan area	133-269	503-815

SOURCES: Minnesota Department of Employee Relations, *Annual Premium Payment Summary*, 2001; U.S. Office of Personnel Management, *2002 FEHB Non-Postal Premium Rates for Minnesota* (October 10, 2001); http://www.opm.gov/insure/health/02rates/non-postal/mn.htm; accessed October 16, 2001; and Office of the Legislative Auditor's analysis of data in Deloitte and Touche, *Detailed Employee Benefit Survey Responses* (Minneapolis, unpublished document, 2001). Excluding the State of Minnesota and the University of Minnesota, 14 public employers and 8 private employers were surveyed.

in about one-half of the private-sector plans. Although the state's low-cost option for individual coverage was higher than two-thirds of the plans offered by 14 public employers in the Twin Cities area, its low-cost option for family coverage was less costly than the majority of public-sector plans.

Employer Share of Premiums

In addition to having higher premiums than most employers nationwide, we found that:

- **In 2001, the State of Minnesota generally paid a higher share of insurance premiums than most other employers—public or private.**

In 2001, the State of Minnesota contributed, on average, 95 percent of the premium for individual health insurance for its employees and 91 percent of the premium for family coverage.[30] These shares are up slightly from the previous year, when the state paid 93 percent of the individual premium and 89 percent of the family premium.

Table 2.10 shows the results of surveys of employers regarding the employer share of insurance premiums for 2001. As shown, both large employers (those with 5,000 or more employees) and state and local governments nationwide paid an average of 85 percent of the individual premium and 79 percent of the family premium for health insurance in 2001.

30 As indicated earlier, the state contributes 100 percent of the low-cost plan's premium for individual coverage and 90 percent of the premium of the low-cost plan for dependent coverage. Because low-cost plans vary by county and not all employees choose the low-cost option, the state's total average contribution may not equal 100 percent for individual coverage and 90 percent for family coverage.

Table 2.10: Employer Share of Average Health Insurance Premiums, 2001

Employer	Employer Share	
	Individual Coverage	Family Coverage
State of Minnesota	95%	91%
Large employers with 5000 or more employees	85	79
Employers offering HMO plans	80	69
State and local governments	85	79
State and local governments offering HMO plans	91	82

SOURCES: Minnesota Department of Employee Relations, *Annual Premium Payment Summary*, 2000; and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2001 Annual Summary* (Menlo Park, and Chicago, IL 2001).

Most employers pay a smaller share of the family premium than the State of Minnesota.

In addition, data from a Workplace Economics study show that state governments paid, on average, 94 percent of the individual premium and 80 percent of the family premium for those plans that enrolled the largest number of employees.[31] About one-half of the states reported that they paid the full cost of the health insurance premium for an individual employee in 2000, and several states paid the entire premium for family coverage.

Most state-level studies also show that the State of Minnesota pays a higher share of the insurance premium than other employers in Minnesota. For example, statewide data collected for a Robert Wood Johnson Foundation study show that Minnesota employers contributed an average of 82 percent of the individual premium and 70 percent of the family premium in 1997.[32] The Minnesota School Boards Association reported that school districts paid, on average, 93 percent of the individual premium for licensed staff and 61 percent of the family premium in the 2000-2001 school year, down from the previous year when the percentages were 97 and 65 percent respectively.

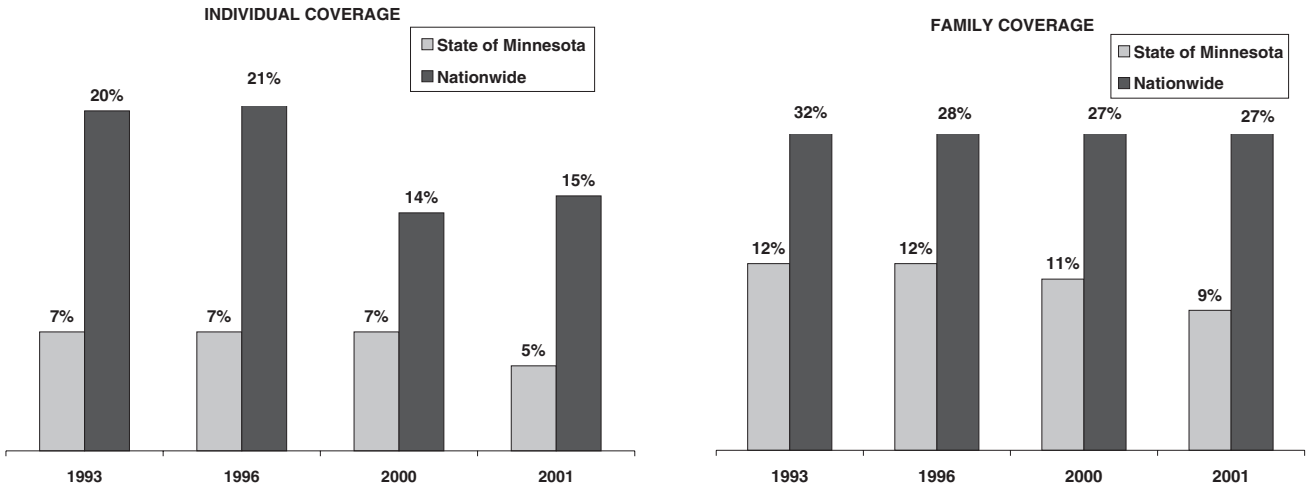
Finally, data from a small sample of 14 public and 8 private employers in the Twin Cities metropolitan area show that public employers generally contributed anywhere from 92 to 100 percent of the premium for individual coverage in their lowest cost plan in 2001 and from 68 to 93 percent of the family premium. Private employers paid from 72 to 96 percent of the individual premium and from 37 to 95 percent of the family premium in their lowest cost plan. Like the State of Minnesota, most public employers (but no private employers) paid the entire premium for individual coverage for their lowest cost health plan in 2001.

Finally, national studies show that employers have not shifted rising costs to employees by increasing their share of the premium. Figure 2.3 compares the average state employee share of insurance premiums with national averages over the last several years. As shown, state employees have consistently paid a smaller

31 Workplace Economics, *2000 State Employee Benefit Survey*.

32 Minnesota Department of Health, *Employer-Based Health Insurance in Minnesota* (St. Paul, 2000), 40.

Figure 2.3: Percentage Increase in Average Employee Share of Health Insurance Premiums, 1993-2001



SOURCES: Department of Employee Relations, *Annual Premium Payment Summaries*, July 1992-2001; and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2001 Annual Survey* (Menlo Park, CA and Chicago, IL, 2001).

share of premium costs than employees nationwide. In addition, the shares of insurance premiums paid by Minnesota state employees and other employees nationwide have actually declined since 1993.

Use of Cost-Sharing Mechanisms

Insurance premiums do not always cover the full cost of providing health care coverage because they exclude out-of-pocket expenses that employees might have to pay, such as co-pays, co-insurance, and deductibles, as described in Table 2.11. Some employers use these mechanisms to (a) pass costs along to employees, thus keeping premiums low, (b) educate employees about the true costs of health care, and (c) reduce unnecessary utilization of health services. We found that:

- **Unlike most employers nationwide, the State of Minnesota did not make extensive use of employee cost-sharing mechanisms, such as co-pays, deductibles, and co-insurance, before 2002.**

In 2001, state employees faced co-pays for emergency room and urgent care visits and for prescription drugs, and co-insurance payments for prosthetics, durable medical equipment, and diabetic supplies. State employees were not required to pay office co-pays, outpatient deductibles, or hospital co-insurance in 2001.

We examined the results of some national and state studies regarding the adoption of various employee cost-sharing mechanisms. We found that, unlike the State of Minnesota, most employers required employees to pay office co-pays. For example, the Kaiser Family Foundation reports that about 90 percent of

Table 2.11: Cost-Sharing Mechanisms

Co-pays are a flat dollar amounts that are charged every time a service is provided and may include doctor visits, prescription drugs, emergency room and urgent care, and other services. For example, health plans may require that members pay a $50 co-pay for each visit to an emergency room.

Deductibles are annual amounts that a plan members must pay each year for certain services before the plan starts paying for these services. A "$100 deductible" means that plan members pay the first $100 per year before the plan will begin covering the cost of those services.

Co-insurances are a percentage of the cost that is charged for certain services after the deductible has been paid. For example, a co-insurance level of 90 percent means that the plan member first pays the deductible, then the plan pays 90 percent of the costs, and the member pays the remaining 10 percent of the costs.

Out-of-Pocket Maximums are the sum of the co-pays, deductibles, and co-insurance that members will have to pay during a single year. There is often a separate out-of-pocket maximum for prescription drugs.

SOURCE: Department of Employee Relations.

Minnesota Advantage's employee cost-sharing requirements are in line with those of other employers.

employees enrolled in HMO plans nationwide had office visit co-pays in 2001. Eleven percent paid $5 per visit, 50 percent paid $10, and 29 percent paid $15 or more.[33] According to a Mercer/Foster Higgins nationwide survey, 94 percent of large employers and 83 percent of government employers that offered HMO plans required physician co-pays that averaged $10 and $9 respectively in 2000.[34] Finally, about two-thirds of the plans that 14 public employers in the Twin Cities metropolitan area offered in 2001and all of the plans that 8 private employers offered required an office visit co-pay that averaged about $14.[35]

Nationwide, employers used deductibles and co-insurance less frequently, depending on the type of health plan offered. For example, one large national survey reports that 30 percent of large employers and 18 percent of government employers that offered HMO plans in 2000 required a hospital deductible in 2000.[36] About one-half of the large employers that offered POS plans and over 90 percent of those with indemnity plans had co-insurance requirements.[37] A recent survey of 14 public employers and 8 private employers in the Twin Cities metropolitan area showed that about one-tenth of the plans offered had deductibles while about one-fourth had co-insurance requirements in 2001.[38]

33 Kaiser Family Foundation, *Employer Health Benefits 2001*, 105. Responses for the remaining 10 percent were either "no co-pay" or "don't know."

34 William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2000: Tables of Survey Responses* (New York, 2001), 32.

35 Office of the Legislative Auditor's analysis of data in Deloitte and Touche, *Detailed Employee Benefit Survey Responses*.

36 Mercer, *Mercer/Foster Higgins National Survey: Tables of Survey Responses*, 32.

37 Ibid., 23, 39. Survey results did not show the percentage of employers with HMO or PPO plans that had co-insurance requirements.

38 Office of the Legislative Auditor's analysis of data in Deloitte and Touche, *Detailed Employee Benefit Survey Responses*.

Health Insurance Benefits as a Percentage of Compensation

Finally, we looked at the percentage of employees' total compensation that is attributable to insurance benefits and found that:

- **The share of state employees' total compensation that is attributable to insurance benefits in Minnesota is similar to the share for government employees nationwide, and somewhat greater than the share for all employees nationwide.**

As shown in Table 2.12, state employee insurance benefits comprised approximately 8 percent of Minnesota state government employees' total compensation in 1999, a share similar to that of other government employees. Nationwide, insurance benefits made up 6 percent of employees' total compensation.

Table 2.12: Insurance Benefits as a Percentage of Compensation, 1999

	Minnesota State Government		State and Local Government		All Employers[b]	
	Hourly Rate	Percentage	Hourly Rate	Percentage	Hourly Rate	Percentage
Total Compensation	$28.44	100%	$28.00	100%	$19.00	100%
Wages and Salary	19.55	69	19.78	71	13.87	73
Insurance[a]	2.27	8	2.22	8	1.13	6
Other Benefits	6.62	23	6.00	21	4.00	21

[a]Includes health, life, and disability insurance.

[b]Includes employers who do not offer health insurance to their employees.

SOURCES: Office of the Legislative Auditor's analysis of data from the State of Minnesota's Payroll System (SEMA4); and U.S. Department of Labor, Bureau of Labor Statistics, *Employer Costs for Employee Compensation* (Washington, D.C., August 2001), Tables 2-3.

FACTORS AFFECTING RISING COSTS

It is difficult for employers to control the major factors affecting rising costs.

A variety of inter-related factors contribute to rising costs for health insurance, not all of which are under the control of employers, including the Department of Employee Relations. According to research literature, the most important factors contributing to recent premium increases include an aging population, prescription drug use, technological advances, market consolidation, and a consumer "backlash" to managed care. We discuss each of these factors below. The following chapters discuss how the state and other employers have responded to several of these factors.

Aging Population

It costs more to provide health care to older employees.

The age of an insured population is an important determinant of health care costs. As employees grow older, health care costs increase. National estimates of annual average expenditures for persons over the age of 45 are approximately twice the average annual expenditures for persons under the age of 45.[39]

We found that:

- **As a group, the state employee population is aging, with an increasing proportion of its employees over 44 years of age.**

The median age of all state workers rose from 38 years of age in 1984 to 45 years in 2000.[40] According to Minnesota Planning, more than one-half of benefit-eligible state employees are between the ages of 40 and 54.

In addition, membership in the state's insurance program, including employees and their dependents, is getting older. According to Department of Employee Relations' data, between 1995 and 2000, the share of members who were more than 44 years old increased 7 percent, while the share of members between the ages of 25 and 44 declined 6 percent.

In comparison, the Minnesota statewide population is estimated to have experienced a 3 percent increase in the percentage of citizens more than 44 years old and a 2 percent drop in the percentage between the ages of 25 and 44 during the same time period.[41] The Minnesota labor force experienced a 4 percent increase in the percentage of workers older than 44 years of age while the share of workers between 25 and 44 years of age decreased 5 percent.

Prescription Drug Spending

According to a recent Minnesota Department of Health report:

- **Consistent with national trends, prescription drug spending for Minnesota employers is increasing faster than any other category of health care expenditures.**

The percentage of health plan spending in Minnesota attributable to prescription drugs increased from 8.7 percent in 1994 to 12.3 percent in 1999.[42] Between 1997 and 1999, prescription drug spending increased at an annual rate of 15.8 percent—nearly twice as fast as total spending and faster than any other category of spending. For example, outpatient services increased 12.5 percent,

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39 Agency for Healthcare Research and Quality, *Health Care Expenses in the United States 1996* (Rockville, MD, 2000); http://www.meps.ahrq.gov/papers/rf12_01/Update3.gif; accessed October 19, 2001.

40 Minnesota Planning, *PopBites: Minnesota's State Government Workforce is Aging* (St. Paul, June 2001).

41 Office of the Legislative Auditor's analysis of data from the U. S. Bureau of the Census.

42 Minnesota Department of Health, *Drivers of Health Care Spending Growth In Minnesota* (St. Paul, February 2001), 2.

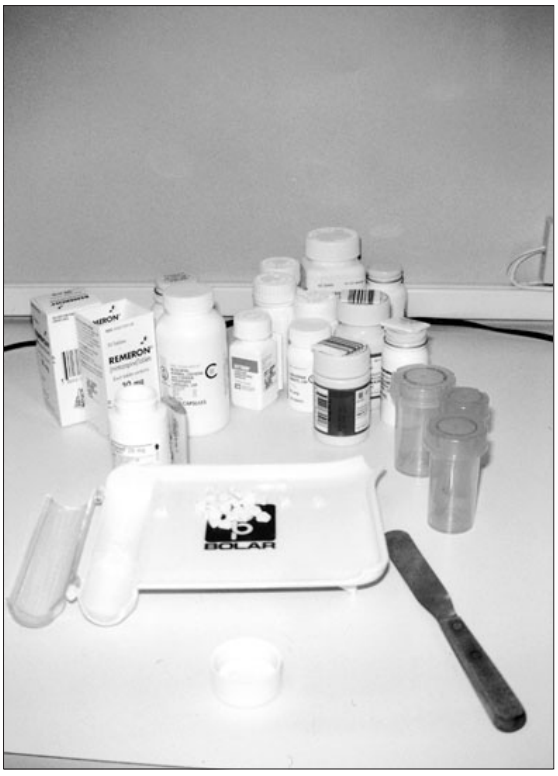
administrative and physician services increased 7.8 and 7.4 percent respectively, and inpatient services increased 5.6 percent.

A recent study found that prescription drug spending nationwide grew 17.3 percent from 1999 to 2000, making it the fastest growing area of health care spending.[43] Prescription drugs accounted for more than a quarter of the total growth in health care spending. The study attributed the rapid growth in prescription drug spending to three factors: increased direct-to-consumer advertising, more coverage by private health insurers, and newer drugs on the market.

According to claims data collected by the Department of Employee Relations, prescription drugs accounted for 21 percent of total state employee health care claims in 2000. Although statewide trend data on total prescription drug claims for state employees are not available, data collected from the individual health plan carriers participating in the state's program show that the proportion of total claims attributable to prescription drugs ranged from 12 to 17 percent in 1996. Similar data for 2001 show these costs ranging from 17 to 23 percent of total claims.

Some studies show that increased advertising by drug companies adds to the cost of prescription drugs.

According to some researchers, increased advertising by pharmaceutical companies and drug company mergers and acquisitions have added to the cost of prescription drugs. For example, BlueCross BlueShield of Minnesota reports that drug company spending on consumer advertising nationwide rose from $1.3 billion in 1998 to $1.8 billion in 1999.[44] According to the National Institute for Health Care Management, growth in drug spending is concentrated in a few therapeutic categories that tend to include heavily advertised drugs.[45] For example, four categories of drugs accounted for 31 percent of the total $42.7 billion increase in drug spending nationwide between 1993 and



Prescription drugs is the fastest growing category of health care spending.

43 Katharine Levit, Cynthia Smith, Cathy Cowan, Helen Lazenby, and Anne Martin, "Inflation Spurs Health Spending in 2000," *Health Affairs* 21, no. 1 (January/February 2002): 172-181.

44 BlueCross BlueShield of Minnesota, *Health Care Cost Solutions* (Eagan, MN, November 29, 2000), 3.

45 National Institute for Health Care Management, *Factors Affecting the Growth of Prescription Drug Expenditures* (Washington, D.C., July 1999), 1.

1998. These four categories include seven of the ten prescription drugs that were most heavily advertised to consumers in 1998. For example, spending on oral antihistamines such as Claritin increased 612 percent between 1993 and 1998, representing 4.5 percent of the total increase in drug expenditures. Spending on antidepressants such as Prozac increased 240 percent, representing 12 percent of the total increase in drug spending. Spending on cholesterol-reducing drugs such as Lipitor increased 194 percent between 1993 and 1998, representing 8 percent of the total increase in drug spending.

Technological Advances

During the past few decades, rapid advances in medical technology, including new medical equipment, procedures, and treatment therapies, have helped many citizens live longer, better-quality lives. At the same time, most analysts agree that:

- **Technological advances, while improving the quality of life, generally raise rather than lower health care costs.**

New treatments or technology are generally more expensive than old ones. For example, a magnetic resonance imaging (MRI) procedure costs more than an x-ray. At the same time, when asked to indicate which recent innovations' absence would have the most adverse impact on the length and quality of life, physicians overwhelmingly pointed to MRI and computed tomography (CY) scanning.[46] According to a health economist at Northwestern University's Kellogg School of Management, treating a heart attack patient costs $10,000 more in inflation-adjusted dollars today than it did in the mid-1980s, but heart attack victims typically live a year longer today than they did in the 1980s.[47]

The impact of new technology is especially apparent in catastrophic care and transplants. Even when new technology is less expensive, it often results in more medical interventions and higher utilization of medical services.

Market Conditions

Three health plan carriers dominate the Minnesota HMO market.

Another factor that is often cited as contributing toward rising health care costs is the changing structure of the health care industry brought on by the increased number of consolidations at both the health plan carrier and provider level. Although consolidation proponents cite efficiency and quality control as the primary motives behind consolidation, opponents emphasize the anti-competitive nature of health care mergers.

- **The State of Minnesota negotiates health plan contracts in a limited marketplace of health plans and providers.**

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46 Victor R. Fuchs and Harold C. Sox, Jr., "Physicians' Views of the Relative Importance of Thirty Medical Interventions," *Health Affairs* 20, no. 5, (September/October 2001): 30-42.

47 Kim Clark and John Fischman, "Out in the Cold," *U.S. News and World Report*, November 12, 2001, 56.

According to the Department of Health, the HMO market in Minnesota is dominated by three large companies that enrolled 91 percent of the fully-insured market in 1999.[48]

In addition to health plan consolidation, health care providers are also moving toward greater consolidation. Partly in response to concerns about revenue levels under managed care, health care providers are reorganizing and consolidating, which in turn give them more leverage when negotiating with health plan carriers. Providers have shown an increased willingness to drop out of managed care networks if they perceive that reimbursement rates are inadequate. For example, one large provider group in the Twin Cities metropolitan area recently rejected one health plan carrier's offer that would have increased physician fees 3 percent in 2002 and also would have allowed the health plan to make certain changes unilaterally.[49]

Managed Care Backlash

Consumer demands and expectations are other factors that research cites as contributing to rising costs—often described as a "backlash" against managed care principles. According to the literature:

- **Consumers have stepped up their demands for more access to health care services.**

Employers nationwide are moving toward less restrictive forms of managed care.

According to a 1997 report by the U.S. General Accounting Office, consumers often view the restrictions inherent in managed care plans as threats to health care quality.[50] Furthermore, consumers think that managed care sometimes saves money by simply rationing services rather than providing services more efficiently. Dissatisfaction with their ability to make health care choices has resulted in consumers moving away from the more restrictive forms of managed care, such as HMOs, into less restrictive models, such as POS and PPO plans[51]

According to the Kaiser Family Foundation, employers are continuing to offer less restrictive forms of managed care plans to their employees.[52] In 2001, 48 percent of employees nationwide were enrolled in PPO plans, up from 41 percent the previous year. Nationwide enrollment in HMO plans was 23 percent in 2001—lower than at any other time since 1993.

In addition, health plans nationwide are becoming less restrictive in that provider networks are getting broader and some managed care requirements, such as gatekeepers and preauthorization requirements, have been relaxed somewhat.

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48 Minnesota Department of Health, *The Minnesota HMO Profile* (St. Paul, May 2001), 10.

49 Glen Howatt, "Medica Dispute May Leave Patients Without a Doctor," *Minneapolis Star Tribune*, December 1, 2001, B1.

50 U.S. General Accounting Office, *Health Insurance Management Strategies Used by Large Employers to Control Costs* (Washington, D.C., 1997).

51 Jeffrey J. Stoddard, James D. Reschovsky, and J. Lee Hargraves, "Managed Care in the Doctor's Office: Has the Revolution Stalled?" *The American Journal of Managed Care* 7, no. 11, (November 2001): 1061-1067.

52 Kaiser Family Foundation, *Employer Health Benefits 2001*, 74-75.

For example, Minnesota state employees do not need a referral to see certain specialists, including obstetricians/gynecologists, chiropractors, and mental health/chemical dependency practitioners.

In addition, consumer concerns have at times encouraged policy makers to pass new laws or regulations that have increased access or choice. On the national level, Congress has been debating passage of a patients' bill of rights since the late 1990s. On the state level, some mandates require that health plans cover certain services or treatments, such as minimum maternity stays, well-child visits, and reconstructive surgery. According to the U.S. General Accounting Office, Minnesota had the second highest number of mandated services in the country in 1996.[53] Estimates concerning the impact that state mandates have on insurance costs in Minnesota vary. The Minnesota Council on Health Plans attributes about 22 percent of the 2001 insurance premium to state-mandated benefits.[54] On the other hand, a Minnesota Department of Health report notes that mandated benefits raise premiums only modestly—an estimated 6.5 percent, with the type of mandate having a more significant impact on premiums than the number of mandates.[55]

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53 U.S. General Accounting Office, *State Mandated Benefits* (Washington, D.C., 1996).

54 Minnesota Council of Health Plans, *Stat! MN Health Care Statistics, http://www.mnhealthplansorg/stat/stat5.html;* accessed August 31, 2001.

55 Minnesota Department of Health, *Mandated Health Insurance Benefits and Health Care Costs* (St. Paul, July 2001), 3.

3 Minnesota Advantage Health Plan

SUMMARY

Concerned about rising health insurance costs, the state negotiated significant changes in the way health benefits are structured, beginning January 2002. Although the state's new plan, the Minnesota Advantage Health Plan, is still built around managed care and managed competition principles, it introduces new cost-control incentives to encourage health care providers to compete with one another, both within and across health plans. In addition, Minnesota Advantage expands the state's use of certain cost-sharing mechanisms, such as co-pays, deductibles, and co-insurance, that other employers have historically used to help control costs. Although Minnesota Advantage incorporates some needed changes into the state's purchasing strategy, some of the plan's cost-control incentives may have limited effects because of market conditions and the high concentration of providers and employees in the lowest cost level. The Department of Employee Relations projects that the state and its employees will spend about $25 million less over the next two years under Minnesota Advantage than they would have spent under the state's previous health plan. Although we believe that the state's new plan should help reduce anticipated increases in health care costs, the extent of cost savings is uncertain. We recommend that the department monitor and evaluate Minnesota Advantage over the next two years, paying special attention to employee and provider incentives to control costs.

The State of Minnesota, like many other employers, has experienced significant increases in the cost of health insurance in recent years and these increases are expected to continue. To help control rising costs, the Department of Employee Relations significantly changed its health benefits purchasing strategy for 2002. This chapter addresses the following questions:

- **How does the state's new employee health insurance plan, the Minnesota Advantage Health Plan, work?**

- **What are the advantages and disadvantages of the various structural features of Minnesota Advantage?**

To address these questions, we reviewed documentation from the Department of Employee Relations. We also interviewed representatives from various state agencies, health plan carriers, and the state's two major public employee unions.

DESCRIPTION OF MINNESOTA ADVANTAGE

The state's new approach borrows strategies used by other large employers.

In 1998 the Department of Employee Relations began working with the state's public employee unions to modify its health insurance purchasing strategy to address rising costs and adverse selection concerns. In mid-2000, the department estimated that overall premiums would increase 13 to 14 percent annually over the next two years if the state did not make significant changes in its purchasing strategy. As shown in Table 3.1, state employees would be especially hard hit: the department projected that employees would be paying 51 percent more in premiums in 2002 and 43 percent more in 2003. Overall, the state's share of premiums would have risen about 11 to 12 percent annually. Based on these projections, the department was concerned that the state would eventually be able to offer only one health plan in the metropolitan area—HealthPartners Classic—and one plan in outstate Minnesota—State Health Plan Select, thereby reducing access, choice, and managed competition.

Table 3.1: Estimated Increase in Premiums Under the 2001 Plan Structure

	Premiums (in millions)[a]			Percentage Increase	
	2001	2002	2003	2001 to 2002	2002 to 2003
Total Premiums	$295.8	$336.3	$386.5	13.7%	14.9%
Employer Share	273.0	301.8	337.1	10.5	11.7
Employee Share	22.8	34.5	49.4	51.3	43.2

[a]The estimates assume that employees do not change health plans.

SOURCE: David K. Haugen, Assistant Commissioner, Department of Employee Relations memorandum to Jo Vos, Project Manager, Office of the Legislative Auditor, November 27, 2001.

In response, the department used its long-standing contract with Deloitte and Touche to develop a new purchasing strategy that it calls the Minnesota Advantage Health Plan. This new plan uses an approach similar to the one that the Buyer's Health Care Action Group developed and implemented in the Twin Cities metropolitan area in 1997.[1] Overall we think that:

- **Minnesota Advantage incorporates some needed changes into the state's health care purchasing strategy, such as using risk-adjusted costs, incentives for providers to compete with one another, and greater employee cost-sharing at the point-of-service.**

1 The Buyer's Health Care Action Group, a coalition of the state's largest employers, focuses on health care reform by trying to (a) align incentives for purchasing and providing care, (b) increase competition among providers, and (c) improve information about the value of health care. Although there are similarities between the approaches adopted by the State of Minnesota and the Buyer's Health Care Action Group, there are also important differences between the two approaches.

Many aspects of the state's purchasing strategy remain unchanged under the new plan. For example, the plan is still build around managed care, managed competition, and self-insurance concepts. The state continues to offer a standard benefits package and employees are still required to select a primary care provider and a health plan carrier. The state continues to pay 100 percent of the premium for individual coverage and 90 percent for dependent coverage. However, as shown in Figure 3.1, Minnesota Advantage introduces three new structural changes: (a) risk adjustment, (b) provider groups clustered into three "cost levels," and (c) expanded employee out-of-pocket costs.

Risk Adjustment

Since introducing a fixed contribution for the lowest cost plan, the Department of Employee Relations has struggled with rising premiums due partly to the concentration of relatively high-cost users of health care in one or two plans. In recent years, premium disparities among plans have increased. For example, in 1998 premiums for the state's most expensive health plan were 147 percent of the lowest cost plan's premiums. By 2002, the department projected that this cost differential would increase to 162 percent.[2] Furthermore, in recent years, enrollment in the two most expensive health plans offered by the state has declined to 5 percent or less in each. A large cost differential and declining market share are signs that the most costly employees are concentrated in one or two plans, causing costs to spiral upward.

The department used "risk-adjusted" costs to develop Minnesota Advantage.

To adjust for the fact that some health plans or providers attract less healthy employees or more complicated cases, the Department of Employee Relations introduced "risk adjustment" as part of Minnesota Advantage. As explained in Table 3.2, risk adjustment is commonly used to account for differences in employee health when comparing costs. The department used its existing contract with Deloitte and Touche to conduct a risk analysis using a diagnosis-based model that Johns Hopkins University developed.[3] This analysis generated "risk-adjusted" costs for each provider group that served state employees in 2000.[4]

The department used risk-adjusted costs to set premiums and to establish out-of-pocket cost-sharing requirements for employees. Risk adjustment should result in employees having better information about each provider group's costs relative to one another. It should also help the groups attract patients based on costs that have been adjusted to account for the types of patients that they treat and give them more flexibility to specialize in various areas such as diabetes or women's health.

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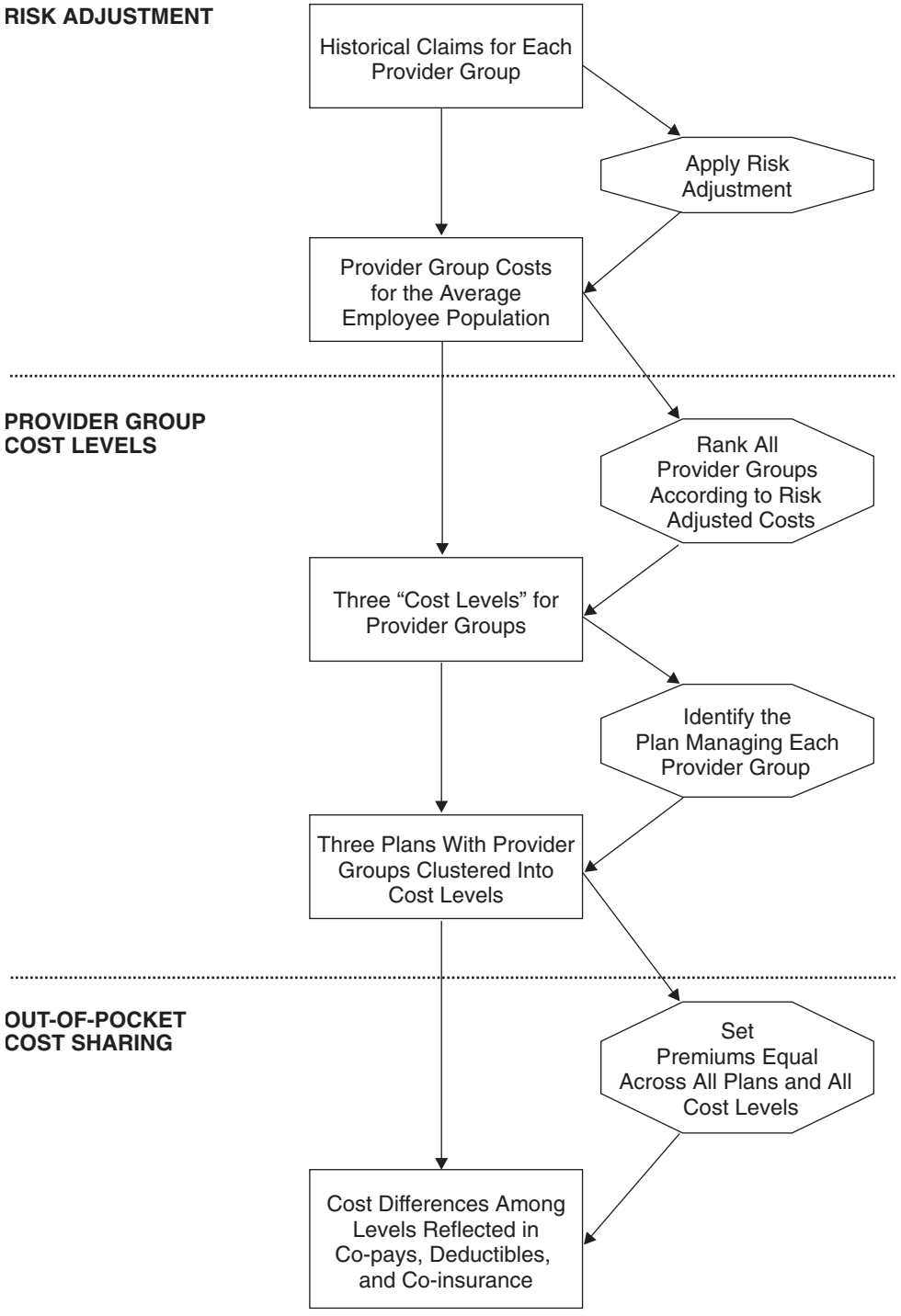
2 Deloitte and Touche, *State Employees Group Insurance Plan (SEGIP): Benefits at the Crossing* (Minneapolis, undated October 2001 version), 38. These projections assumed that employees would not switch to lower cost health plans in response to higher premiums.

3 The Minnesota Advantage Health Plan uses adjusted clinical groups, formerly referred to as ambulatory care groups, developed by Johns Hopkins University. Johns Hopkins University, *The Johns Hopkins ACG Case-Mix System;* http://www.acg.jhsph.edu/what/what.html; accessed October 10, 2001.

4 As we explained earlier, provider groups are organized networks that may include primary care physicians, hospitals, and other specialized services that contract with plan carriers to actually deliver services to plan members. The department has used the phrases "provider group" and "care system" synonymously.

Figure 3.1: The Minnesota Advantage Health Plan Structure



SOURCE: Created by the Office of the Legislative Auditor.

Table 3.2: Risk Adjustment

Risk adjustment is used to adjust for differences in the patient population. It answers the question:

> *If the same patient went for treatment at two different clinics, what would the costs be at each clinic?*

If risk adjustment was able to capture all relevant factors, adjusted costs would reflect an enrollee mix exactly equal to the average in the employee population. Consequently, cost differences would only reflect differences in efficiency and price. Thus, market competition is facilitated if employees are able to make decisions based on risk-adjusted prices.

The adjusted clinical groups (ACGs) used in Minnesota Advantage's risk adjustment have been applied in many settings. Users include the Minnesota departments of Health and Human Services, BlueCross BlueShield of Minnesota, and the Buyer's Health Care Action Group. According to Johns Hopkins University, they perform up to ten times better than age and gender adjustments.

SOURCES: Adapted from Deloitte and Touche, *State Employees Group Insurance Plan (SEGIP): Benefits at the Crossing* (Minneapolis, October 9, 2001); David M. Cutler and Sarah J. Reber, "Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection," *Quarterly Journal of Economics* 113, no. 2 (May 1998); and John Hopkins University, *The Johns Hopkins ACG Case-Mix System*; http://www.acg.jhsph.edu; accessed October 10, 2001.

Based on our review of the literature, we anticipate that:

- **The department's practice of risk adjustment could help limit cost increases that occur simply because the most costly employees are concentrated in one or two health plans.**

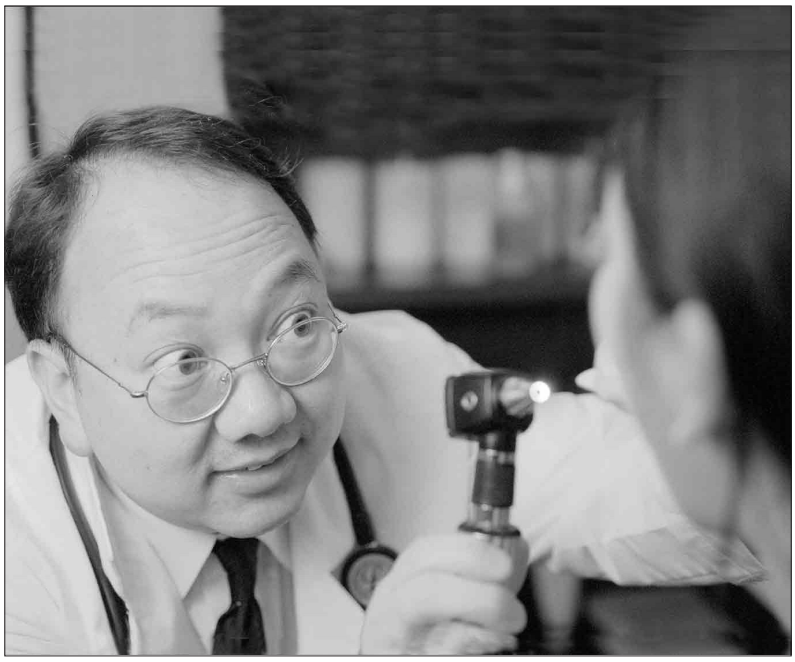
Given the state's anticipated problems with adverse selection, risk adjustment is appropriate. However, using risk-adjusted costs generally raises the cost of less expensive plans while lowering the cost of more expensive ones (it does not change total costs).[5] Because the state has historically paid a greater share of the lowest cost plan, implementing risk adjustment without making any other changes would have likely increased state costs. However, the Department of Employee Relations introduced several other mechanisms to help control total costs and to shift some costs to employees.

Because risk adjustment is a major component of Minnesota Advantage, the department must be able to clearly explain the process to state employees, health care providers, and policy makers. Risk adjustment helps determine each provider group's cost level, thereby affecting its ability to attract state employees. State agency staff and legislators have expressed concerns about how the department used risk-adjusted costs to group providers into cost levels and about the subsequent adjustments that the department made in these groupings after the initial risk adjustment was completed.

5 David M. Cutler and Sarah J. Reber, "Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection," *Quarterly Journal of Economics* 113, no. 2, (May 1998): 433.

Other state agencies also use "risk-adjusted" costs in their insurance programs.

For example, in our interviews, some staff in the departments of Health and Human Services expressed concern that the Department of Employee Relations did not seek input from other state agencies with risk adjustment experience as it developed Minnesota Advantage. The two departments have considerable experience using risk adjustment to help control costs in the state's publicly-funded insurance programs. Although these programs serve populations that are significantly different from the state employee population, the Department of Employee Relations may have benefitted from other departments' input into Minnesota Advantage's design and from their overall understanding and acceptance of the new plan.



The state's health plans provide a full set of benefits.

In addition to working more closely with other state agencies, the department might benefit from becoming involved in a statewide data analysis effort that the Buyer's Health Care Action Group is implementing. As part of this initiative, the group is pooling data from a wide range of employers and applying a common risk adjustment methodology. This initiative could potentially provide more robust information on the relative costs of provider groups in Minnesota, increase the credibility of specific risk adjustment methodologies, and lower the state's administrative costs.[6]

Provider Group Cost Levels

As we explained in Chapter 2, provider groups are fully integrated networks of health care providers that may include primary care physicians, specialists, and hospitals. According to the Department of Employee Relations:

- **Even after risk adjustment, provider groups' costs statewide varied significantly in 2000.**

6 As we discuss in Chapter 5, the department works with the Buyer's Health Care Action Group to conduct a consumer satisfaction survey.

For example, according to data that the department compiled in June 2001, risk-adjusted costs across provider groups ranged from $208 to $340 per member per month for the same services and benefit levels in 2000.[7]

To address cost disparities, the department created "cost levels" by (a) ranking all provider groups, regardless of geographic location or health plan affiliation, according to their average risk-adjusted cost and then (b) dividing the ranking into three groups. These groups, which the department calls cost levels, reflect whether each provider group's risk-adjusted costs are low, moderate, or high. Finally, the department identified the health plan to which each provider group belonged.

Identifying providers by cost level is intended to increase competition among providers and help control costs.

Primary care clinics and providers generally belong to a single provider group. However, provider groups, including member clinics and providers, often contract with multiple health plan carriers. As a result, some provider groups (and their clinics and providers) may be in different cost levels, depending on the specific health plan. For example, Fairview Lakes Lino Lakes Clinic, a member of the Fairview Physician Associates provider group, is affiliated with all three health plans that the state offers. The clinic is a Level I provider in two health plans and a Level II provider in the third. Likewise, Waterville Clinic, part of the Mayo Health System, is a Level I provider under two health plans and a Level III provider in the third.

By establishing three cost levels, Minnesota Advantage aggregates risk adjustment information and allows employees to select a primary care provider and provider group based on whether costs are relatively low, moderate, or high. The cost levels also give each provider group information on its costs relative to other provider groups—information not readily available in the past. Because lower cost levels are expected to be more attractive to many employees, this design is intended to create an incentive for providers to lower costs. A provider group that reduces costs and is re-assigned to a lower cost level may be able to gain a larger share of enrollment.

Due to lack of data, we were unable to estimate the financial impact that introducing cost levels could have on total costs. However, several factors could limit their effect. First:

- **State employees may not make up a large enough share of some providers' patient caseload to motivate price competition.**

With approximately 120,000 members statewide, the state's health insurance program is one of the largest purchasers of health insurance in Minnesota. But this membership, served by over 50 different provider groups, is spread across many local markets. In comparison, the Buyer's Health Care Action Group enrolled 140,000 members in the Twin Cities metropolitan area (10 percent of the local market) with its membership concentrated in 28 care systems. Even at this rate, the group recognized that it had limited purchasing power with any given

7 Deloitte and Touche, *State Employee Group Insurance Plan (SEGIP): Benefits as the Crossing* (Minneapolis, unpublished document June 11, 2001), 21. These figures include administrative costs and have been adjusted to reflect estimated 2002 costs.

care system and was trying to increase its membership to at least 20 percent of the market.[8] Although it is possible that state employees represent a large enough market share to motivate competition in some local markets, the Department of Employee Relations has not analyzed the market share that state employees represent in each local market throughout the state.[9]

In addition:

- **Some provider groups are the only ones that serve state employees in some areas of the state, while provider groups in other areas dominate the local market.**

For example, only one clinic in Mahnomen County participates in the state's program. In western Carver County, only one provider group in Norwood, Waconia, and Watertown, which has about 35 physicians, participates in the state's program. In St. Cloud, three provider groups with seven primary care clinics participate in Minnesota Advantage. These clinics employ at least 125 primary care physicians. Six of the clinics, employing about 113 primary care physicians, are in Level II. Only one primary care clinic, which has about 12 primary care physicians, is in Level I. Because the clinic has a small share of local physicians, it likely serves a small proportion of the state employees in the area. In these types of instances, provider groups and providers may not have significant incentives to lower costs.

Another reason why Minnesota Advantage's ability to encourage provider competition and employee enrollment in low-cost provider groups may be limited is that:

- **Most provider groups are in Level I, and most state employees were already using Level I providers before Minnesota Advantage was implemented.**

As shown in Table 3.3, approximately 53 percent of all primary care clinics that serve state employees are in Level I. In addition, the department estimated that approximately 69 percent of all employees were already using a Level I provider before the new plan was implemented. Because so many employees are already in the lowest cost levels, it may be difficult for the department to motivate additional employees to move to low cost providers in the future.[10]

The department estimates that a small percentage of employees will switch to providers in the lowest cost level.

According to the department's estimates, 5 percent of total plan members would respond to Minnesota Advantage's incentives by switching to the lowest-cost provider, which would bring total enrollment in Level I to 74 percent. The department assumed that, in regions of the state with sufficient competition, 20 percent of state employees and their dependents in Level III and 15 percent in

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8 Milbank Memorial Fund, *Value Purchasers in Health Care: Seven Case Studies* (September 2001); http://www.milbank.org/2001ValuePurchasers/011001value purchasers.html; 22-32; accessed September 26, 2001.

9 David K. Haugen, Assistant Commissioner, Department of Employee Relations memorandum to Jo Vos, Project Manager, Office of the Legislative Auditor, December 21, 2001.

10 Chapter 5 discusses what motivates employees to choose their providers.

Level II would switch to Level I providers, and that 10 percent of members in Level III would move to Level II. Finally, the department assumed that healthy individuals would be more likely to switch to a lower cost level than unhealthy individuals and weighted members accordingly in its analysis.[11] Table 3.3 shows the results of these assumptions.

Table 3.3: Concentration of Providers and Members in the Minnesota Advantage Health Plan by Cost Level, 2002

	Level I	Level II	Level III
Share of Clinics	53%	24%	22%
Share of Members Before Estimated Changes to Lower-Cost Providers	69	22	9
Share of Members After Estimated Changes to Lower-Cost Providers	74	20	6

SOURCES: Share of clinics estimated from the Department of Employee Relations' List of Providers; http:\\www.doer.state.mn.us; accessed December 11, 2001; and Deloitte and Touche, *State Employees Group Insurance Plan (SEGIP): Benefits at the Crossing* (Minneapolis, undated October version and November revision), 25.

Also, because there is a high concentration of providers in Level I, their incentives to lower costs may be limited. Generally, providers in Level I should have an incentive to lower their costs to keep from shifting into a higher cost level in subsequent years. However, Level I providers that have relatively low costs compared with other Level I providers may have less incentive because it is less likely that they will be shifted into a higher cost level in future years. Also, there is little evidence indicating whether providers will proactively lower costs to maintain their position in Level I or whether providers will respond only after they have lost state employees as patients. Some experts that we interviewed thought that some provider groups and providers may not be able to respond to Minnesota Advantage's incentives because they may not be able to effectively determine how the new plan will affect their costs. In addition, provider groups may not be able to negotiate changes with their respective health plan carriers to lower their costs.

To ensure access to Level I providers, the department re-assigned many higher cost providers to the lowest cost level.

Finally, the department re-assigned many higher cost providers to the lowest cost level to ensure that employees have access to a low cost provider in all parts of the state. During union contract negotiations, the department agreed that all employees would have access to a Level I provider within 30 minutes or 30 miles of their worksite or residence. To accomplish this, the department re-assigned many providers from levels II and III to Level I.[12] Department staff indicated

11 Haugen, memorandum, December 21, 2001.

12 Re-assigning provider groups to lower cost levels increases the average cost across all levels and reflects a subsidy from low cost to high cost geographic areas. Although data were not available to determine how this cost shift was shared between the state and employees, it is likely that it increased costs to the state and to members in low cost geographic areas, while lowering costs for members in high cost geographic areas.

that they generally used the following criteria to make these decisions: (a) the number of physicians, (b) the number of clinic sites, (c) risk-adjusted cost, (d) market patterns, and (e) the capacity to serve state employees in the area. The state's public employee unions also made suggestions to the department regarding the placement of providers into specific cost levels that the department also considered.

It is difficult to tell whether the providers that the department re-assigned to Level I have any incentive to lower their costs. Using data that the department provided to us in early December, we estimated that the department moved at least 20 percent of the state's primary care clinics to Level I for a variety of reasons, most often for geographic access. For example, the department moved one clinic in Fairmont, Minnesota from Level III to Level I for access purposes. The clinic has one primary care physician. However, Fairmont has several other primary care clinics already at Level I that have considerably more physicians. In another example, the department re-assigned two primary care clinics in Milaca and Princeton to Level I for access purposes. Because both clinics are affiliated with three health plans each, Minnesota Advantage theoretically should have offered some incentive to the clinics to negotiate lower rates with at least one health plan carrier to move to a lower level. However, the department re-assigned both clinics to Level I under two health plans; the clinic remains a Level II provider for the third plan.

Out-of-Pocket Cost Sharing

Minnesota Advantage increases employee costs at the point of service.

The Minnesota Advantage Health Plan introduces out-of-pocket costs for employees—co-pays, deductibles, and co-insurance—that were used only rarely in the past.[13] The department implemented these cost-sharing mechanisms to (a) increase consumer cost sensitivity, (b) lower utilization, and (c) highlight the relative differences in cost among providers in levels I, II, and III.

Although insurance premiums for individual and family coverage respectively do not vary across health plans or cost levels under Minnesota Advantage, out-of-pocket costs increase across cost levels. For example, the co-pay for an office visit involving an injury or illness is $5 in Level I, $10 in Level II, and $20 in Level III. Table 3.4 shows Minnesota Advantage's monthly premiums for 2002 and Table 3.5 summarizes its employee cost-sharing requirements.

The Department of Employee Relations chose to vary out-of-pocket costs rather than employees' share of premiums to allow employees to switch to providers in other cost levels throughout the year.[14] This approach also allows employees to have family members choose providers in different cost levels as long as they are enrolled in the same health plan. Under Minnesota Advantage, if employees change cost levels, it will only change their obligation for out-of-pocket costs; it will not change their contribution to premiums.[15]

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13 Table 2.11 defines each of these cost-sharing mechanisms.

14 In addition to selecting a clinic during open enrollment, members can switch to a clinic in a different cost level within the same health plan twice a year.

15 Under the Internal Revenue Code, employee premium contributions that are given tax preferred status cannot be changed during the plan year unless a qualified family status change is documented.

Table 3.4: Minnesota Advantage Health Plan Premiums, 2002

	Monthly Premium		Employee Share	
	Individual	Family	Individual	Family
BlueCross BlueShield of Minnesota	$261.44	$768.81	$0.00	$50.74
HealthPartners	261.44	768.81	0.00	50.74
PreferredOne	261.44	768.81	0.00	50.74

SOURCE: Department of Employee Relations.

As shown in Table 3.5, Minnesota Advantage applies out-of-pocket costs to a wide range of services, including office visits involving an injury or illness, outpatient therapy, urgent care, emergency care, inpatient hospital visits, outpatient hospital services, and prescription drugs. Although Minnesota Advantage's out-of-pocket costs reflect a significant change for employees:

- **The potential for reducing utilization is primarily limited to the impact of office visit co-pays.**

Many of the health-related services subject to out-of-pocket cost requirements in Minnesota Advantage are ordered by physicians or involve critical health care and are therefore considered relatively insensitive to co-pay amounts. For example, the department assumed that a $75 co-pay would not typically affect a patient's decision to have outpatient surgery.

Requiring office visit co-pays should reduce utilization of health care.

Other out-of-pocket cost requirements can affect utilization. These include co-pays for emergency room care, prescription drugs, and office visits. The state's health insurance program has included co-pays for emergency room visits and prescription drugs for many years. Minnesota Advantage increases emergency room co-pays from $30 to $50 per visit and prescription drug co-pays from $10 and $21 for formulary and non-formulary drugs to $12 and $25 respectively.[16] For the most part, the department does not anticipate that increases in prescription drug co-pays will have a significant impact on utilization. On the other hand, the department believes that increasing emergency room co-pays to $50 will help prevent an increase in unnecessary emergency room visits, especially in the highest cost level. Overall, the impact of these co-pays relative to other costs diminishes over time and the department may need to index or periodically raise these amounts to maintain their effectiveness.

Having a co-pay for office visits is a new requirement that the department expects to reduce utilization, thereby lowering total health care costs. According to Department of Employee Relations' estimates, having office visit co-pays of $5, $10, and $20 for each of the respective cost levels should reduce health care claims by about 0.6 percent. The department estimates that reducing utilization

16 As we discuss later in Chapter 4, formulary drugs are those that health plans cover at the least cost to employees. Non-formulary drugs may be covered at a higher cost to the employee or may not be covered at all.

Table 3.5: Employee Share of Costs Under the Minnesota Advantage Health Plan

2002 Benefit Provision	Level I	Level II	Level III
Employee Share of Annual Premiums	$0 single $609 family	$0 single $609 family	$0 single $609 family
Preventive Care Services • Routine medical exams, cancer screening • Child health preventive services, routine immunizations • Prenatal and postnatal care and exams • Adult immunizations • Routine eye and hearing exam	$0	$0	$0
Other Services • Lab, pathology, and x-ray • Allergy shots • Blood pressure checks	$0	$0	$0
Office Visits for Illness or Injury • Outpatient visits in a physician's office • Chiropractic services • Outpatient mental health and chemical dependency	$5 co-pay	$10 co-pay	$20 co-pay
Outpatient Physical, Occupational, or Speech Therapy	$5 co-pay	$10 co-pay	$20 co-pay
Urgent Care in a Facility in a Service Area	$5 co-pay	$10 co-pay	$20 co-pay
Emergency Room Care in a Hospital in a Service Area	$50 co-pay	$50 co-pay	$50 co-pay
Inpatient Hospital	$0	$200 co-pay	$400 co-pay
Outpatient Surgery	$0	$75 co-pay	$150 co-pay
Hospice and Skilled Nursing Facility	$0	$0	$0
Prosthetics, Durable Medical Equipment, Diabetic Supplies	20% co-insurance	20% co-insurance	20% co-insurance
Expenses Not Covered Above, Including But Not Limited To: • Ambulance • Home health care • Non-surgical outpatient hospital services: Radiation or chemotherapy Dialysis Day treatment for mental health and chemical dependency	Nothing after $100 annual deductible per person or $200 annual deductible per family	5 percent co-insurance after $150 annual deductible per person or $300 annual deductible per family	10 percent co-insurance after $300 annual deductible per person or $600 annual deductible per family
Prescription Drugs • 34 day supply including insulin; three-cycle supply of oral contraceptives • For brand name drugs when a generic is available, employees pay the co-pay plus the cost difference	$12 formulary $25 non-formulary	$12 formulary $25 non-formulary	$12 formulary $25 non-formulary
Maximum Out-of-Pocket Expenditure for Prescription Drugs	$300 per person $600 per family	$300 per person $600 per family	$300 per person $600 per family
Maximum Out-of-Pocket Expenditure Excluding Prescription Drugs	$500 per person $1,000 per family	$500 per person $1,000 per family	$500 per person $1,000 per family
Maximum Total Employee Expenditure	$800 per person $1,600 per family	$800 per person $1,600 per family	$800 per person $1,600 per family

Shading identifies items where employee costs differ across levels.

SOURCES: Department of Employee Relations, *SEGIP Benefits* (St. Paul, undated); and Deloitte and Touche, *State Employees Group Insurance Plan (SEGIP): Benefits at the Crossing* (Minneapolis, undated November version), 9.

by this amount should decrease the state's share of costs by about $1.4 million in 2002.[17] In addition, the department estimates that having employees pay the new office visit co-pays should save the state another $2.6 million by shifting costs from the state to employees.

Although Minnesota Advantage incorporates some needed changes into the state's insurance program:

- **Varying cost-sharing requirements by cost levels makes decision making more complex for employees as they select a health care provider.**

As shown in Table 3.6, the department estimated how costs for different medical events could vary across cost levels. These data provide some insight into how different employees may be affected by Minnesota Advantage's cost-sharing requirements. The differences in cost between levels I and III for the same service range from $0 to $470 for individual coverage and from $15 to $780 for family coverage, depending on the medical event. These examples also illustrate that costs for the same event can be considerable higher under family versus individual coverage.

The table includes several examples where employees reach their out-of-pocket maximums for either prescription drugs, medical services, or both. As noted earlier in Table 2.11, out-of-pocket maximums represent the most that employees would have to pay in co-pays, deductibles, and co-insurance in a given year. Current out-of-pocket maximums for prescription drugs are $300 and $600 for individual and family coverage respectively, and the maximums for other medical services (excluding prescription drugs) are $500 and $1,000. Assuming that members do not switch providers, the department estimates that 15 percent of members will reach their prescription drug out-of-pocket maximum and 5 percent will reach the medical services maximum in 2002.[18] Overall, the department estimates that 2.33 percent of members will reach both out-of-pocket maximums.[19]

Overall, the department estimates that a small share of state employees will reach their out-of-pocket maximums.

As noted previously, greater use of employee cost-sharing mechanisms has several benefits, including employee education regarding the true costs of health care and reductions in unnecessary utilization of health services. At the same time though, some employees may feel the impact of increased cost-sharing more acutely than others. Using data that we obtained from the Department of Employee Relations, we estimated annual expenditures for a high-cost user of health care as a percentage of the average annual salary for a state employee and as a percentage of a low-range salary. For 2001, we defined a high-cost user as an employee who enrolled in the state's lowest cost plan and reached the

17 Haugen, memorandum, December 21, 2001; and David Haugen (david.haugen@state.mn.us), "Re: Advantage," electronic mail to Jo Vos (January 2, 2002).

18 Haugen, memorandum, December 21, 2001.

19 David K. Haugen, Assistant Commissioner, Department of Employee Relations memorandum to Jo Vos, Project Manager, Office of the Legislative Auditor, November 27, 2001.

Table 3.6: Examples of Employee Costs for Selected Medical Events, 2002

	Cost[a]					
	Individual Coverage			Family Coverage		
Scenario[b]	Level I	Level II	Level III	Level I	Level II	Level III
Dialysis						
13 outpatient dialysis claims	$425	$800	$800	$825	$1,600	$1,600
Maternity						
Prenatal and one inpatient maternity stay	208	418	620	208	418	638
Emergency Episode						
One broken arm	115	120	130	115	120	130
Inpatient Episode						
One heart attack	306	660	686	406	1,186	1,186
Outpatient Surgery						
One ear tube for child with family coverage	N/A	N/A	N/A	15	105	210
Outpatient Surgery						
One outpatient hernia surgery	185	319	444	219	319	444
Inpatient Surgery						
One appendectomy	22	232	452	22	232	452
Inpatient Surgery						
One tonsillectomy	114	344	584	114	344	604
Inpatient Surgery						
One gall bladder surgery	151	419	536	251	469	699
Psychiatric Care						
1 inpatient admit, 1 emergency room visit, 9 physician visits, 101 psychiatric claims	800	800	800	1,400	1,600	1,600
Chemotherapy						
1 inpatient admit, 1 emergency room visit, 9 physician visits, 101 psychiatric claims	752	752	752	998	1,252	1,252
Outpatient Therapy						
20 physician chiropractic visits, 9 physician occupational therapy visits	386	556	716	386	556	896

[a]Does not include annual employee share of premiums ($0 for single and $609 for family coverage). For 2002, annual out-of-pocket maximums for medical services and prescription drugs combined are $800 for individual coverage and $1,600 for family coverage.

[b]Cost scenarios represent examples only and assume a full range of services related to a particular event. Individual experiences may vary. All scenarios assume formulary drug prescriptions.

SOURCE: Office of the Legislative Auditor's analysis of Department of Employee Relations' scenarios under the Minnesota Advantage Health Plan.

out-of-pocket maximum for prescription drugs. For 2002, we included both prescription drug and medical out-of-pocket maximums. As shown in Table 3.7:

- **Under Minnesota Advantage, health care expenditures for some state employees with family coverage could comprise between 5 and 9 percent of their annual salary.**

Under Minnesota Advantage, annual expenditures for a high-cost user of health care, including premium and out-of-pocket costs, could increase from

Table 3.7: Examples of Annual Expenditures for a High-Cost User

	2001		2002	
	Single	Family	Single	Family
Annual Employee Expenditures[a]	$200	$880	$800	$2,200
Expenditures as a Share of Average Annual Salary	0%	2%	2%	5%
Expenditures as a Share of Low-Range Salary[b]	1%	4%	3%	9%

[a]We based 2001 expenditures on employee contributions to premiums and the annual out-of-pocket maximum for prescription drugs. It assumes no emergency room visits and, therefore, may be a low-end estimate. We based 2002 expenditures on annual out-of-pocket maximums for prescription drugs and medical expenditures and employee contributions to premiums.

[b]The low-range salary is based on 2001 salaries for employees represented by the American Federation of State, County, and Municipal Employees, and is inflated for 2002.

SOURCES: Office of the Legislative Auditor's analysis of data from the Department of Employee Relations and the American Federation of State, County, and Municipal Employees.

approximately $200 in 2001 to $800 in 2002 for individual coverage and from $880 to $2,200 for family coverage.[20] We do not have data, however, to determine how many employees this might affect. According to the Department of Employee Relations, the state responded to union concerns about out-of-pocket costs for some employees by proposing a sliding scale health care account to reimburse low-wage employees with high medical costs for their out-of-pocket expenses. But the department stated that the proposal was not acceptable to the unions.

Finally, because the average cost of Level I provider groups is lower than it is for provider groups in other cost levels, having employees select Level I provider groups should reduce overall health care costs.[21] However:

- **Under Minnesota Advantage, some state employees may have more incentive to move to lower cost providers than other employees.**

While all employees in Level I can anticipate lower costs than employees in other cost levels, the magnitude of these differences will vary according to their (and their family's) anticipated health needs. For example, employees or their dependents who are high-cost users of health care and who anticipate reaching the out-of-pocket maximums will likely have less incentive to select a Level I provider over a more expensive one. On the other hand, moderate users of health

20 We did not base estimated costs for a high-cost user in 2001 on the annual out-of-pocket maximums because employees never reached these amounts. Rather we based estimates on employees' share of the low-cost plan's premium, the pharmacy out-of-pocket maximum, and an assumption of no emergency room visits. A $30 co-pay was required for emergency room visits in 2001 and this would narrow the difference between the 2001 and 2002 estimates.

21 While total costs should be reduced by employees moving to Level I, we do not have data to determine how this cost reduction would be distributed between savings to the state through lower premiums and savings to employees through a combination of lower premiums and lower out-of-pocket costs.

care could save a significant amount of out-of-pocket costs by selecting a lower cost provider. The financial incentives are less compelling for low-cost users of health care because they may not face a significant enough differential in out-of-pocket costs across levels to move to lower cost providers.


Plan members have some costs at the point of service.

Paying some costs "out-of-pocket" should increase employees' incentives to control and manage their health care costs.

The cost decreases associated with moderate users of health care selecting providers in lower cost levels are likely to offset any cost increases associated with low-cost users of health care selecting providers in higher cost levels. However, the cost levels in Minnesota Advantage are based on the assumption that most employees will move to lower cost levels, and this in turn will create incentives for providers to lower their costs. Therefore, the movement of members into higher cost levels may limit the incentives for providers to lower their costs.

According to the Buyer's Health Care Action Group, annual employee costs should differ across levels by approximately $120 for individual coverage and $360 for family coverage to provide meaningful distinction among cost levels. Under Minnesota Advantage, an individual or family anticipating one or more typical health care episodes will face a differential of roughly this magnitude or greater. However, an individual expecting to use only preventive care and one or two office visits will face very little cost difference across levels. For example, an individual would pay only $10, $20, or $40 for two office visits and preventive care. Consequently, some employees may choose to move from the lowest cost plan available in 2001 to a high cost level in 2002.

If the department had established different premiums across the cost levels and used the same out-of-pocket costs for each level, it would have provided employees with a defined choice at the time of enrollment—each employee would have known with certainty the cost implications of choosing a higher cost provider and the financial incentives for employees would not have varied based on health care usage. On the other hand, varying out-of-pocket costs gives employees the flexibility to move to providers in different cost levels throughout the year.

BUDGET IMPACT OF THE MINNESOTA ADVANTAGE HEALTH PLAN

The department projects modest savings from Minnesota Advantage.

Using data developed by the Department of Employee Relations, Table 3.8 compares Minnesota Advantage's estimated impact on employer and employee costs in 2002 and 2003 with what expenditures might have been had no changes been made to the state's program. As shown, the department estimates that Minnesota Advantage should reduce anticipated increases in health care costs by about $25 million over the next two years—about 3 percent of total expenditures. The department expects the state to spend about $5 million less each year under Minnesota Advantage, while employees are expected to spend about $1 million less in 2002 and $14 million less in 2003.

Table 3.8: Estimated Impact of the Minnesota Advantage Health Plan on Total Health Care Costs

	Estimated Costs (in millions)					
	2002			2003		
	2001 Plan Structure[a]	Minnesota Advantage	Difference	2001 Plan Structure[a]	Minnesota Advantage	Difference
Total Premiums	$336.3	$315.7	($20.6)	$386.5	$352.9	($33.6)
Employer Share	301.8	296.9	(4.9)	337.1	331.9	(5.2)
Employee Share	34.5	18.8	(15.7)	49.4	21.0	(28.4)
Out-of-Pocket Costs[b]	13.0	27.6	14.6	14.3	28.6	14.3
Employer Share	0.0	0.0	0.0	0.0	0.0	0.0
Employee Share	13.0	27.6	14.6	14.3	28.6	14.3
Total Health Care Costs	349.3	343.3	(6.0)	400.8	381.5	(19.3)
Employer Share	301.8	296.9	(4.9)	337.1	331.9	(5.2)
Employee Share	47.5	46.4	(1.1)	63.7	49.6	(14.1)

[a]Estimates under the 2001 plan structure assume that employees do not change health plans despite large premium increases. Therefore, this is an upper bound estimate of total 2001 costs.

[b]Out-of-pocket costs for the 2001 plan structure and 2003 are estimated based on annual costs in an undated spreadsheet from the Department of Employee Relations.

SOURCES: Office of the Legislative Auditor's analysis of data from: Premium costs from an undated spreadsheet from the Department of Employee Relations; David K. Haugen, Assistant Commissioner, Department of Employee Relations memorandum to Jo Vos, Project Manager, Office of the Legislative Auditor, November 27, 2001; David K. Haugen, Assistant Commissioner, Department of Employee Relations memorandum to Jo Vos, Project Manager, Office of the Legislative Auditor, December 21, 2001; and David Haugen (david.haugen@state.mn.us), "Re: Advantage," electronic mail to Jo Vos (January 3, 2002).

Minnesota Advantage appears to shift a greater share of costs to employees.

In addition, in comparison with the state's previous plan, Minnesota Advantage appears to shift a greater portion of total health care costs to employees in 2002 and 2003. Using Department of Employee Relations' data, we estimated the employee-employer shares of total health care costs under Minnesota Advantage. As shown in Table 3.9, employees' share of total costs are estimated to increase from 11 percent in 2001 to 14 percent in 2002, with employee expenditures shifting from premium contributions to out-of-pocket spending. The state's share of total costs is estimated to decrease from 89 percent in 2001 to 86 percent in 2002.

Table 3.9: State and Employee Shares of Total Health Care Costs

	Estimated Costs (in millions)			Share of Total		
	2001	2002	2003	2001	2002	2003
Total Premiums[a]	$295.8	$315.7	$352.9	100%	100%	100%
Employer Share	273.0	296.9	331.9	92	94	94
Employee Share	22.8	18.8	21.0	8	6	6
Out-of-Pocket Costs[b]	$ 11.7	$ 27.6	$ 28.6	100%	100%	100%
Employer Share	0.0	0.0	0.0	0	0	0
Employee Share	11.7	27.6	28.6	100	100	100
Total Health Care Costs	$307.5	$343.3	$381.5	100%	100%	100%
Employer Share	273.0	296.9	331.9	89	86	87
Employee Share	34.5	46.4	49.6	11	14	13

[a]Premium costs from an undated spreadsheet from the Department of Employee Relations.

[b]Out-of-pocket costs are estimated based on annual costs in an undated spreadsheet from the Department of Employee Relations. The estimated total out-of-pocket costs do not account for potential changes in utilization; however, the impact on the employee share of costs is anticipated to be negligible.

SOURCES: Office of the Legislative Auditor analysis of data from: David K. Haugen, Assistant Commissioner, Department of Employee Relations memorandum to Jo Vos, Project Manager, Office of the Legislative Auditor, November 27, 2001; David K. Haugen, Assistant Commissioner, Department of Employee Relations memorandum to Jo Vos, Project Manager, Office of the Legislative Auditor, December 21, 2001; and David Haugen (david.haugen@state.mn.us), "Re: Advantage," electronic mail to Jo Vos (January 2, 2002).

Overall, we think that:

- **The Minnesota Advantage Health Plan should reduce anticipated increases in health care costs, but the extent of cost savings is uncertain.**

There are several reasons for this. First, department projections depend to a large extent on how accurately it has projected what costs would have been if the state had not changed its program and simply maintained the "status quo." For example, in its status quo projections, the department assumed that employees would not change health plans as their share of insurance premiums increased in 2002 and 2003. We think that it is reasonable to assume that some employees might have switched to lower cost plans given the department's premium projections and the historical enrollment patterns that we discussed in Chapter 2. In comparing the status quo to Minnesota Advantage, the department assumed that 5 percent of employees would move to lower-cost providers under the new plan. But without an analysis of how employee movement from high cost to low cost plans might contribute to adverse selection, it is not possible to determine how employee movement would affect total costs.

Second, how employees and providers respond to Minnesota Advantage's incentives to control costs will affect potential cost savings. According to the department, two provider groups have recently negotiated new financial arrangements with their health plan carriers for 2002 that should increase

savings to the state beyond what is shown in its estimate.[22] But, as discussed previously, several factors may weaken the new plan's incentives for providers and employees to control costs further, including local market conditions and the high concentration of providers and employees already in the lowest cost level.

Third, the Department of Employee Relations had difficulty supplying us with accurate, reliable data on the insurance program for state employees and we have not independently verified the department's figures. Department staff had problems (a) answering questions about the data that they did submit, (b) reconciling inconsistent data, and (c) answering basic questions about the new plan's design. According to department staff, a number of factors contributed to their difficulties. Because the department was in the midst of developing a new health plan with union input, it had to make frequent modifications to the plan that were sometimes difficult to keep track of and document. Also, the department had to deal with the state employee strike and implement one of the latest and shortest health insurance open-enrollment periods ever. Finally, the department was negotiating new contracts with the state's health plan carriers during the same time period.

RECOMMENDATION

The Department of Employee Relations should monitor and evaluate the Minnesota Advantage Health Plan over the next two years, paying special attention to employee and provider incentives to control costs.

As part of its ongoing responsibilities, the department will need to identify the information that needs to be collected in order to evaluate the new plan and then ensure that the data are being accurately collected. The department could use preliminary data concerning the state's first year's experience with the new plan to help modify Minnesota Advantage during the next round of negotiations with the unions and carriers. But the more critical analysis would focus on the experiences of providers and employees over the second year of implementation. This would allow sufficient time for providers and employees to become familiar with the new plan and respond to its cost-control incentives. These outcomes could then be used to evaluate the effectiveness of Minnesota Advantage.

22 The cost savings from a third provider group that reduced its reimbursement rates to move to a lower cost level are already included in the department's estimates.

4 Structural Alternatives

SUMMARY

Overall, the State of Minnesota has already incorporated many structural options that the literature suggests can help control rising health insurance costs. Although several alternatives that the state has not implemented might have potential for cost savings, such as certain defined contribution plans, they do not appear to be feasible options at this time. The state has already implemented the most widely used defined contribution approaches: a fixed contribution and flexible spending accounts. We recommend that the Department of Employee Relations monitor other employers' experiences with some of the alternatives currently being used. Also, as health care costs continue to rise, the department's policy decisions related to allocating costs between the state and employees will take on greater significance.

The previous chapter on the Minnesota Advantage Health Plan documents the current structure for offering health insurance benefits to state employees. This chapter describes structural alternatives that could potentially be implemented to improve the cost effectiveness of the state's health care benefits package. It also identifies how some of the Department of Employee Relations' policy decisions affect the distribution of costs between the state and its employees. Specifically, this chapter addresses the following questions:

- **In what alternative or additional ways could the state structure its health insurance program to help control costs for state government and/or its employees?**

- **What are the advantages and disadvantages of each option?**

To answer these questions, we reviewed the literature on health insurance and compared available alternatives to the state's current plan design. In addition, we interviewed industry experts, health plan representatives, and state health insurance regulators.

As we described in Chapters 2 and 3, the department has implemented many cost-control features related to managed care and managed competition principles. Table 4.1 summarizes several structural alternatives for cost control and identifies the alternatives that the state has not implemented. Overall:

Table 4.1: Structural Alternatives for Controlling Total Health Insurance Costs

Alternative	Use in the State Employee Health Insurance Program: Implemented	Not Implemented
Self-insure to eliminate some of the carrier charges associated with fully-insured plans	✓	
Offer managed care plans, such as HMOs or PPOs, that include management tools for controlling costs	✓	
Provide employees with a choice among several plans and set the employer contribution based on the lowest cost plan	✓	
Require co-pays, deductibles, and co-insurance	✓	
Require prescription drug co-pays	✓	
Establish higher co-pays for brand name drugs with generic drug substitutes	✓	
Establish different categories for prescription drug co-pays or implement prescription drug co-insurance.		✓
Establish a separate contract for prescription drug benefits		✓
Offer a high deductible health insurance plan and a personal health care savings account		✓

SOURCE: Compiled by the Office of the Legislative Auditor.

- **The Department of Employee Relations has already incorporated many of the structural features that the literature identifies as potentially promoting cost control, such as self-insurance, managed care plans, and employee co-pays, deductibles, and co-insurance.**

The following sections describe three commonly discussed innovations that the department has not implemented: (a) alternative designs for prescription drug co-pays; (b) health plans that "carve-out" specific types of services into separate contracts; and (c) defined contribution plans that focus on increasing employee control over their health care dollars. We also describe how costs are distributed between the state and its employees.

PRESCRIPTION DRUG CO-PAYS

As noted in Chapter 2, prescription drug costs are one of the fastest growing categories of health care spending. In response, the Department of Employee Relations took the positive step of purchasing pharmacy benefits based on the quality and effectiveness of drugs. Specifically, the state requires that health plan carriers establish "formularies" for prescription drugs. As shown in Table 4.2,

Table 4.2: Formulary and Non-Formulary Drugs

A *formulary* drug is included in a list of drugs that are covered by a health plan at the least cost to the employee.

A *non-formulary* drug may be covered at a greater cost to the employee or not at all.

The process for developing a formulary varies by health plan. The formularies for State of Minnesota employees:

- are lists of preferred drugs selected by a professional committee of physicians and pharmacists on the basis of quality and efficacy;
- include both generic and brand name drugs;
- vary by health plan carrier; and
- require that, when a brand name drug is prescribed when a generic substitute is available, the employee pays the co-pay plus the cost difference between the brand name and the generic drug.

SOURCE: Department of Employee Relations, *Summary of Benefits* (St. Paul, 2001).

formularies for state plans are lists of preferred drugs that are selected by a professional committee of physicians and pharmacists on the basis of quality and effectiveness. An employee's cost for prescription drugs is determined by whether the drug is included on the formulary list. The state uses a two-tiered co-pay structure for prescription drugs that requires a $12 co-pay for formulary drugs and a $25 co-pay for non-formulary drugs.[1]

In recent years, many employers have implemented a three-tiered structure based on the availability of generic or non-brand name drugs, as shown in Table 4.3. The percentage of covered employees with this type of three-tiered program increased from 29 percent in 2000 to 36 percent in 2001.[2] While this approach could lower state costs by shifting more costs to state employees and possibly reducing utilization, there are limitations to cost-savings when using a three-tiered structure. Some researchers suggest that this approach has failed to control costs

Table 4.3: Typical Three-Tier Prescription Drug Co-Pay Structure

Level of Co-Pay	Prescription Drug Type
$$$	Brand name drugs—generic substitute available
$$	Brand name drugs—no generic substitute available
$	Generic drugs

SOURCE: Compiled by the Office of the Legislative Auditor.

1 Employees also pay the cost difference whenever a brand name drug is prescribed in lieu of a generic one. Members must pay the full cost of drugs not covered by the state's health plans, too.

2 Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2001 Annual Survey* (Menlo Park, CA and Chicago, IL, 2001), 118.

because drug manufacturers have increased the price of generic drugs in recent years, thereby minimizing the price difference between generic and brand name drugs.[3] Others suggest that the approach has failed to substantially increase consumer use of less expensive drugs because co-pays are low relative to the actual costs of the drugs.[4]

- **Minnesota Advantage does not include several prescription drug cost-sharing options: lower employee costs for drugs that substitute for more expensive medical treatment; higher employee costs for "lifestyle" drugs, such as Viagra; and employee co-insurance for certain types of drugs.**

Some insurance carriers currently offer some of these alternative options. For example, Humana just began offering a four-tiered pharmacy benefit that is based on a drug's acquisition cost, as well as on the savings the insurer expects to realize from not having to provide other medical services at a later date. Three tiers require various levels of co-pays and the fourth requires a co-insurance of 25 percent of the drug's cost.[5]

Some employers have implemented more complex prescription drug co-pay structures than has the State of Minnesota.

One advantage of a more complex structure, like the Humana approach, is that it can make distinctions among different types of drugs based on effectiveness, anticipated reductions in other medical costs, or an assessment of the clinical benefits of treatment.[6] It could also better integrate pharmacy and medical benefits and, in some cases, establish out-of-pocket expenses that more closely reflect the cost difference among drugs.

Employers are trying different prescription drug co-pay structures to control rising costs.

On the other hand, one of the most significant disadvantages suggested in the literature is that

3 Steve Perlstein, "Four-Tier Approach Injects Consumerism Into Drug Benefit," *Managed Care* (August 2001); http://www.managedcaremag.com/archives/0108/0108.fourtier.html; accessed October 23, 2001.

4 Perlstein, "Four-Tier Approach;" David H. Kreling, *Cost Control for Prescription Drug Programs: Pharmacy Benefit Manager PBM Efforts, Effects, and Implications*, Background report prepared for the Department of Health and Human Services' Conference on Pharmaceutical Pricing Practices, Utilization and Cost (Washington, D.C., August 2000), 6-7.

5 Perlstein, "Four-Tier Approach."

6 Perlstein, "Four-Tier Approach;" A. Mark Fendrick et al., "A Benefit-Based Copay for Prescription Drugs: Patient Contribution Based on Total Benefits, Not Drug Acquisition Cost," *The American Journal of Managed Care* 7, no. 9, (2001): 861-867; and Michael Dalzell, "Pharmacy Copayments: A Double-Edged Sword," *Managed Care* (August 1999); http://www.managedcaremag.com/archives/9908/9908.pharmcopay.html; accessed October 23, 2001.

such structures require health plan carriers to make complex decisions when placing drugs into specific tiers. For example, Humana must estimate anticipated cost savings associated with avoided medical treatments when establishing the formularies for its four-tiered prescription drug benefit. Opinions are mixed as to whether available research is adequate to support a co-pay structure that depends on evaluating the range of benefits associated with drug treatments. Also, the potential impact on utilization and cost control is uncertain. At this time, there is little empirical evidence that documents how effective these approaches would be in practice.

While a new co-pay structure could reduce state costs by shifting a higher proportion of costs to employees, it is not clear whether an overall reduction in pharmacy costs could be achieved while promoting appropriate utilization. Research shows that co-pays can reduce the number of prescriptions used and can shift use to lower cost drugs.[7] However, research on whether these impacts are the result of more or less appropriate drug utilization is limited. Some suggest, based on historical out-of-pocket expenditures for drugs, that employees can bear additional costs without adversely affecting utilization.[8] However, others are concerned that if prescription drug co-pays are too high, individuals will not comply with their full course of treatment.[9] The actual impact on utilization depends on many factors, including the specific structure of the formulary for each tier and the associated co-pay amounts.

RECOMMENDATION

Because prescription drug costs continue to be an area of high growth and innovation in the health insurance market, the Department of Employee Relations should evaluate the potential cost-effectiveness of a new prescription drug co-pay structure.

As part of its evaluation, the department should analyze its data warehouse to identify (a) the drug claims that drive the highest costs for the state on an annual basis and (b) the drug claims that drive the highest costs per member. Based on this analysis, the department should work through its ongoing support contract and annual negotiations with health insurance carriers to evaluate the feasibility of implementing a new pharmacy co-pay structure.

SEPARATE CONTRACTS FOR SPECIFIC SERVICES

One alternative many employers have used to address concerns about health care benefits is to establish separate contracting arrangements for specific health care

7 Kreling, *Cost Control for Prescription Drug Programs*, 6-7.

8 Dalzell, "Pharmacy Copayments: A Double-Edged Sword."

9 Katherine Swartz, "The View From Here: Be Creative in Consumer Cost-Sharing for Pharmaceutical Benefits," *Inquiry–The Journal of Health Care Organization, Provision, and Financing* (2001); http://www.inquiryjournal.org; accessed September 17, 2001.

services. These arrangements, often referred to as "carve-outs" or "carve-ins," are described in Table 4.4. They are used because an employer or health plan carrier believes that a specialized contract can better manage the cost and quality of specific services.

Table 4.4: Typical "Carve-Out" and "Carve-In" Provisions

A ***Carve-Out*** is a direct contract between the employer and a specialized carrier for a specific set of health care services. Under this arrangement, employees choose among competing health plans for all of their health care except for the carved-out service. This service is provided through a single contract. Employees are not given a choice of plans for the carved-out service.

A ***Carve-In*** is an alternative form of carve-out where a health plan chooses to subcontract the management and provision of key services to a specialized organization.

SOURCE: Richard G. Frank and Thomas G. McGuire, "The Economic Function of Carve Outs in Managed Care," *The American Journal of Managed Care* 4 (Special Issue 1998): 31-39.

Carve-outs are a common approach for addressing quality issues or controlling costs for specialty services such as prescription drugs, mental health, or substance abuse benefits. Table 4.5 shows that nationally over one-half of covered employees of very large employers received prescription drug benefits through a carve-out in 2001 and over one-third received mental health/substance abuse benefits through a carve-out. In addition, managed care organizations are experimenting with diagnosis-related carve-outs for conditions such as asthma, cancer, chronic obstructive pulmonary disease, congestive heart failure, and diabetes.

Because pharmacy carve-outs are the most common type of specialized contracting and because prescription drugs continue to account for a growing share of medical expenditures, we reviewed the potential benefits of implementing a pharmacy carve-out for state employees. A pharmacy carve-out offers specialized management that may help control costs and improve quality. A contractor that specializes in pharmacy benefits may be better able to develop

Table 4.5: Share of Insured Workers Receiving Benefits Through Carve-Outs, 2001[a]

Type of Carve-Out	All Firms	Very Large Employers[b]
Prescription Drug	32%	52%
Mental Health/ Substance Abuse	22	37

[a]Percentages represent insured workers nationwide and includes carve-outs established through direct employer contracts or health plan subcontracts.

[b]Employers with more than 5,000 employees.

SOURCE: Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2001 Annual Survey* (Menlo Park, CA and Chicago, IL, 2001), 125, 127.

formularies, establish vendor relationships, measure quality and appropriate utilization, monitor costs, and deal with unique legal or regulatory issues. Because it also offers a mechanism for dealing with variations in service intensity, quality, and benefit design across plans, it may prevent plans from competing to attract only the low-cost employees. This could reduce any adverse selection problems driven by pharmacy benefits (although we found no empirical evidence demonstrating this effect).[10]

There are several challenges to successfully implementing contract carve-outs, including:

- increased administrative costs,
- technical difficulties in sharing data across carriers,
- carrier reluctance to release data that are often viewed as proprietary,
- difficulties in coordinating care,
- potential employee dissatisfaction because of a perceived loss of choice related to pharmacy benefits, and
- an increase in the employer's responsibility to dictate the terms of the pharmacy benefits contract.

"Carving out" some health services from health plans is difficult.

A "carve-in" contract also provides specialized management, but it does not have the potential to eliminate variations across plans. As described in Table 4.4, a carve-in is another form of a carve-out where a health plan carrier subcontracts the management and provision of certain services to a special organization. While this type of subcontracting is common, some evidence suggests that managed care organizations are increasingly able to build this type of expertise in-house. One researcher found that, as managed care organizations consolidate and grow, in-house expertise is often more efficient and effective than using a pharmacy benefits manager.[11] Another recent study found that large HMOs most frequently subcontract for services to administer the pharmacy benefit and they are more likely to provide complex services related to utilization management through in-house capabilities.[12]

Overall, we think that:

- **The gains from creating a pharmacy carve-out for state employees are likely to be limited because the state is already benefitting from pharmacy-specific expertise.**

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10 Richard G. Frank and Thomas G. McGuire, "The Economic Functions of Carve Outs in Managed Care," *The American Journal of Managed Care* 4 (Special Issue, 1998): 31-39.

11 John A. Marcille and Paul Wynn, "Reinventing the PBM," *Managed Care* (April 1997); http://www.managedcaremag.com/archives; accessed October 23, 2001.

12 Tim Sawyers, "Test Prospective PBM Before Signing Contract," *Managed Care* (March 2000); http://www.managedcaremag.com/archives; accessed October 23, 2001.

HealthPartners is one of three health plan carriers used by the state.

Each of the state's three health plan carriers administers its own prescription drug program

Currently, each of the state's three health plan carriers administers its own prescription drug program. For example, BlueCross BlueShield of Minnesota subcontracts for pharmacy benefits while HealthPartners provides pharmacy benefits through in-house expertise. Although the co-pay structure is the same across plans, each carrier develops its own formulary list and implements separate cost-control practices.

The Department of Employee Relations considered implementing a pharmacy carve-out a few years ago and indicated that it might evaluate this alternative again in the near future. If the department were to pursue a separate contract for pharmacy services, it could eliminate the current variation in practices across plans or could identify one vendor that is more efficient than others. Because the department has not identified adverse selection as a problem that is specific to pharmacy benefits, we do not believe that there would be significant gains from simply eliminating variation across plans. Therefore, the primary benefit of evaluating this option would be to assess the relative efficiency of the specialized management offered by the existing plans and other potential contractors. If the state identifies a single contractor that is significantly more efficient in providing pharmacy benefits than the existing plans, the potential cost savings would need to outweigh the disadvantages associated with contract carve-outs. Based on our interviews with industry experts, the problems associated with data sharing and coordination of care may be the most difficult obstacles for the state to address.

DEFINED CONTRIBUTION OPTIONS

Defined contribution options vary in how much control employees have over health care dollars.

Health plans with defined contribution options involve an employer committing a specific dollar amount toward employees' health care benefits instead of providing a package of benefits with open-ended costs. These approaches typically shift the risk and responsibility of managing those dollars to employees. As shown in Table 4.6, defined contribution approaches fall along a continuum, depending on how much control employees have over spending. They range from group plans, which give employers the most direct control over how dollars are spent, to individual health benefit accounts, which significantly increase employees' control.

We found that:

- **The Department of Employee Relations has implemented the most common defined contribution options—a fixed-dollar contribution and flexible savings accounts.**

As discussed in Chapter 2, the state's health care purchasing strategy is based on managed competition principles in that the state makes a fixed contribution to employees' health insurance premiums. Since 1989, the state has contributed the entire premium of the low-cost plan for individual coverage and 90 percent of the premium of the low-cost plan for dependent coverage. Under the Minnesota Advantage Health Plan, the state uses premiums combined with out-of-pocket cost sharing to continue the use of a fixed contribution approach. In addition, the state offers employees a pre-tax medical/dental expense account that allows employees to pay out-of-pocket medical and dental expenses with pre-tax dollars.

However, current interest in defined contribution approaches focuses on individual medical accounts for employees. Employers are interested in using these accounts to respond to several factors, including:

- the resurgence of high health care inflation,
- a backlash by employees and physicians against managed care,
- employees' desire for increased choice,
- the potential for increased litigation and employer liability,
- high administrative costs, and
- increased health care utilization.

As shown in Table 4.7, many of the new approaches to defined contribution try to maintain the advantages of group insurance while introducing some of the advantages of individual accounts. For example, one of the plan choices available

Table 4.6: Defined Contribution Options

Option	Status Under the State's Program	Description
Employer-Sponsored Group Benefits with a Defined Contribution		
Fixed-Dollar Contribution from the Employer	Available	An employer that offers a choice of health plans contributes a fixed amount to the cost of health benefits and requires employees to pay for any additional premium costs above this amount. In this option, the employer retains the role of pooling individuals for purchasing health insurance.
Cafeteria Plans or Flexible Benefits (Section 125 of the Internal Revenue Code)[a]	Not available	Cafeteria plans are tax-preferred plans that allow an employee to choose between cash and directing a portion of dollars to "qualified benefits." Allowable benefits include, but are not limited to, health coverage (group medical, dental, or vision), group term life insurance (up to $50,000), accidental death insurance, short or long-tem disability insurance, dependent care expense reimbursement, and medical expense reimbursement. They are used to allow the employee share of health insurance premiums to be paid on a pre-tax basis. Employees must make benefit elections prior to the beginning of each plan year.
Individual Health Benefit Accounts with a Defined Contribution		
Health Care Reimbursement Accounts or Flexible Spending Accounts	Available for child care, health, and dental expenses	These are personal accounts funded with tax-free contributions and used primarily for qualified medical expenses not otherwise covered by insurance. These funds cannot be used for medical insurance premiums, cannot be accumulated for use at a later date (unused funds at the end of the plan year are forfeited), and are not portable. Employer contributions may also be made to these accounts. Employees must elect the amount of salary reduction prior to the beginning of each plan year.
Personal Health Accounts	Not available	These are personal accounts funded with tax-free contributions that can be used to buy health insurance or pay for medical expenses not otherwise covered by insurance. Unused amounts are being rolled over and accumulated from year to year. The accounts only include employer contributions.
Medical Savings Accounts	Not available to large employers	These are personal accounts funded by tax-free contributions. Under current federal laws, the accounts are only available to employees of firms with fewer than 50 employees, the self-employed, or the uninsured. The funds can be used to pay itemized health care bills; can be accumulated for use in future years; and can be withdrawn for other purposes after paying taxes and fees. These accounts can include both employer contributions and employee contributions, but cannot be used to purchase insurance.
Stipend for Health Care Purchases—Higher Wages in Lieu of Health Insurance	Not available	A stipend for health care purchases increases salaries and removes the employer entirely from the role of providing health benefits. This approach is often referred to as the most "pure" form of defined contribution.[b] Under this approach, employees and the employer lose the current tax advantages of health insurance purchasing. This option is not feasible due to loss of tax preferred status for health insurance payments.

[a]The term cafeteria plan and Section 125 plan are sometimes used interchangeably to describe several types of flexible benefit arrangements, including flexible spending accounts. Section 125 of the Internal Revenue Code allows employers to chose from four basic options: 1) tax-exempt employee contributions to insurance premiums, 2) medical reimbursement flexible spending accounts, 3) dependent care reimbursement flexible spending accounts, and 4) a full cafeteria plan that provides a choice between a taxable benefit and a qualified non-taxable benefit.

[b]In some cases, employers provide a voucher instead of increased cash to preserve the tax advantage. This would be similar to providing an employer contribution to a personal health account and allowing individuals to use this amount to purchase insurance or health care in the individual market.

Shading indicates the alternatives that are feasible for the state health insurance program and are not already implemented.

SOURCES: Aggregation of information from Robert A. Conner, "Movement Toward Individual Health Benefit Accounts," *Managed Care* (November, 2000); and PricewaterhouseCoopers, *An Employer's Guide to Consumer-Directed Healthcare Benefits* (October 2001).

Table 4.7: Comparison of Group and Individual Insurance

Advantages	Disadvantages
Group Insurance	
• Pooling of sicker and healthier people so cross subsidies can occur • Economies of scale in administration • Lower health care prices due to clout from group purchasing • Better information on the quality of care due to the role of the employer • Tax benefits	• Decision making based on group averages, which translates to fewer individual choices and less individual influence concerning covered services and providers
Individual Insurance	
• Greater individual choice with respect to providers and covered services • Less intrusion into the physician-patient relationship • Less inefficiency due to over-utilization (if an individual is allowed to keep account surpluses)	• Segmentation of the insurance market, leaving sicker people in traditional plans with higher premiums • Higher administrative costs • Higher health care prices due to less purchasing clout • Poorer information on the quality of care • Potential to neglect preventive care

SOURCE: Robert A. Connor, "Movement Toward Individual Health Benefit Accounts," *Managed Care* (November 2000); http://www.managecaremag.com/archives; accessed October 23, 2001.

to employees at the University of Minnesota is a high-deductible group insurance plan with a personal health account offered through Definity Health. We found that:

- **Large employers, like the State of Minnesota, are more likely to offer plans that include a personal health account combined with group insurance rather than plans that require employees to purchase insurance individually.**

Many employers struggling with the costs of group insurance may find the full range of defined contribution approaches attractive because they offer ways to provide health benefits at a lower cost to the employer. For some employers, these approaches allow them to offer a limited health benefit rather than none at all. However, large employers that already offer group health insurance, like the State of Minnesota, have fewer options for cost savings, since individual insurance is typically more expensive than group insurance. Furthermore, the individual health insurance market is not accessible to some individuals that are perceived to be high risk.

For example, the Employee Benefit Research Institute estimates that premiums would be 32 percent higher for individual insurance rather than group insurance for employees in companies with more than 1,000 workers.[13] Much of the difference in costs can be attributed to the limited risk pool for individual insurance plans, but administrative costs also account for a substantial portion of the cost difference. Administrative costs for individual plans are often as high as 40 percent of premiums, while administrative costs average 15 percent or less in group plans.[14]

Personal Health Accounts With a Group Insurance Plan

The most feasible defined contribution approach for the state health insurance program is to offer a personal health account along with some form of group health insurance.[15] However:

- **While personal health accounts may generally improve employee satisfaction and help control costs, the Department of Employee Relations would probably need to develop a customized plan for state employees.**

To help ensure cost savings and maintain quality health benefits, the state would need to:

- balance the advantages of expanded employee choice with a more limited role for the state;
- limit adverse selection;
- provide employees with a high level of information;
- meet statewide access needs; and
- maximize the benefits available under the current tax code.

Personal health accounts expand employee choice over providers and coverage.

We discuss each of these considerations below.

The most significant advantage of personal health accounts is that they expand employee choice of both providers and types of coverage. In addition, some of the new products eliminate managed care requirements, such as mandatory referrals or pre-authorization that some employees may find objectionable.

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13 Sally Trude and Paul B. Ginsberg, "Are Defined Contributions a New Direction for Employer-Sponsored Coverage?," *Issue Brief,* no. 32, (Washington, D.C.: Center for Studying Health Systems Change, October 2000), 3.

14 Ginny Cady, "Next Stop—Defined Contribution Health Plans," *American Federation of State, County and Municipal Employee,* no. 2, (2001); http://www.afscme.org; accessed October 26, 2001.

15 Expanding the use of cafeteria plans would require the state to either increase the total dollar contribution for benefits or allow employees to decrease the dollars contributed to an existing benefit, such as salaries, in order to increase the dollars for an alternative benefit. Evaluating this option is beyond the scope of the report.

Expanded choice may be particularly attractive to employees who previously had only a single plan offered or a limited choice of providers or who have a strong interest in expanding coverage. For example, the University of Minnesota is using a personal health account and high deductible insurance plan offered by Definity Health as one way to address employee desires to expand access to alternative health care providers.

There are disadvantages associated with expanded choice and increased employee control over health care dollars. For example, the Department of Employee Relations would play a less significant role in (a) negotiating rates; (b) ensuring quality, accountability, and patient safety; and (c) resolving customer service issues and disputes over coverage. Generally, personal health accounts require far more employee involvement and decision making than are required under the Minnesota Advantage Health Plan.

Because defined contribution products are relatively new, there is little empirical evidence regarding how these plans affect cost. Based on our review of theoretical arguments and simulation research, we found that:

- **A defined contribution plan may be less expensive than other plans, but if offered as a choice among multiple plans, it could increase total costs across all plans through adverse selection.**

Defined contribution approaches are sometimes recommended as a mechanism for limiting the employer contribution and shifting future cost increases to employees. However, in practice, defined contribution approaches do not appear to facilitate cost shifting, particularly in a highly unionized setting, such as in Minnesota. Employers have not been able to fully shift cost increases to employees despite a change in plan structure because they must continue to offer benefits and compensation that will attract and retain employees. A recent study found that employers who implemented defined contribution approaches did not increase employee contributions significantly more than those who did not implement such plans.[16] The real potential for defined contribution approaches to control cost is through employee incentives to reduce utilization. Personal health accounts increase employee awareness of health care costs and create an employee incentive to save for future medical needs. Several simulation models predict that this will lower utilization and reduce health care costs.[17]

On the other hand, research also indicates that implementing a defined contribution plan as a choice among multiple plans could increase adverse selection. The results of simulations are mixed and depend on plan design, but they generally indicate that a disproportionate share of healthy people will select a defined contribution approach.[18] The long-term result could be an increase in overall premiums and a reduction in plan choice.

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16 PricewaterhouseCoopers, *An Employer's Guide to Consumer-Directed Healthcare Benefits;* http://www.pwcglobal.com; accessed October 2001.

17 Robert A. Connor, "Movement Toward Individual Health Benefit Accounts," *Managed Care* (November 2000); http://www.managedcaremag.com/archives; accessed October 23, 2001.

18 Ibid.

In addition to designing an approach to control total costs, employers offering personal health accounts need to address a number of equity considerations. Employers must decide whether to provide the same amount of money to employees with different risk levels, as well as how much to provide employees with families and employees in different geographic locations.

Another consideration in evaluating defined contribution approaches is that employees need considerable information to help them understand and effectively use a personal health account. We think that:

- **If the state were to offer personal health accounts, employees would need accurate information on price, quality of providers, and health care outcomes.**

For example, it could be difficult for employees to make purchasing decisions on a fee-for-service basis because they would need to find out in advance what specific procedures will cost. Many of the new defined contribution products provide additional information to help employees manage their health care dollars. As we note in Chapter 5, the state currently provides limited information on the quality of health care. Unless the state purchases an existing product or works with carriers to invest in such products, these difficulties may offset the potential gains in employee satisfaction initially associated with expanded choice.

Another consideration is that the availability of health insurance products offering personal health accounts is limited. We found that:

- **Based on our initial review, few currently-available defined contribution products offer the geographic coverage required by the state health insurance program.**

Any defined contribution plan offered by the State of Minnesota would have to address a requirement for statewide access.

Many defined contribution products are being offered by new companies, and some have limited markets. For example, two defined contribution products from companies in Minneapolis include Vivius and Definity Health. Vivius, which offers a customized provider network, a health spending account, and a high deductible insurance benefit, was first offered in the Twin Cities metropolitan area and Kansas City in 2001. This product could not offer the geographic coverage required by the state. Definity Health offers a personal health account with a high deductible plan and its members include such Fortune 500 companies as Aon Corporation, Charter Communications, Medtronic, Textron, and Raytheon as well as other employers such as the University of Minnesota, the Pacific Business Group on Health, and Ridgeview Medical Center. Definity Health has a network of providers covering portions of the state outside of the Twin Cities metropolitan areas; however, an analysis would need to be undertaken to determine whether this coverage would be sufficient to meet the wide coverage needs of the state. Aetna HealthFund, which is being offered for 2002, is the first defined contribution plan to be offered by a national, full-service health benefits company. In addition, Humana is considering offering a defined contribution plan in the future.

Finally, if the state were to offer personal health accounts, it would need to carefully evaluate the tax implications of the specific plan design:

- **Although many companies have begun to use these accounts, the Internal Revenue Service has not officially authorized the carry over of these pre-tax dollars from year to year, and accumulated account balances are not portable under current tax rules.**

Recent tax code interpretations make a wide range of new products possible. However, these interpretations are based on unofficial Internal Revenue Service statements indicating that if employer contributions to individual accounts are segregated from employee contributions, they can be rolled forward for use in future years. As of December 2001, official Internal Revenue Service guidance is unclear on this issue. Furthermore, accumulated amounts in personal health accounts cannot be taken as cash rather than health benefits. Therefore, the funds are not portable upon termination of employment.[19] Nonetheless, some employers have proceeded with implementing these products.

RECOMMENDATION

Given the high level of interest in defined contribution approaches, the Department of Employee Relations should monitor the experiences of other large employers with defined contribution plans.

The department should pay special attention to the additional information that state employees will need to effectively use such a program as well as to issues related to geographic access, equity, and taxes.

DISTRIBUTION OF COSTS

Like all health insurance programs, the state's program determines the share of costs borne by employees, the level of state funding provided for different employee groups, and the subsidies provided across certain populations (for example, across geographic regions or from individuals to families). In addition, many of the decisions that the Department of Employee Relations has made, in conjunction with the state's public employee unions, may affect other state programs or policy goals. This section outlines the decisions related to (a) the relationship between individual and family premiums, (b) the employer share of family premiums, and (c) required participation in the health insurance program.

Relationship Between Individual and Family Premiums

In 1997 the Department of Employee Relations implemented a standard ratio that limits the premium for family coverage to 2.5 times the premium for individual

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19 PricewaterhouseCoopers, *An Employer's Guide*, 35-40.

coverage. The department did this to prevent health plan carriers from under-bidding for individual contracts in order to gain enrollment of healthy state employees. To avoid having the premium for family coverage subsidize the individual (or vice versa), the ratio should be equal to the ratio of the average cost for individual coverage to the average cost of family coverage.

Family coverage premiums are 2.9 times the premium for individual coverage.

For 2002, the department increased the ratio from 2.5 to 2.9. Thus, the 2002 premiums were established so that the premium for family coverage is 2.9 times the premium for individual coverage. According to Department of Employee Relations' data, the average family contract covered 3.2 persons in 2001. However, the department indicated that the 2.9 represents an upper bound of an appropriate ratio because dependents generally cost less than active adults. Table 4.8 illustrates how different ratios affect individual versus family premiums and the share of costs for the state versus employees.

Table 4.8: Comparison of Different Ratios of Individual to Family Premiums[a]

	2.5 Ratio	Industry Standard 2.7 Ratio	Minnesota State Advantage Plan 2.9 Ratio	3.2 Ratio
Individual Premium	$279	$262	$247	$226
Employee Share	0	0	0	0
Employer Share	279	262	247	226
Family Premium	698	709	718	732
Employee Share	42	45	47	51
Employer Share	656	664	671	681

[a]Based on enrollment and premium estimates for the 2001 plan year and assumes that total revenue generated from premiums is constant.

SOURCES: Office of the Legislative Auditor's analysis of data provided by the Department of Employee Relations, including July Premium Payment Summary, templates from health plan carriers, and responses to interview questions.

Using 2001 enrollment and premium estimates, we estimated that changing from 2.5 to 2.9 for the 2001 plan year would have shifted approximately $1.8 million in costs from the state to its employees. We assume that the cost shift in 2002 would be about the same magnitude. Using a 2.9 ratio instead of the industry standard of 2.7 shifted approximately $864,000 more in costs from the state to its employees.

The department indicated that it considered this a reasonable approach, but did not provide an analysis of how state costs for family coverage are similar to or different than industry averages. The decision to exceed the industry standard of 2.7 somewhat offsets the relatively large employer share of the family premium that the state pays compared with other public and private employers, as we discussed in Chapter 2.

Employer Share of Family Premiums

The state paid an average of 91 percent of the cost for family health insurance in 2001 and is expected to pay an average of 90 percent in 2002.[20] In comparison, as we discussed in Chapter 2, employers with more than 5,000 employees and state and local government employers paid an average of 79 percent for family coverage in 2001.[21]

The state generally pays a higher share of the family premium than other employers do.

Although employees' share of costs increases under Minnesota Advantage, the state's plan may continue to be more attractive than plans offered by private employers. For some employees, the state's insurance plan may be more affordable and provide comparable coverage than a plan offered through a spouse's employer.

Table 4.9 illustrates the choice a family in this situation might face. It is a hypothetical example based on national averages of employee cost-sharing requirements that other employers have established. Although the specific health plans available through employees' spouses will vary from the average, the example illustrates that, for some employees, premiums are likely to be lower in the state's plan while out-of-pocket costs are likely to be comparable. While families consider many other factors in choosing a health plan, it is reasonable to assume that, for some families, the lower premiums will result in members selecting the state's plan.

To the extent that some employees are choosing the state's insurance program over a plan offered by a spouse's employer because of these cost considerations, the total insurance costs for the state as an employer are higher than they would be if the employee costs for family coverage in the state's program were more comparable with other Minnesota employers. No data were available on the number of state employees that could obtain family coverage through their spouse's employer.

Reducing the employer contribution to family premiums would make the state's plan more comparable to other options in the Minnesota market. Table 4.10 illustrates the potential cost impact from reducing the state's share of the family premium. The Department of Employee Relations does not collect data that suggest how many employees might switch to their spouse's plan if their share of the premium for the state's plan increased. However, it is reasonable to assume that some of the plans offered by other employers would compare more favorably and an unknown percentage of state employees would use their spouse's rather

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20 As discussed in Chapter 2, this contribution rate is based on union-negotiated contracts that require the state to pay 90 percent of dependent coverage and 100 percent of the lowest-cost option for individual coverage. The employer share for family premiums is calculated based on 90 percent of dependent coverage plus 100 percent of individual coverage.

21 Recent data on the employer share of premiums in Minnesota are not available. However, a 1997 survey conducted in conjunction with the Robert Woods Johnson Foundation indicates that the employer share of family coverage in Minnesota for all employers averaged 70 percent. National statistics from 1996 to 2001 indicate that for all size employers, the average employer contribution to family coverage has been relatively stable and very comparable to the contribution rates in Minnesota–-approximately 72 percent. Kaiser Family Foundation, *Employer Health Benefits 2001*, 87; and Minnesota Department of Health, *Employer-Based Health Insurance in Minnesota* (St. Paul, February 2000), 42.

Table 4.9: Hypothetical Comparison of Employee Cost-Sharing Requirements for Family Coverage, 2002

Cost-Sharing	State Plan	Spouse's Plan
Employee Share of Monthly Premium	$51	$187[a]
Employee Share of Annual Premium	609	2,243
Annual Deductibles[b]	200–600	406
Office Visit Co-Pays[c]	5–20	5–15
Co-insurance Rates[d]	0–10%	0–40%

[a]Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2001 Annual Survey* (Menlo Park, CA and Chicago, IL, 2001). The employee's share of the premium under the spouse's plan is based on the 2001 average monthly premium for all employers and inflated to 2002 at a rate equal to the percentage increase experienced by the state health insurance program from 2000 to 2001 (17.76 percent).

[b]The annual deductibles for the state plan reflect the range of deductibles across cost levels. The annual deductible for the spouse's plan is based on the 2001 average for all employers, which we did not adjust to account for potential changes from 2001 to 2002.

[c]Office visit co-pays for the state plan reflect the range of co-pays across cost levels. Co-pays for the spouse's plan reflect the range of 2001 co-pays required for at least 90 percent of employees in HMO or PPO plans. We did not adjust the estimate for the spouse's plan to account for potential changes from 2001 to 2002.

[d]The co-insurance rates for the state plan reflect the range of co-insurance required across cost levels. The co-insurance rates for the spouse's plan reflect the range of 2001 co-insurance rates required in PPO plans.

SOURCES: Office of the Legislative Auditor analysis of Department of Employee Relations' and national data.

Table 4.10: Hypothetical Example of the Impact of a Reduction in the State Share of Family Coverage

	State Contribution to Family Coverage					
	90%	87%	85%	83%	81%	79%
Employee Share of Monthly Premium	$51	$66	$76	$86	$96	$107
Employee Share of Annual Premium	609	791	913	1,035	1,157	1,279
Annual Decrease in State Cost Due to Fewer Members[a] (in millions)	N/A	2.54	2.50	2.46	2.42	2.39
Annual Cost Shifted from the State to Employees (in millions)	N/A	5.5	9.1	12.8	16.5	20.1

[a]For illustration purposes, this example reflects the decrease in state costs associated with a 1 percent reduction in the number of family contracts resulting from increasing employees' share of premiums and a corresponding shift of state employees to family coverage offered by a spouse's employer.

SOURCE: Office of the Legislative Auditor's analysis of data from the Department of Employee Relations.

than the state's plan for family coverage. As shown in Table 4.10, we used a 1 percent reduction in family contracts (301 employees) to illustrate potential state savings from employees opting for individual rather than family coverage and covering their families through their spouse's employer. For example, reducing the employer share of family coverage from 90 percent to 85 percent would shift approximately $9 million in costs from the state to employees. Under this scenario, the state would still pay, on average, a higher share of employee premiums than other employers and the potential for adverse selection problems would likely be limited. In addition, if 1 percent of employees chose to cover their dependents through their spouse's plan, total costs for the state's health insurance program would be reduced by approximately $2.5 million.

Required Participation in the State Health Insurance Program

The state does not allow its employees to opt out of its insurance program.

The state reduces variability in health care revenues and expenditures by requiring that all state employees accept health insurance. An employee that wishes to decline coverage has traditionally been assigned to the lowest-cost plan and counted as an individual contract. Under the Minnesota Advantage Health Plan, there is no employee cost for individual coverage; therefore, all employees are enrolled and counted as individual contracts. Requiring employee participation in the state's insurance program is an atypical insurance practice in Minnesota that would need to be revised if the state aligned the employee share of individual premiums more closely with practices used by other employers nationwide.

If the state required an employee contribution for individual coverage—for example, a charge to the employee of $40 a month—individuals would need the option to decline coverage, particularly if they could demonstrate health insurance coverage from another source. This may be an issue in the future if the state continues to align its program with national practices. The average employee contribution for individual coverage in 2001 was 15 percent of the premium in a national survey.[22] If this percentage is applied to the state's premiums for individual contracts in 2001, we estimated that it would shift approximately $22.8 million in costs from the state to employees.

22 Kaiser Family Foundation, *Employer Health Benefits 2001,* 87.

5 Administrative Options

SUMMARY

The Department of Employee Relations uses a variety of administrative tools that research suggests may be effective in helping control health care costs. These mechanisms are designed to (a) help ensure that the state employee insurance fund is solvent, (b) keep health plan administrative costs low, and (c) hold health plan carriers accountable for tracking costs and quality and reporting that information to the state. For example, the department's primary administrative tool for controlling health plan costs is financial incentives built into carrier contracts, an approach just recently implemented for all three carriers. The department's ability to contain health care costs through administrative actions alone is limited; employees' efforts to manage their health care needs through disease management and wellness activities can also help control rising costs. To help employees make informed decisions about their health care, the department should collect and disseminate quality-related information regarding health plan carriers.

As discussed previously, the Department of Employee Relations has introduced several structural changes to help contain insurance costs. Regardless of any structural approach, administrative strategies are also important for ensuring cost-effective plan performance. Under the Minnesota Advantage Health Plan, the department administers a self-insured plan but contracts with health plan carriers for day-to-day administrative services and provider networks. This chapter focuses on the following research questions:

- **What administrative mechanisms has the Department of Employee Relations implemented to help control rising insurance costs?**

- **What additional administrative options do state and federal regulatory agencies, health plan accrediting organizations, and the research literature recommend to help address rising insurance costs?**

- **To what extent do state employees have access to adequate information for making cost-effective decisions about their health care options?**

To answer these questions, we examined state laws, health plan contracts, and standards suggested by the health care industry and the federal government. We also talked with staff from several agencies, including the departments of Employee Relations, Commerce, Health, and Human Services, and met with representatives from the state's major health plans and employee unions.

We did not evaluate the quality of carriers' services or the quality of providers' medical care or practice patterns. Rather, we focused on the Department of Employee Relations' administrative strategies to contain health care costs in several areas, including fund solvency, administrative costs, contract administration, and monitoring and managing costs, services, and utilization.[1]

ENSURING INSURANCE FUND SOLVENCY

As part of its administrative responsibilities for overseeing state employee health insurance benefits, state statutes require that the Department of Employee Relations manage an employee insurance trust fund and ensure that the fund retains adequate reserves to pay for health care claims.[2] The department uses several strategies to control its risk for losses and maintain the solvency of the fund.

Controlling Financial Risk

As we described in Chapter 2, self-insuring means that the state assumes the financial risk of health care costs for employees. "Stop-loss insurance" and "reinsurance coverage" are strategies that provide additional protection to cover high-cost cases that an employer cannot absorb and spread across its members. We found that:

- **The State of Minnesota purchases stop-loss insurance and reinsurance coverage to protect against high-cost claims and to reduce its financial risk.**

The state shifts some financial risk to health plan carriers by purchasing this coverage from each carrier, thereby providing a financial incentive for the health plans to manage their own health care costs. Generally, the stop-loss coverage limits the state's liability by providing carrier insurance coverage for claims that exceed a negotiated amount. The reinsurance coverage applies to individual cases where expenses exceed a certain amount for such things as major organ transplants.

Nationally, about 91 percent of all employers with self-funded plans reported carrying stop-loss insurance in 2000.[3] Of employers with self-funded PPO plans, about 59 percent of government employers reported carrying stop-loss insurance, while only one-third of large employers (more than 20,000 employees) did so.[4]

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1 Due to time constraints, we did not conduct a full management audit of the department's performance. For example, we did not evaluate the department's contract negotiation methodology or the quality of its oversight of carriers' daily operations and complaint resolution processes.

2 *Minn. Stat*. (2000), §43A.30, subd. 4-6.

3 William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2000: Report on Survey Findings* (New York, 2001), 23.

4 William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2000: Tables of Survey Responses* (New York, 2001), 18.

Actual cost-savings achieved through stop-loss insurance are difficult to quantify, particularly when estimating the impact of the cost-control incentive on carrier and provider behavior. Although premium costs for stop-loss insurance are typically low (less than $2.00 per employee per month depending on coverage), these costs must be weighed in light of the actual claims covered by the insurance. The effectiveness of the stop-loss insurance is also contingent on the department's ability to negotiate coverage levels that will help contain costs. According to our analysis of Department of Employee Relations' data, aggregate claims exceeded the negotiated level by slightly more than $2 million in 2000 and stop-loss insurance covered these costs. The state's stop-loss and reinsurance premiums for this same period were approximately $0.6 million, for a total reduction in medical costs of about $1.4 million.

Maintaining Reserves

Self-insured plans can be financed either by paying claims out of operating funds or through a fund specifically established to pay for medical claims. The state's approach is to pay claims out of an insurance trust fund, which requires maintaining adequate funds to pay for submitted claims, incurred but unreported claims, and unexpected medical claims.

Although the state eliminated paying risk charges to carriers by becoming self-funded, some of the state's recent costs for health insurance are attributed to building the statutorily-required reserves. The fund is built up from employee premiums, insurance refunds, and investment income and losses, among other sources.

The department sets reserve standards for the state employee insurance fund.

Minnesota statutes do not set forth specific reserve standards for the state employee insurance fund, however, the department uses a standard developed internally. Generally, the department's goal in January 2002 was to maintain a reserve of 11 percent of annual incurred claims to cover incurred but not reported claim liabilities, and an additional 15 percent of annual incurred claims to maintain a contingency reserve to cover the risk of unanticipated events that could cause claims to exceed revenues. This standard is somewhat different than the state's reserve standards for health plan carriers, which require them to maintain reserves equal to a percentage of one to four months of annual claims and administrative expenses, depending on the plan type.[5] State law does not specifically require that the department report to the Department of Commerce regarding the plan's fund solvency as it does for other insurance carriers.[6] At the request of the federal government, however, department staff prepare an annual report to advise the federal government about the fund's solvency and insurance premiums for federal employees covered by the state plan.

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5 For example, *Minn. Stat*. (2000), §62D.042 requires that HMOs maintain a reserve between 8.33 and 25 percent of total expenses incurred during the most recent calendar year, but not less than $1.0 million. *Minn. Stat.* (2000) §62C.09 specifies an alternative standard for non-HMO carriers that requires a reserve between 16.67 and 33.33 percent of the sum of claims and administrative expenses during the most recent calendar year.

6 According to Minnesota Department of Commerce staff, state statutes do not clearly address reporting requirements for the Department of Employee Relations. Because the Department of Employee Relations must report to the Legislature regarding funding needs, the Department of Commerce does not review the solvency of the state employee insurance fund.

For our study, we were unable to accurately assess the solvency of the insurance fund. First, the department was unable to provide us with timely, reliable data regarding the fund balance and target reserve needs. Second, the department periodically adjusts the target reserve needs in response to various factors, such as anticipated medical cost increases and the level of risk-sharing that carriers are willing to accept each contract year.

For example, the department indicated that its original target goal for the 2001 fund reserves was to maintain $58.4 million in its contingency reserve to cover reported medical claims and an additional $39.8 million to cover projected incurred but unreported claims, for a total reserves need of $98.2 million.[7] According to the department's December 2001 memorandum, the insurance fund held approximately $84 million in total reserves as of September 2001. However, in late January 2002, department staff advised us that the fund reserve figures they had given us earlier did not accurately reflect all of the dollars that could be attributed toward the reserves. In addition, they indicated that the department had lowered its target reserve needs in April 2001.[8] According to revised data supplied by the department, the fund held $97.8 million in reserves as of December 2001, which is 102.3 percent of the department's overall goal.

A variety of factors affect the solvency of the fund. For example, fund reserves included about $6.5 million from investment income for 2001.[9] The Legislature also appropriated about $2.4 million in fiscal year 2000 to help maintain adequate reserves during the department's transition to self-funding. (The Legislature appropriated a similar amount for fiscal year 2001.) Other factors affecting fund reserves include increased medical utilization and costs. Any remaining revenues resulting from gains following final settlements of medical claims and expenses also affect the fund. For example, our analysis of the Department of Employee Relations' data for 2000 shows that the state health insurance program experienced about $0.6 million in losses (excluding the $2.4 million general fund appropriation) following final settlement of premium revenues, medical claims, carrier settlements, and administrative expenses. In addition, as we described earlier, the department invested significant resources in designing and implementing structural changes under the Minnesota Advantage Health Plan. Designing and implementing any future structural changes in the state health plan will likely have similar costs and should be weighed against any potential long-term gains.

Close monitoring of the insurance fund could help the state assess the impact of Minnesota Advantage.

Lack of historical information regarding the impact of employee cost-sharing and provider incentives on the state's future health care costs under the Minnesota Advantage Health Plan make it difficult to determine whether the current fund balance will be adequate to merit a reduction in employee premiums or agency fees. Close monitoring of the fund's balance should help evaluate the effectiveness of the new plan's incentives to control costs and the subsequent adequacy of reserves.

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7 David Haugen, Assistant Commissioner, Department of Employee Relations memorandum to Jo Vos, Project Director, Office of the Legislative Auditor, December 12, 2001.

8 Mr. Budd Johnson, interview by author, Telephone conversation, St. Paul, Minnesota, January 31, 2001; and Budd Johnson (budd.johnson@state.mn.us) "Phone Conversation," electronic mail to Valerie Bombach (February 1, 2002).

9 Haugen, memorandum, December 12, 2001.

KEEPING ADMINISTRATIVE COSTS LOW

As a measure of cost-effective service, experts suggest that health plan administrative expenses not exceed 10 to 15 percent of premium costs, a ratio often referred to as the "administrative loss ratio."[10] For the state, these administrative costs include the Department of Employee Relations' internal administrative expenses, the department's fees for consultant services, and fees state agencies pay the department to administer the state health plan. The department's administrative expenses also include fees paid to carriers to administer the individual health plans.

Using data supplied by the Department of Employee Relations, we found that:

- **In 2000, the department's total health plan administrative costs were a relatively low share of total health plan premiums.**

For contract year 2000, the state's total health plan administrative costs were approximately $30.5 million, or about 9 percent of the total $345 million for employee premiums. Of this amount, the department's administrative expenses, including expenses for overseeing carriers' plan performance and managing the state employee health benefits program, were about $3.4 million, or 1 percent of 2000 medical premium revenues. To fund these administrative expenses, state agencies, the Legislature, and the judicial branch paid the Department of Employee Relations about $3.70 per member per month to administer the state health plan, or more than $3.6 million for 2000.[11] Health plan carriers' administrative expenses, including premiums for stop-loss insurance and reinsurance, were much greater than department costs, about $27.1 million dollars, or 7.9 percent of the state's total medical premiums.[12]

Administrative expenses for the state's health plans were consistent with industry standards.

Contracting for Services

Consistent with practices in other states, the Department of Employee Relations has worked with a private consulting firm to help evaluate and design benefits. In a recent RAND study, about 65 percent of large employers operating a self-insured health plan reported that they hire external consultants to help make decisions about benefit designs.[13] In addition, while employers using consultants

10 Julia Phillips, actuary, Minnesota Department of Commerce, In-person interview by author, St. Paul, Minnesota, September 25, 2001.

11 Estimates include fees paid by the University of Minnesota and excludes fees for dental, disability, life insurance, other fully-insured plans, as well as fees for administering benefits under the Consolidated Omnibus Budget Reconciliation Act, four-week leave of absence coverage, and miscellaneous programs.

12 Because premiums for stop-loss insurance and reinsurance pay for carrier administrative costs as well as claims costs, the amount of administrative expenses may be overstated by including stop-loss coverage. However, these premiums represent a small share of our estimate of total administrative expenses.

13 M. Susan Marquis and Stephen H. Long, "Who Helps Employers Design Their Health Insurance Benefits?," *Health Affairs* (January/February 2000): 136.

were somewhat more likely to offer a choice of plans, there was no systematic relationship between the use of external consultants and employers' plan costs, whether measured by current premiums or premium increases.

Since 1985, the department has retained the same consultant, Deloitte and Touche, to provide actuarial analysis and consultation regarding health plan costs, premium setting, program evaluation, and strategic planning. For example, the consultant provides ad hoc analysis on such issues as trends in medical care costs and provider services. The consultant also manages the department's data warehouse that is comprised of claims information submitted by the carriers.

As part of contract oversight, state policies require that agencies clearly specify the role of external consultants, including proposed activities, in their consultant contracts.[14] However, we found that:

- **The department has not consistently specified consultant tasks and responsibilities in its contracts.**

Although the department's contracts specify proposed projects and needs, they do not clearly identify work deadlines, itemized lists of work products, or parameters for project-specific tasks. Although we recognize that the nature of the consultant's work requires the department to have some flexibility in planning and assigning tasks to its consultant, we found that the department maintained little documentation of the consultant's final work products. In addition, a large share of the department's administrative costs in recent years was due to consultant costs. For example, for calendar year 2000, we estimated that $891,000 (about 26 percent) of the department's $3.4 million in administrative costs were attributed to consultant costs. Consultant costs for July 2000 to November 2001 were more than $1.8 million for services such as risk adjustment, data warehouse management, developing the Minnesota Advantage Health Plan, joint-labor management meetings, carrier contract negotiations, and general consulting.[15]

About one-fourth of the department's administrative costs were consultant fees.

Throughout our study, we also observed that:

- **The department relies too much on its consultant to provide certain basic information about its health plan program—information that should be maintained in agency files and readily available to policy makers.**

For example, department staff advised us that qualitative analyses of the costs of employees' use of medical services that were used to help develop the Minnesota Advantage Health Plan were maintained by the consultant, not the agency. Similarly, department staff had to refer to the consultant to obtain documentation

14 Minnesota Department of Administration, *Professional and Technical Services Contracts Manual* (St. Paul, September 2001), sec. 9, 6.

15 David K. Haugen (david.haugen@state.mn.us), "RE: Advantage," electronic mail to Jo Vos (December 24, 2001).

of estimates for the new state health plan's total costs, risk-adjusted costs for provider groups, and total consultant costs.[16]

The department's lack of internal documentation extended to other health plan programs. When asked to provide data on past years' total employee participation and average contribution into the state's medical pre-tax program, the department had to obtain the information from the program contractor. Typically, state agencies monitor program participation rates as part of general housekeeping responsibilities.

Increased documentation could improve oversight of consultant services and Minnesota Advantage.

RECOMMENDATION

The Department of Employee Relations should develop a more comprehensive description of consultant duties and required work products in its contracts. The department should document and retain evidence supporting key decisions pertinent to its health insurance program in agency files.

Implementing these strategies could help the department manage consultant costs, improve contract oversight, and build the department's internal capacity to manage the insurance program.

CONTRACT ADMINISTRATION

As part of its responsibilities for administering the state health plan, the department negotiates contracts with health plan carriers and defines carrier performance requirements—activities that are important for containing costs.

Negotiating Contracts

According to a 1997 U.S. General Accounting Office study, aggressive contract negotiations are critical to enhancing purchasing leverage and containing costs.[17] A 2001 survey of employers also found that 73 percent of employers cited contract negotiations as critical to containing health care costs.[18] Although the department advised us that it negotiates with carriers prior to renewing contracts, we found that:

16 In a 1999 financial audit of the Minnesota Department of Corrections, our office noted similar concerns about this consultant's retention of agency documents supporting qualitative decision making. See: Office of the Legislative Auditor, *Selected-Scope Financial Audit Report: Department of Corrections* (St. Paul, June 1999), 17-18.

17 U.S. General Accounting Office, *Health Insurance: Management Strategies Used by Large Employers to Control Costs* (Washington, D.C., 1997), 39-41.

18 Watson Wyatt, *Maximizing the Return on Health Benefits: 2001 Report on Best Practices in Health Care Vendor Management* (Washington, D.C., 2001), 9.

- **The department's negotiating leverage is somewhat weakened by the limited number of carriers capable of meeting the geographic, network, and capacity standards required for the state employee population.**

Consolidation of the health care industry has weakened the state's negotiating leverage.

Under Minnesota statutes, the department has discretionary authority to select and enter into contracts with those carriers that the department deems are best qualified to meet the needs of the state employee population.[19] According to the department, there are a limited number of carriers capable of meeting its minimum requirements, such as provider service capabilities and geographic-access standards.[20] As we discussed in Chapter 2, increased consolidation of the health care industry has affected competition and purchasers' negotiating leverage nationwide. Although the department has attempted to increase competition under the Minnesota Advantage Health Plan by creating costs levels, the department's ability to affect the health insurance market environment is limited.

Improving Carrier Performance

According to the U.S. General Accounting Office, financial incentives built into contracts can lead to lower administrative expenses and more cost-effective medical services.[21] Generally, financial incentives are intended to encourage carriers and providers to offer cost-effective care by establishing performance targets. For example, carriers may be expected to meet a target goal of containing overall annual chemical dependency service costs to an 8 to 12 percent increase over the previous year. For incentives to be effective, however, financial penalties and rewards should be significant compared with overall earnings. As with all contract elements, the terms and conditions of financial compensation are subject to negotiation and require that carriers agree to tie their services to performance pay and penalties.

Other states use financial incentives to improve health plan performance. For example, the California Public Employee and Retirement System puts up to 2 percent of health plan premium revenue at risk for meeting plan-specific performance targets.[22] The incentives include financial penalties for not meeting these targets, and California health plan carriers report that the financial penalties definitely affect their efforts to meet performance standards.

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19 *Minn. Stat*. (2000), §43A.23, subd. 1.

20 *Minn. Stat*. (2000), §§43A.23. subd 1; 62D.124.

21 U.S. General Accounting Office, *Medicare Contracting Reform: Opportunities and Challenges in Contracting for Claims Administration Services* (Washington, D.C., 2001), 6; and U.S. General Accounting Office, *Medicare: HCFA Should Exercise Greater Oversight of Claims Administration Contractors* (Washington, D.C., 1999), 6-7

22 Jack A. Meyer, et al., *Report on Report Cards: Initiatives of Health Coalition and State Government Employers to Report on Health Plan Performance and Use of Financial Incentives* (Washington, D.C.: Economic and Social Research Institute, 1998), 40.

We found that:

- **To help control costs and ensure quality performance, the Department of Employee Relations uses financial incentives to improve health plan and provider performance.**

The department incorporates financial incentives based on performance into carrier contracts, with varying results. By shifting some financial risk to carriers, the department encourages the health plans to effectively manage care and control costs. Generally, the provisions require that carriers place 10 percent of their overall administrative fee at risk for meeting predefined performance standards, with compensation subject to financial penalties or incentive pay. We found that:

- **In 2000, health plan carriers easily met certain performance targets; other performance goals were not met and the department reduced carrier compensation as a result.**

Financial incentives and penalties built into carrier contracts can help control health care costs.

In 2000, the contract incentives covered a range of health plan activities.[23] For example, some incentives emphasized cost control, such as specifying target ranges for aggregate chemical dependency services costs. Others focused on providing preventive care and improving health care outcomes, such as level of cholesterol screening or nicotine cessation counseling—medical services that some studies have found to likely yield long-term savings.[24] Other incentives required the carriers to ensure efficient or effective operations, such as a having a high percentage of claims processed timely or high customer satisfaction levels. To facilitate performance comparison across plans, the department used similar measures for all plans. The department weighted the incentives according to its assessment of each carrier's need to improve certain services.

- **Although the department began using financial incentives for all three carriers in 2000, it has not yet established a schedule to periodically adjust performance measures.**

Two carriers only recently agreed to accept financial incentives as part of their service contracts. On the other hand, the department has been incorporating financial incentives into one carrier's contract for several years, but it has not significantly changed the performance measures during that time. By focusing only on select activities, the health plans could benefit financially by achieving performance goals in certain areas to the potential detriment of performance in other activities.[25] In addition, financial incentives tied to health care services, such as cancer screening rates, were just recently incorporated into all carriers' contracts.

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23 At the department's request, we have not reported specific information about carriers' financial incentives in accordance with data practices requirements. The department classifies carrier contracts as non-public pursuant to *Minn. Stat*. (2000), §13.37.

24 Ashley B. Coffield, et al., "Priorities Among Recommended Clinical Preventive Services," *American Journal of Preventive Medicine* 21, no. 1, (July 2001): 6.

25 U.S. General Accounting Office, *Opportunities and Challenges in Contracting*, 10.

RECOMMENDATION

The Department of Employee Relations should consider periodically adding or changing performance measures for financial incentives to encourage improvement over a broad range of services.

Although continuity of performance measures is essential to assessing carrier performance over time, in instances where carriers have consistently met or exceeded them, the department should consider either increasing the performance standards or changing the focus of financial incentives to address service areas needing improvement. For example, the department could specifically target performance incentives to services receiving high levels of customer complaints—information that the department currently collects. For the state's public health plans, the Minnesota Department of Health consistently uses and rotates HEDIS performance measures to evaluate the carriers' performance.

Compensating Providers

Health plan carriers may also attempt to contain costs through a variety of mechanisms that are characteristic of managed care, as shown previously in Table 2.1. Approaches to compensating providers include reducing provider payments, capitation rates, or strict payment schedules for medical services. According to Minnesota statutes:

- **The department is not directly involved in contract negotiations with health care providers; instead, plan carriers negotiate fees with provider groups and pharmacies.**

Pharmaceutical rebates from drug manufacturers helped reduce state health care costs in 2000.

The departments' ability to control costs while maintaining plan choice and geographic access is partially contingent on providers accepting the carriers' proposed reimbursement levels and managed care controls, which we describe later in this chapter.[26] However, as part of carrier contracts, the department (a) requires minimum provider performance levels regarding health care and (b) establishes targets for containing aggregate carrier cost increases for certain services. For example, the department sets carrier performance targets for the overall plan costs of chiropractic services based on per member per month claims. In addition, the department requires that carriers share any settlements or rebates that they negotiate with pharmaceutical suppliers. Department of Employee Relations' data show that pharmaceutical rebates reduced the department's health plan administrative costs by $2.2 million in 2000.

26 *Minn. Stat*. (2000), §43A.23, subd.1 allows the Department of Employee Relations to contract with health plan carriers, and does not specifically grant the department authority to contract directly with providers.

MONITORING HEALTH CARE COSTS AND SERVICES

Consistent monitoring of health plan activities and outcomes is a critical part of state oversight of health plans. Several administrative mechanisms, such as auditing claims and reporting on health plan activities, help the department assess health plan performance, guide resources, and control costs.

Auditing Claims

Systematic review of health care claims can help identify billing inaccuracies.

The U.S. General Accounting Office suggests that systematic audits of plan internal controls, such as procedures for processing claims, can help identify overpayments and underpayments due to error or fraud. Although we did not examine the extent to which payment and billing errors occur in the state plan, a 2001 national survey found that 13 percent of patients receiving medical care reported experiencing billing and payment problems with their private insurance.[27] Also, the U.S. General Accounting Office has estimated that health care fraud accounts for about 10 percent of all claim dollars paid; other estimates range from 3 to 25 percent.[28] In 1998, employers and carriers nationwide saved $11.41 for every dollar spent on anti-fraud efforts, such as auditing claims and conducting awareness programs for policyholders.[29] While we did not review or find any evidence of carrier or provider fraud in our study, we found that:

- **In 2000, the department did not ensure consistent auditing of health carrier performance and billing practices.**

The department required two of its three health plan carriers to conduct an independent audit of books, records, documents, and accounting procedures and practices for contract year 2000.[30] The department did not require the third carrier to have a similar audit, nor was one completed.[31] According to the department, an audit was not required in order to allow the carrier sufficient time to modify its practices in accordance with the state insurance plan. In addition, the department

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27 Kaiser Family Foundation and Harvard School of Public Health, *National Survey on Consumer Experiences With and Attitudes Toward Health Plans: Key Findings* (Menlo Park, CA, August 2001), 1.

28 Thomas D. Musco and Kathleen H. Fyffe, *Health Insurer's Anti-Fraud Programs* (Washington, D.C.: Health Insurance Association of America, 1999), 2.

29 Ibid., 2, 16.

30 The audits were based on the standards recommended by the American Institute of Certified Public Accountants' *Statement on Auditing Standards (SAS) 70: Reports on the Processing of Transactions by Service Organizations*. Our office made similar findings in previous audits of the department and recommended that the department use the SAS 70 format as a guide for improving internal controls and carrier oversight. Office of the Legislative Auditor, *Financial Audit Report: Department of Employee Relations* (St. Paul, April 1996), 7; and Office of the Legislative Auditor, *Financial Audit Report: Department of Employee Relations* (St. Paul, February 1997), 12.

31 Budd Johnson (budd.johnson@state.mn.us), "FW: state fund questions (AUDIT REVIEW)," electronic mail to Valerie Bombach (November 13, 2001). In lieu of a similar SAS 70 audit, one carrier was required to perform an internal review and report on its performance regarding 2000 performance standards. According to the department, the carrier completed the summary report.

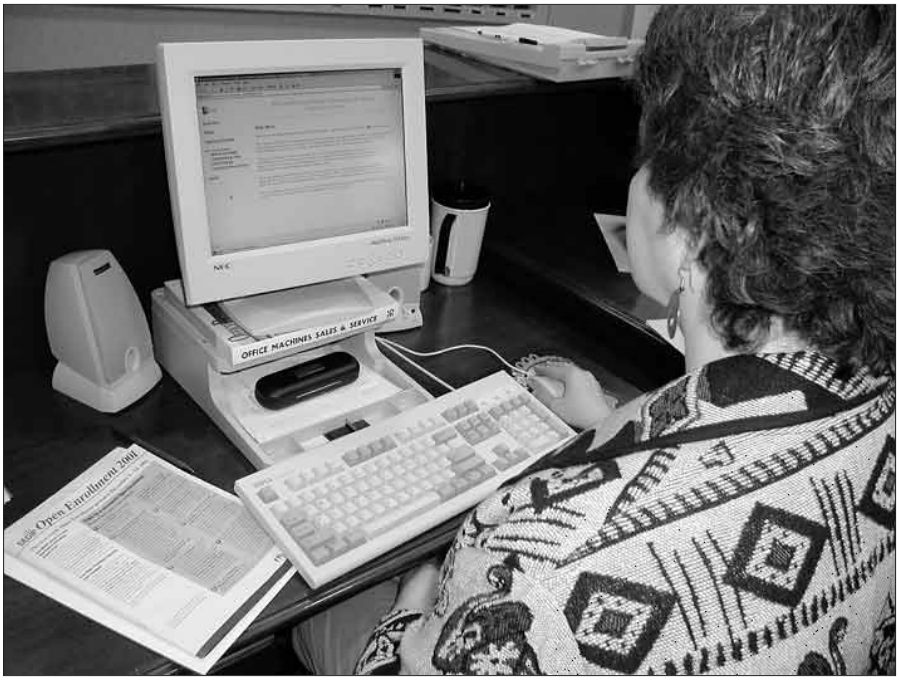
relies on the carriers to conduct self-audits for reporting outcomes for the performance incentives and penalties.

RECOMMENDATION

The Department of Employee Relations should ensure consistent auditing of health plan performance, including financial incentives, to help identify potential problems and increase cost savings.

Billing statements can educate members about the actual costs of health care.

Also, unlike some other states, the department does not have a member-initiated claims audit program, whereby health plan members review their bills for accuracy and receive cash awards for finding errors. According to a 1999 national survey, 11 states included employee member self-audits as part of their cost-management programs for their indemnity/PPO plans.[32] Although used primarily for helping to identify fraud in health care, 55 percent of health carriers nationwide reported relying on consumer awareness of services as key to identifying billing inaccuracies.[33] The department may want to explore the effectiveness of member-initiated claims audits for some or all medical services. For member-initiated claims audits to be implemented, members must receive a detailed "explanation of benefits" statement after receiving medical services. Although such activities may not lead to significant cost savings for the state, they could serve to educate employees about the costs of their health care. Information on health care costs are particularly important for helping employees make health



Employees need information about costs to make decisions about their health insurance.

32 Segal Company, *1999 Survey of State Employee Health Benefit Plans* (Washington, D.C., 2000), 17. The survey question pertained to practices for indemnity/PPO plans only and did not include HMO plans.

33 Musco, *Health Insurer's Anti-Fraud Programs*, 16-17.

care decisions under the cost-sharing requirements of the Minnesota Advantage Health Plan.

Assessment and Reporting on Performance

Nationwide, 53 percent of large employers reported that they conduct a formal quality assessment of performance prior to contracting with carriers and their provider networks. About 88 percent of these employers stated that the "quality of medical care" is a "very important" criterion in their assessment process.[34] However, fewer employers actually cited specific plan components that may be considered indicators of quality. For example, of government employers that conducted a formal quality assessment of their plans, 75 percent reviewed utilization data, 65 percent reviewed provider credentials, and 39 percent reviewed the frequency of certain prevention and screening procedures.[35] Also, 44 percent reviewed the plan's ability to manage chronic diseases as part of their formal assessment.

We found that:

- **The department collects comprehensive information on costs and carrier operations, but limited information on the quality of health care services.**

As part of plan oversight and selecting health carriers, the department does not conduct a formal quality assessment of services, such as reviewing provider credentials, utilization data, medical procedure frequency, prevention and screening procedure frequency, health care outcomes data, or provider ability to manage chronic diseases.[36]

Although the state does not require it, its health plans are nationally accredited.

Other mechanisms help the state ensure that health plan services are reviewed. For example, although accreditation is not a state requirement, all of the state's health plans are nationally accredited; this independent scrutiny can help the department monitor health care costs and quality. Generally, the accreditation process requires the plans to meet minimum standards in a range of services and activities, such as claims processing performance and medical screening rates. In 2000, two plans had some level of National Commission for Quality Assurance (NCQA) accreditation and the other was accredited by the American Accreditation HealthCare Commission. According to a 2001 national survey, about 55 percent of very large employers reported that NCQA accreditation was "somewhat" or "very important."[37] Nationally, about 71 percent of government employers and 59 percent of employers with 20,000 or more employees required their HMOs to have some level of national accreditation.[38]

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34 Mercer, *Mercer/Foster Higgins National Survey,* 17.

35 Mercer, *Mercer/Foster Higgens National Survey: Tables of Survey Responses,* 11.

36 Department of Employee Relations' response to the *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2001* (St. Paul, unpublished document), 17. Final survey results are due for publication in March 2002.

37 Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2001 Annual Survey* (Menlo Park, CA and Chicago, IL, 2001), 71.

38 Mercer, *Mercer/Foster Higgins National Survey: Tables of Survey Responses*, 36.

To help monitor carrier performance, the department requires that plan carriers report on such things as general costs, medical trends, high-cost cases, patient use of medical services, and general cost-savings from managed care activities. Carriers are subject to monetary penalties for failing to comply with reporting requirements. According to department staff, the carriers meet the contract reporting requirements and have never been penalized for failing to comply.

RECOMMENDATION

The Department of Employee Relations should require that carriers report more qualitative information, such as health care outcomes, as well as their initiatives to improve health care quality.

Additional information on health care services could improve state plan oversight.

Part of the plans' accreditation processes requires carriers to produce information on health care outcomes, such as disease screening rates. Providing this previously-prepared information to the department should involve minimal costs and would help the department assess service quality for the state plan. In addition, the department could consider collecting additional information, such as costs pertaining to high-cost/high occurrence diagnosis-related-group services, to assess employee health care needs and target resources.

MANAGING COST-EFFECTIVE HEALTH CARE

As described in Chapter 2, the state's health plan carriers use managed care strategies, such as requiring primary care physicians or "gatekeepers." Other strategies, such as reducing medical errors, can help control costs.

Managed Care

Generally, cost-containment features of managed care are intended to control patient use of expensive medical services by imposing requirements or restrictions on coverage. In theory, managed care should also involve facilitating appropriate patient care, not simply denying access to more expensive services. This includes targeting care toward actual cost-drivers, such as patients with chronic diseases, and not limiting care management to preventive services.[39]

We found that:

- **The department requires carriers to use certain managed care strategies, such as gatekeepers and referrals, but relies on carriers' and providers' expertise to determine the appropriateness and necessity of care.**

39 U.S. General Accounting Office, *Management Strategies*, 51.

The department pays carriers for general managed care services and does not micro-manage medical care, such as requiring specific utilization review under certain scenarios. This hands-off approach also helps preserve the confidentiality of members' medical care and avoid potential conflicts of interest. Generally, the department requires that carriers use their best efforts to effectively manage all health care. For example, the carriers should promote integrated health care delivery management, the efficient use of inpatient care (particularly for large cases), the efficient use of outpatient care and drugs, and preventive care.

At the same time, the department requires the use of gatekeepers and referrals for specialists. According to a 1997 national study, 46 percent of patients with private insurance were required to use gatekeepers.[40] One study reported a slight increase nationally between 1996 and 1999 in the number of health insurance contracts that require gatekeeping functions.[41] However, unlike fully-insured plans, the state plan does not require mandatory standing referrals, which would provide that patients with certain medical needs cannot be required to repeatedly obtain referrals to specialists.[42]

The state requires some basic managed care strategies, such as using primary care physicians, in its health plans.

As discussed in Chapter 2, the effects of managed care activities on employers' costs can be difficult to measure. The savings achieved by managed care vary according to the stringency of controls. While implementing managed care activities generally requires additional costs and resources, "gatekeepers," referral restrictions, preauthorizations, and reducing inpatient hospital care have been shown to contain overall health care costs.[43]

The department also offers a mail order drug benefits program, an established cost-savings strategy whereby employees may order long-term supplies of maintenance drugs purchased at reduced costs to the employee and the plan.[44] Nationally, about 90 percent of large employers (more than 5,000 employees) had mail order pharmacy programs in 2000.[45]

Reducing Medical Errors

Errors in medical care also contribute to health care costs. Although experts disagree on the number and cost of medical errors, a recent controversial study

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40 Center for Studying Health System Change, "Results from the Community Tracking Study," *Data Bulletin*, no. 7, (Washington, D.C., Fall 1997), 2.

41 Jeffrey J. Stoddard, James D. Reschovsky, and J. Lee Hargraves, "Managed Care in the Doctor's Office: Has the Revolution Stalled?," *American Journal of Managed Care* 7, no. 11, (1997): 1063.

42 Due to concerns about increased state costs, *Minn. Stat*. (2001), §62Q.58, subd. 1a, 5(c) exempts the state's health plans from issuing mandatory standing referrals.

43 For example, see: U.S. General Accounting Office, *Managed Health Care: Employers' Costs Difficult to Measure* (Washington, D.C., 1993), 12, 13, 34; and U.S. General Accounting Office, *Pharmacy Benefit Managers: FEHBP Plans Satisfied with Savings and Services, But Retail Pharmacies Have Concerns* (Washington, D.C., 1997), 11, 13. We did not evaluate the level and appropriateness of carriers' and providers' managed care activities. Rather, we focused on the department's oversight of carriers' managed care activities.

44 A study by the U.S. General Accounting Office found that mail-order drug benefits programs typically save money. See: U.S. General Accounting Office, *Pharmacy Benefit Managers*, 10-14.

45 U.S. Chamber of Commerce Statistics and Research Center, *The 2000 Employee Benefits Study* (Washington, D.C., 2000), 34.

by the Institute of Medicine estimated that annual national costs of preventable adverse medical events (including lost income and disability costs) ranged from $17 billion to $29 billion in 1996, of which health care costs represented over one-half.[46] The total national costs associated with adverse and preventable adverse events represented about 4 and 2 percent respectively of national health care expenditures in 1996. While cost estimates may vary, most studies agree that medical errors are controllable and that improving patient safety and preventing adverse events are important cost-saving initiatives.[47]

Reducing errors and improving cost-savings can be achieved by a set of procedures that identify, evaluate, and minimize hazards.[48] While providers can help reduce medical errors through such activities as ongoing training and following established practice protocols, carriers, employers, and employees can also play a role in reducing patient errors.

As health care purchasers, employers can use purchasing leverage in the marketplace by emphasizing quality—specifically, patient safety—in its contracts.[49] Contracts can include financial incentives for carriers to demonstrate continuous improvement in reducing medical error. Employees can help reduce adverse medical care reactions by advising physicians about all medications they are taking and asking for information in terms they understand before accepting medication or treatment.

We found that:

- **In 2000, the department implemented a limited patient safety initiative as part of its carrier contract financial incentives.**

The department required one carrier to mail patient safety information to members that advised them on how to become more involved with patient safety and reducing adverse events. The other two carriers were not required to provide similar information to their members.

Obtaining information about patient safety and medical errors is difficult.

Currently, the department does not require carriers to collect and report information pertaining to patient safety and health care errors. According to the department, providers' contracts with carriers prohibit the release of this information. Although there are several national and state initiatives to collect standardized information on patient safety issues and medical errors, without a mandatory reporting system on standardized, defined, adverse events, it is difficult to develop baseline information and measure health plan improvement. The 2001 Legislature directed the Department of Health to study factors influencing patient safety and health care quality in Minnesota, including such

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46 Linda T. Kohn, ed., *To Err Is Human: Building a Safer Health System* (Washington, D.C.: Institute of Medicine, 1999), 27. The study defined "preventable adverse event" as injury caused by the medical management of a disease or the condition of the patient.

47 Kohn, *To Err Is Human*, 57; and John D. Birkmeyer, ed., *Leapfrog Patient Safety Standards: Economic Implications* (Washington, D.C., June 2001), 2-3; www.leapfrog.com; accessed October 15, 2001.

48 Kohn, *To Err Is Human*, 58.

49 *Ibid.,* 133, 139-140.

things as staffing levels in health care facilities.[50] The goal is to encourage the exchange of information regarding medical errors in a protected manner so that Minnesota health care providers can learn from each other's experiences and prevent future mistakes. A report is due to the Legislature in early 2002.

MANAGING EMPLOYEE NEED FOR HEALTH CARE

Some alternatives to managing the supply of health care involve managing employees' need for health care through activities such as preventive care, disease management, health promotion, education, and self-care training. Many recent studies suggest that focusing on managing health care demand will likely yield both short-term and long-term savings, particularly in light of the nation's aging population.[51] Table 5.1 describes some typical strategies for managing employees' need for health care.

Table 5.1: Typical Managed Care Activities to Control Employee Need for Care

Disease Management involves training patients to actively monitor their condition to prevent acute complications, as well as educate these patients on modifying behaviors that can exacerbate their disease.

Disease Prevention includes primary prevention activities, such as immunizations, to avoid severe illnesses. Secondary prevention activities involve early detection of disease, such as blood test screening for diabetes, to help reduce the impact of the disease.

Self Management involves making health advice resources available to patients to allow them to make decisions about their own health care. Examples include education brochures, as well as 24-hour clinic phone lines staffed by nurses to provide an assessment about the nature and severity of the patient's condition—advice that can reduce costly emergency room visits.

Wellness Programs focus on preventing illness by promoting healthy lifestyles, such as physical exercise, good nutrition, and smoking cessation.

SOURCE: Compiled by the Office of the Legislative Auditor.

Health education and wellness programs are particularly important in light of the increased average age of state employees.

Although studies disagree on the extent to which prevention and early detection of diseases reduce long-term costs, some studies suggest that targeted prevention efforts for certain diseases, such as hypertension and cholesterol screening, can yield significant savings.[52] In addition, disease management and self-care for certain diseases, such as asthma, can reduce the incidence of costly emergency room visits.[53] Generally, most managed care cost savings are achieved by reducing costly inpatient hospital

50 *Minn. Laws* (2001) ch. 9, art. 1, sec. 59.

51 Segal Company, *Executive Letter 1998* 22, nos. 1, 2, (Washington, D.C., 1998).

52 Coffield, "Priorities Among Recommended Clinical Preventive Services," 6.

53 U.S. General Accounting Office, *Pharmacy Benefit Managers,* 13.

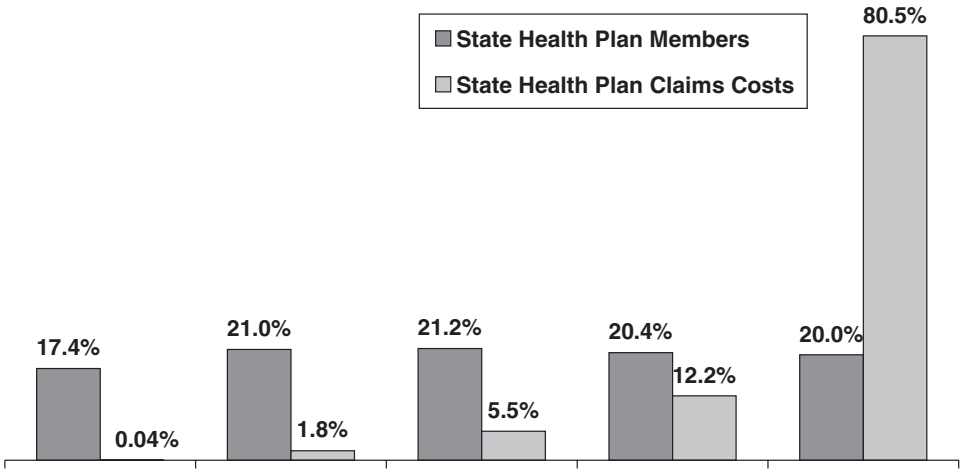
admissions, length of hospital stays, and emergency room visits.[54] One study noted that, based on the reduction of hospitalization costs for asthma-related admissions, the one-year cost-benefit ratio was 1:1.59.[55] Other costs for chronic illnesses include sick pay and lower worker productivity. For example, a national study reported that smokers are absent from work between 2 and 5.5 days more per year than non-smokers.[56]

Disease management helps reduce costly emergency room visits.

Disease management programs produce cost-savings by targeting the population responsible for most health care expenditure.[57] The programs are typically tailored to a type of disease or condition and are designed to help individuals take better care of themselves through diet, exercise, and self-monitoring. For example, one approach may include establishing a call center, staffed by health care professionals, to advise members about programs and follow up on members' compliance with doctors' orders. Using data supplied by the Department of Employee Relations and as shown in Figure 5.1, we found that:

- **About 20 percent of the state employee population accounted for about 80 percent of the state plan's 2000 medical claims costs.**

Figure 5.1: Percentage of State Health Plan Claims Costs by Plan Members, 2000



SOURCE: Office of the Legislative Auditor's analysis of the Department of Employee Relations' 2000 medical claims data.

54 For example, see: U.S. General Accounting Office, *Managed Health Care: Effect on Employers' Costs Difficult to Measure*, 21; and RAND Health Research Highlights, *How Does Managed Care Affect the Cost of Mental Health Services?*; www.rand.org/publications/RB/RB4515/; accessed November 30, 2001.

55 Segal Company, *Executive Letter*, 7.

56 James Bost, et al., *The State of Managed Care Quality: Industry Trends and Analysis 2001* (Washington, D.C.: National Committee for Quality Assurance, 2001), 21.

57 Segal Company, *Executive Letter*, 6-7.

By contrast, about 17 percent of the member population accounted for less that .05 percent of 2000 medical claims costs, for an average of $4.50 per individual.[58] In 2000, medical claims totaled about $328 million. Because recent data suggest that people in general may be living less healthy lifestyles, focusing on managing member need for health care is becoming increasingly important. The Health Care Financing Administration predicts a 10 percent increase over the next 10 years in the number of people with chronic illnesses.

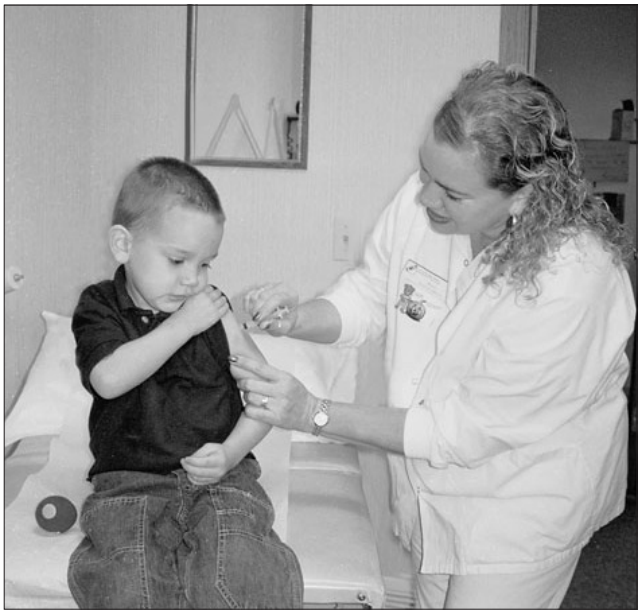
Nationwide, people are living less healthy lifestyles, which contributes to increased health care utilization.

According to the National Center for Chronic Disease Prevention and Health Promotion, the percentage of Minnesota adults who are considered obese has been steadily climbing, increasing from 10 percent in 1990 to 17 percent in 2000.[59] Meanwhile, the percentage of overweight adults climbed from 34 percent in 1990 to an all time high of 43 percent in 1998, and then dropped to 38 in 2000. Overweight and obese individuals are at increased risk for high blood pressure, high cholesterol, diabetes, and heart disease. On the other hand, cigarette smoking, the leading cause of preventable illness and death in the United States, is responsible for most lung cancer, emphysema, and chronic bronchitis cases in the nation.[60]

We found that:

- **State employees have access to many health education and self-care services, which may lead to short-term and long-term cost savings.**

As part of the state health plan, the department requires carriers to develop, maintain, and refine programs concerning disease management, health promotion, and health education. This includes providing preventive care, such as routine physical exams and routine cancer screening, and materials pertaining to health education and self-care. In addition, the department directly promotes health and wellness, such as smoking cessation or weight management programs, through health fairs and events conducted around



Preventive care, such as immunizations, helps control health care needs and costs.

58 Excludes medical claims for University of Minnesota employees.

59 National Center for Chronic Disease Prevention and Health Promotion, *Behavioral Risk Factor Surveillance System: Trend Data—Minnesota*; http://apps.nccd.cdc.gov/brfss/Trends/trendchart.asp?qkey=10010&state=MN; accessed November 6, 2001.

60 Bost, *The State of Managed Care Quality*, 27.

the state, its website, and promotional mailings.[61] The department also administers the state's Health Promotion Grant Program, which provides funding and materials to state agencies for health promotion and disease prevention programs. The department trains and supports agencies' health promotion coordinators, who choose how and what activities they want to deliver to their employees. These activities can vary across agencies and may include programs and materials, such as stress management or healthy aging education. From 1996 to 2000, the department funded up to $40,000 each year for state agencies' health promotion initiatives, with grants ranging from $25 to $3,100.

Although specific services may vary across carriers, the department requires them to provide health management services, such as self-care books, nurse advice hotlines to help members assess the urgency and need for physician care, and health risk appraisals. Carriers must also provide chronic disease management programs for cancer, diabetes, heart disease, and hypertension. According to a 1999 national study, 23 states provided health education materials or classes and 24 states provided health care screening for their employees as part of their indemnity/PPO plans.[62] Nationally, more than one-half of government employers with HMO health plans provided disease management programs for asthma, cardiovascular disease, diabetes, and cancer.[63] Less than half of the employers provided disease management for depression.

Employee participation in health promotion activities could help control state health care costs.

Similar to most other government employers nationally, the department provides an employee assistance program that includes brief therapy for mental health or substance abuse problems, as well as voluntary screening and referral services. Nationally, about 79 percent of government employers and 84 percent of employers with more than 20,000 employees offered an employee assistance program in 2000.[64] Thirty-three states provided employee assistance programs for mental health and substance abuse for state employees in 1999.[65]

Studies have found varying levels of short- and long-term savings from health education and wellness efforts.[66] These savings, however, are partially contingent on employee participation in the programs and employee willingness to adopt a healthy lifestyle. To help assess the value of providing these services, we encourage the department and agencies to consistently measure overall participation rates.

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61 Coverage for lifestyle modification care is limited to prescription medications for tobacco/smoking cessation. The state does not provide cost coverage for such things as nutrition classes, weight loss management, physical activity, or alcohol prevention. Information on the costs and benefits of providing coverage for these items is limited. While extending coverage to include lifestyle modification benefits would increase immediate costs, any cost savings as a result of behavior modification would be difficult to measure.

62 Segal Company, *1999 Survey*, 17. The survey question pertained to indemnity/PPO plans only and not HMO plans.

63 Mercer, *Mercer/Foster Higgins National Survey: Tables of Survey Responses*, 35.

64 *Ibid*., 46.

65 Segal Company, *1999 Survey of State Health Benefits Plans*, 17. The survey question pertained to indemnity and PPO plans only and not HMO plans.

66 Segal Company, *Executive Letter*, 6.

Annual health fairs help educate members about state health care services.

INFORMING EMPLOYEES ABOUT HEALTH CARE OPTIONS

In order for employees to make informed choices about their health care, they need comprehensive information about the available insurance plan options. Information on health care services, such as cost, quality, and customer satisfaction, help employees manage their insurance needs.

Assessing the state health plan on an ongoing basis helps identify which services are working well and those service areas needing improvement or modification to better meet enrollee needs. According to a recent study, only 35 percent of Fortune 500 companies regularly compile comprehensive quality information about employee health care options.

We found that:

- **Although the department uses evaluation tools, such as complaint tracking and customer surveys, to gather feedback on services, it collects and disseminates limited in-depth information about the quality of health care outcomes.**

The department requires carriers to track and report member inquiries and complaints to varying degrees. In addition, state statutes require that the department track the number, type, and disposition of complaints and report the

results each biennium to the Legislative Coordinating Commission Subcommittee on Employee Relations.[67]

The department periodically surveys state employees to gather feedback on some health care services.

To obtain employee feedback on health plan and medical services, the department conducts a customer satisfaction survey every two years. The survey is conducted jointly with the Buyer's Health Care Action Group to ensure that results are representative of provider groups' performance, as well as to minimize survey costs. The survey instrument uses questions from the Consumer Assessment of Health Plans, an industry-accepted model instrument that asks employees to rate various services, such as clinic waiting time and how well doctors communicate. The department shares the results with carriers and discusses strategies for improving performance as results indicate. Nationally, only 23 percent of government employers and 33 percent of employers with more than 20,000 employers reported that they conducted their own customer satisfaction surveys of employees.[68]

According to the federal Advisory Commission on Consumer Protection and Quality in the Health Care Industry, consumers need adequate, accurate information to determine whether health plans and provider groups meet their individual needs.[69] Consumers need both plan and provider group-specific comparative data on the cost and quality of the available options to help them make informed decisions. The commission also suggests that consumers must take steps to become more knowledgeable about health plan coverage and options, such as costs, benefits, and referral rules, in order to support a quality, cost-conscious environment.

Among other benefits, disclosing quality-based information can encourage competition in the health care market on the basis of quality as well as price and can contribute to price stability.[70] This information also helps hold plans accountable to quality expectations in the face of pressures to reduce costs.

Defining quality information that is meaningful to patients can be difficult and providing the information in an easily interpreted format can also be challenging. Studies disagree on what measures and data are true indicators of quality; many agree that measuring quality should involve evaluating health care outcomes. In addition, because clinics can contract with more than one carrier, the value of clinic-level quality information may be diminished by the extent of clinic overlap across plans.

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67 *Minn. Stat*. (2001), §43A.31, subd. 2.

68 Mercer, *Mercer/Foster Higgins National Survey: Tables of Survey Responses*, 36.

69 President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Consumer Bill of Rights and Responsibilities* (Washington, D.C., 1997). The Commission recommended that consumers have access to a broad range of accurate, easily understood information on the characteristics, policies, procedures, experience, and performance of physicians, facilities, and plans to help them make informed health care decisions.

70 Lewin Group, Inc., *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals* (Falls Church, VA, 1997), 3-5; and Meyer, *Report on Report Cards, 9.*

One study found that the key factors that consumers say influence their selection of a health plan are: (a) keeping the same doctor, (b) costs, (c) extent of services covered, (d) quality of care provided, including customer satisfaction and evaluation of services, convenience, and number of complaints, and (e) how easy it is to resolve administrative problems.[71] Some people also choose providers based on subjective information, such as peer recommendations. In addition, consumers that are satisfied with their current provider are unlikely to investigate alternatives.

Comprehensive information about health care quality would help members make decisions under Minnesota Advantage.

The benefits of providing comprehensive plan information are not without costs. According to a national consulting firm, collecting and providing insured consumers with the cost and quality information suggested by the Commission was estimated to cost from $0.80 to $2.17 per insured person per month in 1997, phased in over a one-year period.[72]

Because the Minnesota Advantage Health Plan requires employees to select health care clinics and provider groups, complete information about health care options is particularly important. For the cost-sharing incentives to perform as intended, employees must be able to make informed choices about health care options. We found that:

- **The department provides employees with information about costs, coverage, and customer satisfaction, but limited information on health plan quality.**

For example, the results of the biennual customer satisfaction survey are included in open enrollment materials. Employees can also access forms, enrollment information, plan selection instructions, and plan comparisons from the department's website. The website also includes links to the carriers' websites and medical information websites. Although the department does not require the carriers to do so, HealthPartners posts performance results on its website. Plan websites also provide access to some on-line physician specific information, such as education and accreditation. However, to access information about consumer complaints about physician performance, employees must independently contact the Minnesota Board of Medical Practice.

RECOMMENDATION

The Department of Employee Relations should make available more comprehensive information pertaining to the quality of health care plans and providers and combine those data with currently-available data on cost and consumer satisfaction.

For example, the department could consider giving employees additional quality information, such as the number and type of complaints for each plan or provider group, or some results of plans' performance regarding selected financial incentives, such as health care outcomes. In reporting information to employees,

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71 Meyer, *Report on Report Cards*, 25-27.

72 Lewin Group, *Consumer Bill of Rights and Responsibilities,* 28.

some employers use NCQA-recommended measures, such as screening rates for cholesterol and breast cancer. Some employers report member satisfaction levels, such as satisfaction with doctors or perceptions of quality of care—usually based on surveys. Some states report on administrative and customer service indicators, such as waiting time for appointments and number of complaints.[73] For example, Wisconsin's Department of Employee Trust Funds provides state employees with data on employee complaints by type of complaint and health plan.[74] Because the Department of Employee Relations and carriers currently compile this information for other purposes, costs for modifying the information into a user-friendly format should be minimal.

Some states, such as California, provide its state employees with a more comprehensive "report card" that combines various aspects of health care coverage, such as costs and health care quality, in one package so that employees can compare the information simultaneously. Generally, report cards present information that assess the performance of plans or providers, including consumer satisfaction, meeting standards for process or medical outcomes, or the provision of certain services. They may also provide information about accreditation status, overall quality scores, and costs. Report cards also provide indirect incentives to plans to improve their quality scores. For the information to be useful, however, the data must be accurate and reliable. Some states, such as Missouri, independently audit the information before reporting it to ensure that it accurately represents the actual quality of services.[75]

At the same time, employees must become familiar with how to use performance-related information. One study found that the greatest challenges involve educating consumers to ensure that they understand the measures and their significance and then motivating them to use the information.[76] Unless employees are able to understand and interpret the information, the market-competition process breaks down and high-performing plans may not be rewarded with high enrollment.

Since 1995, the Minnesota Health Data Institute and the Minnesota Department of Health have been working on a quality measurement program to gather and disseminate comparative information on the quality of health care delivery, outcomes, costs, and services in Minnesota.[77] Although outcomes thus far have been limited in scope, their research could help the Department of Employee Relations evaluate state health plan services. In addition, coordination among the agencies in assembling and disseminating this information could help reduce the department's costs in providing employees with quality information about health services.

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73 Meyer, *Report on Report Cards*, 13.

74 Wisconsin Department of Employee Trust Funds, *It's Your Choice, 2002* (Madison, WI, October 2001), E—18-E—20.

75 Meyer, *Report on Report Cards,* 90.

76 *Ibid.,* 127.

77 *Minn. Stat*. (2001), §62J.301. As the Department of Employee Relations pointed out in its response to our report, the department is, by statute, a member of the Minnesota Health Data Institute's Board of Directors.

Summary of Recommendations

- The Department of Employee Relations should monitor and evaluate the Minnesota Advantage Health Plan over the next two years, paying special attention to employee and provider incentives to control costs (p. 51).

- Because prescription drug costs continue to be an area of high growth and innovation in the health insurance market, the Department of Employee Relations should evaluate the potential cost-effectiveness of a new prescription drug co-pay structure (p. 57).

- Given the high level of interest in defined contribution approaches, the Department of Employee Relations should monitor the experiences of other large employers with defined contribution plans (p. 67).

- The Department of Employee Relations should develop a more comprehensive description of consultant duties and required work products in its contracts. The department should document and retain evidence supporting key decisions pertinent to its health insurance program in agency files (p. 79).

- The Department of Employee Relations should consider periodically adding or changing performance measures for financial incentives to encourage improvement over a broad range of services (p. 82).

- The Department of Employee Relations should ensure consistent auditing of health plan performance, including financial incentives, to help identify potential problems and increase cost savings (p. 84).

- The Department of Employee Relations should require that carriers report more qualitative information, such as health care outcomes, as well as their initiatives to improve health care quality (p. 86).

- The Department of Employee Relations should make available more comprehensive information pertaining to the quality of health care plans and providers and combine those data with currently-available data on cost and consumer satisfaction (p. 95).

Further Reading

Bost, James. *The State of Managed Care Quality: Industry Trends and Analysis 2001.* Washington, D.C.: National Committee for Quality Assurance, 2001.

Johns Hopkins University. *The Johns Hopkins ACG Case-Mix System.* Website http://www.acg.jhsph.edu/what/what.html.

Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits 2001 Annual Survey.* Menlo Park, CA and Chicago, IL, 2001.

Kohn, Linda T., Janet M. Corrigan, and Molla S. Donaldson, eds. *To Err is Human: Building a Safer Health System.* Washington, D.C.: Institute of Medicine, 1999.

Kreling, David H. *Cost Control for Prescription Drug Programs: Pharmacy Benefit Manager PBM Efforts, Effects, and Implications.* Background Report prepared for the Department of Health and Human Services' Conference on Pharmaceutical Pricing Practices, Utilization and Cost. Washington, D.C., August 2000.

Mechanic, David. *Mental Health and Social Policy: The Emergence of Managed Care.* Needham Heights, MA: Allyn and Bacon, 1999.

Mercer, William M. *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2000.* New York, 2001.

Meyer, Jack A., Elliot Wicks, Lise S. Rybowski, and Michael J. Perry. *Report on Report Cards: Initiatives of Health Coalitions and State Government Employers to Report on Health Plan Performance and Use of Financial Incentives.* Washington, D.C.: Economic and Social Research Institute, 1998.

Milbank Memorial Fund. *Value Purchasers in Health Care: Seven Case Studies.* September 2001. Website http://www.milbank.org/2001ValuePurchasers/011001valuepurchasers.html.

Minnesota Department of Employee Relations. *Report of the Postretirement and Active Employee Health Care Task Force.* St. Paul, MN: December, 2000.

Minnesota Department of Health. *Drivers of Health Care Spending Growth in Minnesota.* St. Paul, MN: February 2001.

_____. *Employer-Based Health Insurance: Types and Choice of Plans.* St. Paul, MN: April 2000.

_____. *Mandated Health Insurance Benefits and Health Care Costs.* St. Paul, MN: July 2001.

_____. *The Minnesota HMO Profile.* St. Paul, MN: May 2001.

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. *Consumer Bill of Rights and Responsibilities*. Washington, D.C.: 1997.

PricewaterhouseCoopers. *An Employer's Guide to Consumer-Directed Healthcare Benefits.* Website http://www.pwc.golba.com.

U.S. General Accounting Office. *Health Insurance Management Strategies Used by Large Employers to Control Costs.* Washington, D.C.: May 1997.

_____. *Medicare Contracting Reform: Opportunities and Challenges in Contracting for Claims Administration.* Washington, D.C.: June 2001.

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Memorandum

To: Roger Brooks, Deputy Legislative Auditor
From: David K. Haugen, Assistant Commissioner
Date: February 8, 2002

Re.: DOER response to OLA report, "State Employee Health Insurance"

Thank you for the opportunity to review and comment on the OLA report, "State Employee Health Insurance." As the state's human resource agency, the Department of Employee Relations (DOER) is responsible for designing, implementing, and administering employee compensation, including fringe benefits. State employee health coverage is provided through the State Employees Group Insurance Program (SEGIP). It is a significant part of state employee compensation, and for some employees is likely to be equal in importance or even more important than wages. "State Employee Health Insurance" is a notable and highly visible topic not only for state employees, but for state government and state taxpayers as well.

As the OLA report notes, rising health care costs are challenging all employers. The report provides useful information on this complex issue, on approaches to address health care costs, the State Employee Group Insurance Program (SEGIP), and the new state employee health benefits program, Advantage. While we agree in large part with the majority of the report, there are a number of points that we feel would benefit from further clarification, elaboration, or changes in emphasis. Our comments and suggestions follow below and focus in three main areas:

- Discussion of the new Advantage health benefits program for state employees;
- Additional strategies for health care cost containment; and
- DOER level of assistance to the study and relation to its consultant.

Advantage program

The report describes a number of reasons that health care costs continue to grow at rapid rates and what the state has done to address health care cost escalation. It focuses in particular on the State's new "Advantage" health benefits program for employees. The report's "Major Findings" summary section states that Advantage

> *"incorporates needed changes in the design of health benefits for state employees that should help reduce anticipated health care cost increases in health care costs, but the extent of the cost savings from the new plan is uncertain."*

The report also describes in some detail a number of factors that the OLA believes could limit Advantage's potential in controlling costs.

We agree that there is inherent uncertainty in any cost savings estimate, that bringing rising health care costs under control will continue to be a challenge, and that the Advantage program in and of itself is not a panacea. However, in focusing on the uncertainty and perceived limits of Advantage's estimated cost savings, the OLA report fails to note or appropriately emphasize several key points, including:

- Continuing the status quo employee health insurance program was no longer an option, and a change was essential to address concerns about the imminent loss of higher priced health options under the status quo. Their loss would have meant fewer health care providers and choices available to state employees, resulting in both short term and long term higher costs for less product.

  Advantage was designed and bargained with the unions representing state workers to preserve current levels of access to providers while addressing costs for employees and the state. While there is inherent uncertainty in any cost savings estimates, the prospects for cost savings under Advantage were much more certain than under continuation of the status quo or any other solution conceivable during the most recent round of collective bargaining. (While it is not included in the report summary of major findings, as we also discuss below, the report indicates that the state is already using most of the health care cost containment strategies that other employers have used or are considering. Advantage is a new innovation designed specifically to meet the state's needs.)

- Most importantly, the potential of Advantage has already been shown in practice. A number of care delivery systems have already responded to Advantage's three-tiered cost level design by reducing their reimbursement rates in order to be placed in a lower cost group than they were originally assigned. These savings are in no way uncertain, but have been demonstrated, and amount to millions of dollars.

One of the OLA's "key recommendations" is that DOER should monitor and evaluate Advantage over the next two years, paying special attention to employee and provider incentives to control costs. We agree, and we fully plan to monitor Advantage and to continue to make any improvements or changes which might be indicated to maximize the performance of the program.

<u>Additional Health Care Cost Containment Strategies</u>

The report describes a number of additional potential health care cost containment strategies in use or being considered by other employers. It also inventories which of these strategies DOER has instituted or is considering. While it is clear that DOER has implemented the majority of them, and has valid reasons to be further reviewing and assessing those which it has not adopted, this point is not included with the key findings at the beginning of the report. In addition, some of the strategies discussed in the report do not receive a balanced, critical evaluation. While they may be of interest conceptually, it is important to consider them carefully and cautiously before adopting or implementing them.

For example, the report describes potential cost savings from allowing employees to "opt out" of SEGIP coverage, or from raising the cost of family coverage to employees such that it would encourage dependents to leave SEGIP and enroll in a spouse's plan. While a reduction in the number of persons covered through SEGIP would seem to be a relatively simple way to reduce costs, the issue is more complicated, due to "adverse selection" issues.

In situations where persons can choose to take health coverage or "opt out", there is always a concern that the healthier persons may leave the insurance pool. Loss of the healthier members concentrates the risks and losses of those remaining behind, and results in higher premiums for those who remain in the pool. This "adverse selection" against the pool could create what the insurance industry has termed a "death spiral" of ever increasing costs and a steadily shrinking base over which to spread them. Our discussions with other public sector jurisdictions and employers indicate that this is often a significant issue where opt out provisions have been implemented. The Wyoming state employee health insurance program recently made the headlines in that state with news reports describing their plan as being in a "death spiral", due in large part to adverse selection caused by healthier employees and families opting out of coverage.

The state is committed to exploring and using appropriate tools and strategies that add value to state employee compensation and for taxpayers. As the state's pioneering implementation of the managed competition strategy and the Advantage program have demonstrated, it has been and will continue to be an innovator in many areas of health benefits administration. However, as with the opt out strategies above, many health care cost containment approaches that seem conceptually correct or are appropriate for other employers may not have the same potential for savings for SEGIP.

One cost containment strategy with particular promise for long term cost savings and improved health outcomes and productivity is greater emphasis on health promotion, prevention, and wellness. The OLA report notes the state's existing commitment in these areas and their potential to reduce costs. In January 2002, DOER further intensified and focused its efforts in these areas by establishing a new risk management/total absence management unit within a newly configured Labor Relations-Total Compensation division. The purpose of the new risk management unit is to better understand the burden of illness and disability of state employees, and to develop targeted interventions to help prevent and limit otherwise costly illnesses and injuries. The unit brings together previously separate units from Workers' Compensation Safety and Industrial Hygiene, Workers' Compensation Disability Management, State Employee Health Promotion Program, and the Employee Assistance Program to work as a single, integrated group to most effectively address costs related to health care and workers compensation claims, as well as due to absences from work and lost productivity.

In addition, the OLA reported on the need to continue to assess and promote quality while addressing costs. DOER has been an active innovator in this area as well, helping develop and refine one of the largest, most sophisticated surveys of employee experiences with the health care system in the country. The OLA report noted the role of the Minnesota Health Data Institute (MHDI) and the Department of Health in developing a quality measurement program. It did not mention however, that under statute (Minnesota Statutes 62J.451), DOER is a member

of the MHDI board of directors, has participated fully in all MHDI activities, and contracts with MHDI as project manager for its biennial employee survey. DOER also participates in a variety of community health care quality efforts, including membership with the "Leapfrog" group convened by the national Business Roundtable to address patient safety issues. Most recently, DOER was appointed as one of three executive-branch, cabinet-level state agencies to the recently formed Governor's Task Force on Health Care Quality and Costs.

DOER Level Of Assistance To The Study And Relation To Its Consultants

The OLA reports that in some instances DOER had problems providing accurate, reliable data concerning the state employee insurance program. It also reported that the state relies too much on its consultants to provide basic information about its health plan program – information that should be maintained in agency files and readily available to policy makers. In addition, based on its findings that DOER has not consistently specified consultants tasks and responsibilities in its contracts, the OLA's second key recommendation in the report is that DOER should develop a more comprehensive description of consultant duties.

As noted in the report, the period during which the OLA conducted its study and wrote its report was one of the most unique and challenging in DOER's history, and possibly that of any state agency. During this period, DOER was directly involved in: preparations and follow-up for the narrowly averted government shut-down in June, 2001; development and bargaining of the Advantage health benefits program; the largest strike of state employees in state history, and one of the largest in the nation; settlement of the strike; implementation of the Advantage plan, including the shortest, latest annual open enrollment, for one of the biggest benefits changes, ever; planning and implementing budget reductions and reorganization to address a state revenue shortfall. Despite these challenges, DOER worked actively to assist the study as effectively as possible, making staff, consultants, and information resources available.

As described in the report, DOER, like most other employers, relies on outside consultants to aid in administering the program. The consultants were charged with the significant development effort in Advantage of risk adjusting health care claims data and using the data in modeling scenarios to examine the cost implications of benefit design and program changes.

These claims data are private, confidential, nonpublic data protected by both state and federal statute. Congress addressed the need for national patient record privacy standards in 1996 with the passage of the Health Insurance Portability and Accountability Act (HIPAA) and subsequent rules which were released in 2001. However the timeline and scope of the final implementation of the rules remains clouded as a result of recent presidential action delaying certain aspects of HIPAA implementation.

DOER's consultants have established stringent confidentiality protections to safeguard the data used in developing and testing the Advantage concept. It has been important during development of Advantage and the recently completed bargaining with the unions that DOER's consultants maintained ready access to claims data for modeling and program refinements. During this period there has also been considerable uncertainty regarding the outcome of pending HIPAA legislation and rules. DOER's consultants have provided not only the technical

expertise and capabilities to process the data, but also an important added confidentiality safeguard while the implications and requirements of HIPAA are clarified.

We will continue to assess the needs for the availability and maintenance of data between DOER's consultants and DOER. Overall, we will seek a balance between privacy protection for the members of SEGIP and having sufficient and appropriate types of data within the department to respond to data requests and/or business analysis.

The OLA notes that insufficient documentation of work products and duties exists in the contracts with the consultant. It is difficult for the contract process to anticipate consultant needs and tasks during the collective bargaining process in particular, in addition to various requests from independent billing units, agencies, the Legislature and other stakeholders. The flexibility in our current process is probably, in large measure, why our administrative costs are much less than the industry standard. However, a high level of documentation for work products and requests was consistently maintained in the form of emails, memos, notes, and other communication for all work performed. We also met as well as discussed via telephone or email the status of various deliverables no less than weekly, and often – especially at the height of collective bargaining with the unions – daily or even several times a day. We are continuing to improve the level of documentation, both as indicated for contracts, and for all other vendor and consulting work as well. We are also in the process of upgrading and integrating our fifteen year old computer system for administering health insurance into the state's SEMA4 system, to access and provide greater levels of information, with higher levels of consistency and uniformity.

Again, we want to express our appreciation for the OLA's work and this opportunity to comment on the report "State Employee Health Care Costs." An important step in helping address health care costs is to provide information and facilitate discussion of this important issue.

cc: Julien Carter, Commissioner

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