THE 1996 MINNESOTA HMO

Profile

a comparative analysis of
MINNESOTA MANAGED CARE
ENROLLMENT, FINANCIAL
and UTILIZATION DATA
for public and private markets

published by the
HEALTH ECONOMICS PROGRAM
of the Minnesota Department of Health

September 1997

INTRODUCTION

An Overview

This profile evaluates and compares select information from Minnesota HMOs to help you examine patterns in the public and private sectors of the state's health care market, thus facilitating policy and administrative decisions that will continue to improve the quality of care, cost effectiveness, and health status of Minnesotans enrolled in managed care plans.

Comparisons among managed care plans are especially relevant as Minnesota proceeds with efforts to move all state public program enrollees into managed care.

The Data Reported

Minnesota HMOs are regulated by the Managed Care Systems section of the Minnesota Department of Health. HMOs are required to file an annual statement detailing financial performance, enrollment base descriptions, utilization statistics, and quality measures with the Minnesota Commissioner of Health.

The utilization information in this profile applies only to an HMO's commercial, Prepaid Medical Assistance Program (PMAP), and General Assistance Medical Care (GAMC) enrolled populations.

The Health Economics Program

This profile was published by the Health Economics Program (HEP) within the Minnesota Department of Health. HEP conducts research and applied policy analysis to monitor and report changes in the state's health care market. HEP provides information to policy makers, purchasers, health plans, providers and consumers to increase their awareness and understanding of factors that influence health care costs, quality of care, and access to health services in Minnesota.

The Minnesota HMOs

Altru Health Plan
(was Northern Plains Health Plan)
1000 South Columbia Road
Grand Forks ND 58201
701.780.1600 or 1.800.675.2467

Blue Plus
(a Blue Cross Blue Shield MN product)
3535 Blue Cross Road
Eagan MN 55122
612.456.8000

First Plan of Minnesota
1010 Fourth Street
Two Harbors MN 55616
218.834.7207

HealthPartners, Group Health Plan, NWNL Health Network
8100 34th Avenue South
Minneapolis MN 55440
612.883.7000

Mayo Health Plan
21 First Street SW #401
Rochester MN 55902
507.284.8274

Medica Health Plans
5601 Smetana Drive
Minnetonka MN 55343
612.945.8000

Metropolitan Health Plan
(referred to as MHP)
822 South Third Street #140
Minneapolis MN 55415
612.347.6308

UCare Minnesota
2550 University Ave #201S
Saint Paul MN 55114
612.647.2632

Comments?

This profile summarizes only a portion of the data reported to the Minnesota Commissioner of Health by HMOs. We hope you find this profile useful. Please call us at 612.282.6367 or email HEP@health.state.mn.us if you have suggestions or comments about this profile.

You can locate our Internet website at www.health.state.mn.us/divs/hpsc/hep/hepintro.htm to order other reports from the Health Economics Program.

ENROLLMENT

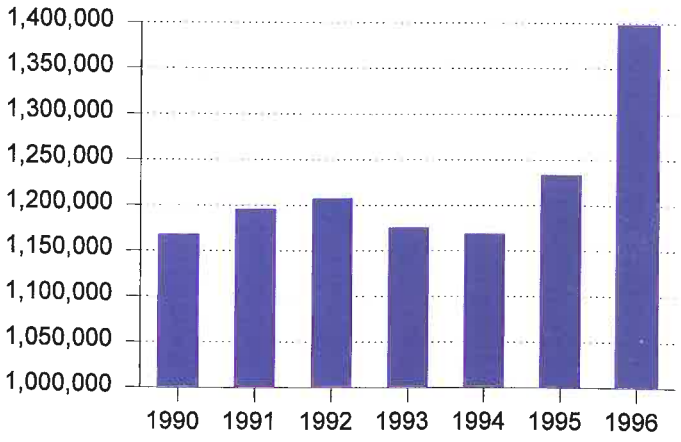
Fully-Insured HMO Enrollment

	Commercial		Medicare Risk		Medicare Non-Risk		PMAP & GAMC		MinnesotaCare		1995	1996	% change
HMO	1995	1996	1995	1996	1995	1996	1995	1996	1995	1996	TOTAL	TOTAL	1995-96
Blue Plus	49,110	56,361	522	805	10,128	9,236	10,441	10,134	0	51,063	70,201	127,599	82%
First Plan	9,100	9,566	0	0	1,003	978	77	3,133	0	1,077	10,180	14,754	45%
Group Health	102,658	97,541	17,174	17,513	46	0	0	0	0	0	119,878	115,054	-4%
HealthPartners	306,777	307,262	0	0	19,747	16,361	19,902	25,015	0	10,827	346,426	359,465	4%
MHP*	6,218	6,617	0	0	0	0	23,680	23,021	0	717	29,898	30,355	2%
Mayo	3,699	4,651	0	0	600	559	0	0	0	0	4,299	5,210	21%
Medica	463,327	533,815	40,193	37,567	32,643	37,887	53,315	71,592	0	4,179	589,478	685,040	16%
Altru**	0	463	0	0	0	0	0	0	0	0	0	463	*n/a*
NWNL***	18,981	0	0	0	0	0	4,343	0	0	0	23,324	0	*n/a*
UCare	0	0	0	0	0	0	39,073	42,184	0	16,005	39,073	58,189	49%
TOTAL	959,870	1,016,276	57,889	55,885	64,167	65,021	150,831	175,079	0	83,868	1,232,757	1,396,129	13%

** Metropolitan Health Plan*
*** formerly Northern Plains Health Plan*
**** NWNL Health Network, purchased by HealthPartners 12/31/95*

Fully-insured HMO enrollment in Minnesota grew 13.3% during 1996, from 1,232,757 in 1995 to 1,396,129 in 1996. This is the second consecutive year of increased enrollment for fully-insured HMO products. Although several plans gained members during 1996, Blue Plus and Medica accounted for the majority of the total increase. The reason for growth was different for these two plans.

Fully-Insured HMO Enrollment



The movement of MinnesotaCare enrollees to HMO products accounted for nearly all (89%) of Blue Plus' 1996 enrollment increase, while commercial product enrollment accounted for nearly three-quarters of Medica's 95,562 member increase.

The enrollment of state program recipients in Minnesota HMOs continues to be a major contributor to overall plan increases. More than half of the increase in fully-insured HMO enrollment during 1996 resulted from the movement of MinnesotaCare enrollees to HMO products. In addition, Prepaid Medical Assistance Program (PMAP) and General Assistance Medical Care (GAMC) HMO enrollment continued to climb, with combined enrollment increasing over 16% in 1996.

Medicare risk product enrollment in Minnesota declined for the second consecutive year. Recent action at the federal level will improve payments to health care plans for enrolling Medicare beneficiaries in most areas of Minnesota, which may result in a future increase for Medicare managed care products.

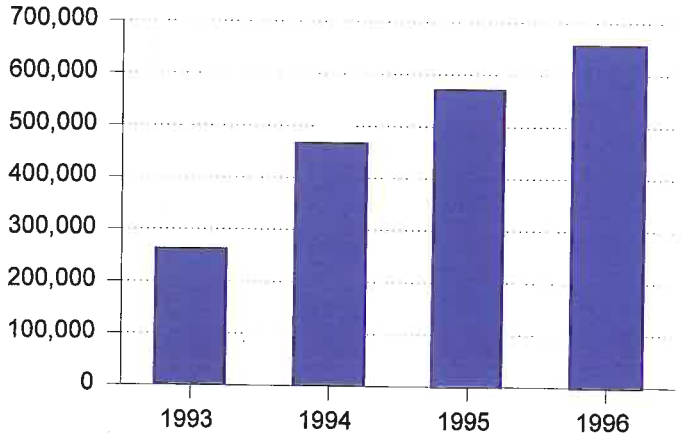
ENROLLMENT

Enrollment in HMO self-insured products continues to increase. Under a self-insured product, an HMO provides administrative and network services, but does not accept financial risk for the enrollee's use of health services.

As shown in the table to the right, over 600,000 Minnesotans, almost 13% of the state's population of 4.6 million residents, are enrolled in self-insured HMO products. Nearly 30% of the state's population is enrolled in a fully-insured HMO product. These products include enrollees from all federal and state public programs.

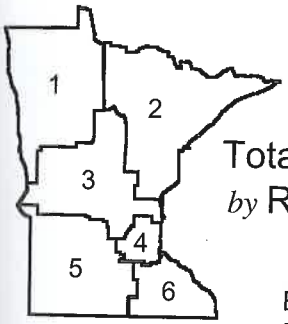
HMO enrollment continues to be concentrated in the Twin Cities metro area, with 44.2% of the population enrolled in fully-insured HMOs (nearly 80% of total enrollment). Combined, Medica, Group Health and HealthPartners account for nearly 90% of the metro fully-insured HMO enrollment.

Self-Insured HMO Enrollment



Combining fully-insured and self-insured enrollment, over 40% of Minnesota's population is enrolled in HMO products, with concentration heaviest in the Twin Cities metro area, where over 60% of the metro population is enrolled in either fully-insured or self-insured HMOs.

Most of the *growth* in enrollment during 1996 was in Greater Minnesota. Nearly three-quarters of fully-insured HMO enrollment growth in 1996 was in areas outside of the seven county metropolitan area.



Total 1996 HMO Enrollment *by* RCB Regions

	RCB1	*RCB2*	*RCB3*	*RCB4*	*RCB5*	*RCB6*	TOTAL *in* MN
Blue Plus	8,166	23,751	21,880	48,195	12,457	10,305	124,754
First Plan	0	14,278	0	0	0	0	14,278
Group Health	26	217	8,657	103,444	125	830	113,299
HealthPartners	3,363	643	17,610	318,221	4,242	8,155	352,234
MHP	5	11	167	30,114	18	19	30,334
Mayo	0	0	5	20	104	4,730	4,859
Medica	10,386	26,523	71,242	542,108	16,032	8,422	674,713
Altru	424	0	0	0	0	0	424
UCare	4	1,942	3,771	49,668	2,551	253	58,189
FULLY-INSURED HMO:	22,374	67,365	123,332	1,091,770	35,529	32,714	1,373,084*
% of RCB population	8.9%	19.1%	19.2%	44.2%	7.0%	7.5%	29.5%
SELF-INSURED HMO:	18,357	35,915	71,445	409,184	31,008	28,224	594,133**
% of RCB population	7.3%	10.2%	11.1%	16.6%	6.1%	6.5%	12.8%
TOTAL HMO *% of RCB population:*	16.2%	29.3%	30.3%	60.8%	13.2%	14.0%	42.2%

** does not include 23,045 members living outside of MN in border communities*
*** does not include 12,485 members living outside MN and 47,966 members whose place of residence is unknown*

FINANCIAL

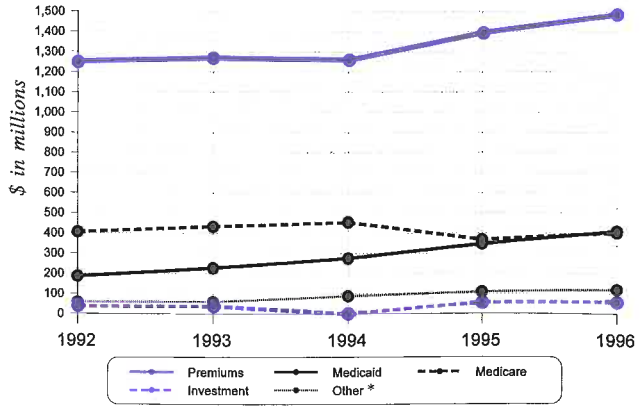
1996 HMO Overview

	Revenue	Expenditures	Net Income	Net Worth
Blue Plus	145,074,009	146,396,240	(1,322,231)	13,594,934
First Plan	26,138,705	25,932,197	206,508	4,112,436
Group Health	301,681,000	297,326,000	4,355,000	46,896,000
HealthPartners	591,419,000	588,200,000	3,219,000	90,621,000
Mayo	8,459,316	8,438,535	20,781	1,604,529
Medica	1,231,229,861	1,234,128,668	(2,898,807)	166,340,441
MHP	67,858,188	68,520,223	(662,035)	17,793,071
Altru	648,581	774,811	(126,230)	266,710
UCare	100,008,669	96,906,381	3,102,288	18,820,825
TOTAL	2,472,517,329	2,466,623,055	5,894,274	360,049,946

HMO revenue for 1996 totaled almost $2,473 million. Total revenue, all income generated by an HMO's operation, includes premiums, government payments for Medicare and Medicaid, investment income, fee-for-service payments, administrative fees, and other miscellaneous income. Total revenue grew 8.9% during 1996, and 27.6% over the five year period from 1992 to 1996.

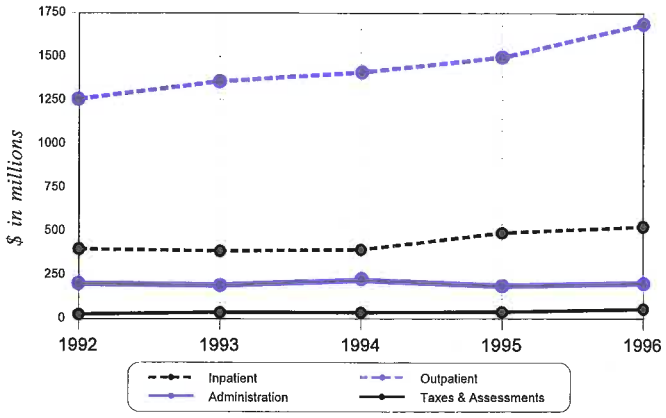
Since 1992, HMO expenditures have grown at a faster pace than their revenues. Total expenditures include hospital and medical costs, salaries, taxes, fees, assessments, and administrative costs. Total expenditures grew 11.5% in 1996, reaching almost $2,467 million, and 31.8% between 1992 and 1996. The greatest rate of increase was in outpatient costs, while administrative expenditures have been stable.

Total HMO Revenue



* *Other revenue includes dental, income from subsidiary operations, and other miscellaneous revenue*

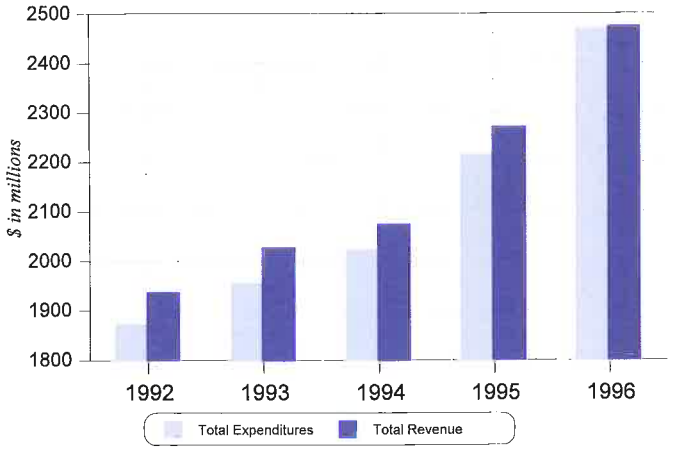
Total HMO Expenditures



Net income is another way of explaining the revenue and expenditures relationship. Net income is the amount of income remaining after total expenses have been subtracted from total revenue. HMO average net income was more than $50 million each year from 1992 through 1995, then fell to $5.9 million in 1996. This represented a decrease of $52 million from 1995, when total net income was almost $58 million. All but one HMO experienced some drop in net income during 1996, and four plans (Blue Plus, Medica, MHP and Altru) ended with a loss. Competition between health plans may have contributed to this loss, if premium prices were held down to gain a larger share of the health care market.

The net worth (total assets minus total liabilities) of some HMOs will likely continue to decrease in future years, as it did in 1996, as HMOs dip into assets because revenues do not cover expenditures. This could cause further disturbance in the health care market if premiums are increased drastically or benefits are reduced, resulting in enrollees shifting to plans with lower premiums or benefits that have not been reduced. A portion of the increase in revenue and expenditures can be attributed to the 13.3% increase in enrollment during 1996.

Revenue & Expenditures

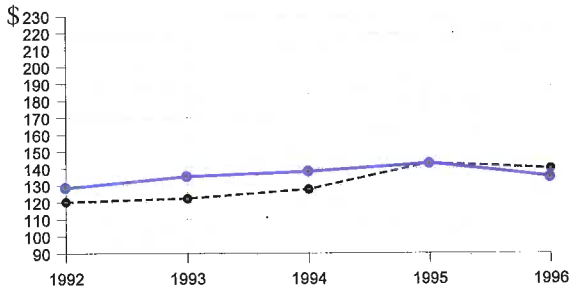


Premium revenue per member per month (PMPM), which includes commercial and dental premiums, and all Medicaid and Medicare payments, is the average monthly revenue an HMO receives for each of its enrolled members. The figures to the right show premium revenue PMPM and total expenditures PMPM for the three largest HMOs and UCare, which has only public plan enrollees.

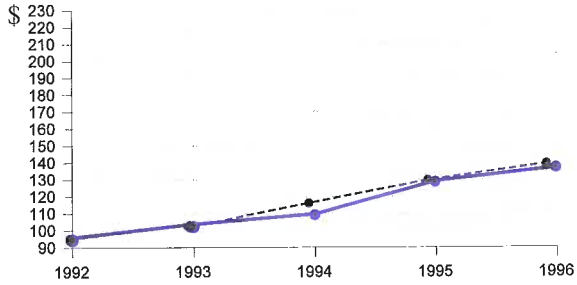
In 1996, while some HMOs' average premium revenues PMPM were keeping pace with their average expenditures PMPM, Blue Plus and Medica (also MHP and Altru, not shown in these figures), were not. Medica's average premium revenue PMPM decreased .2% from 1995 to 1996, while their average expenditures PMPM increased 2.7%. For all HMOs, average premium revenue PMPM increased 15.5% over the five year period from 1992 to 1996, while average expenditures PMPM increased 21.7% for the same period.

Premium Revenue and Expenditures per member per month (PMPM)

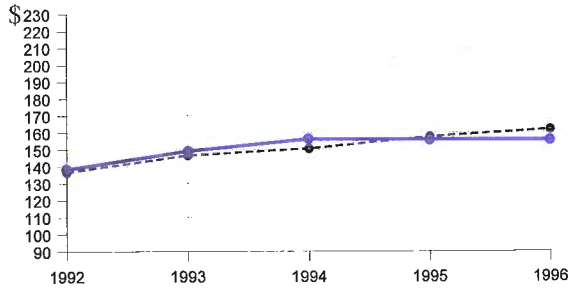
Blue Plus



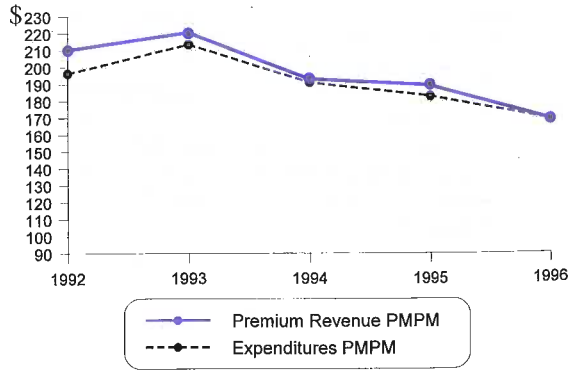
HealthPartners



Medica



UCare



UTILIZATION

The National Committee for Quality Assurance (NCQA) has developed the Health Plan Employer Data and Information Set (HEDIS©), now in its third revision. HEDIS© is a set of standard performance measures designed to ensure that purchasers and consumers have information to reliably compare managed care health plans. HEDIS© measures do not account for factors beyond a plan's control, such as characteristics inherent in member populations or geographic regions in which plans operate. If the data are not corrected for these factors, health plan performance may not be assessed correctly.

The process for correcting for the known sources of fluctuation is known as risk adjustment. Measures reported in this utilization section are not risk adjusted, because data reported to the Minnesota Department of Health are currently not adequate to perform the necessary adjustments. The Department is committed to the continuing development and refinement of performance measures and data.

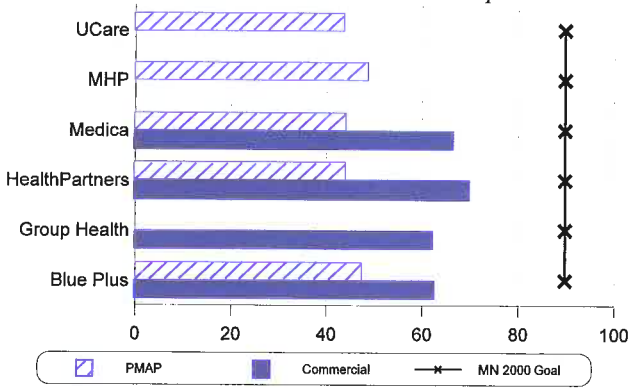
	PMAP	*GAMC*	*Commercial*
Altru			x
Blue Plus	x	x	x
First Plan	x	x	x
Group Health			x
HealthPartners	x	x	x
Mayo			x
Medica	x	x	x
MHP	x	x	x
UCare	x	x	

Many plans offer Prepaid Medical Assistance Program (PMAP) and General Assistance Medical Care (GAMC) options, but due to the small numbers reported, some plans' performance measures are not reported here. Comparing public and private enrollee utilization is useful, as some HMOs have experienced large PMAP enrollment increases since 1994.

Although HEDIS© was developed to facilitate comparisons between health plans, another important use is to track health plan activity over time. While the data show that public health goals for these preventive measures are not yet being met, they do not explain *why* the goals are not being met. Future reports will help to chart health plan progress in improving access to a basic standard of care and improved health for all Minnesotans, especially children.

Childhood Immunizations

% Two Year Olds with Vaccinations Complete



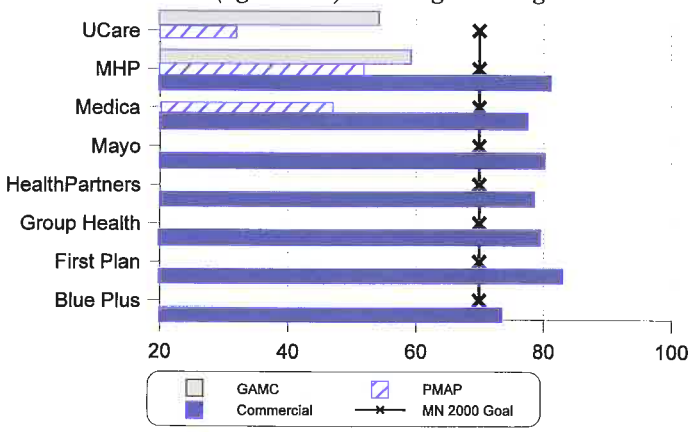
The childhood immunization graph above shows the percentage of PMAP and commercially enrolled children turning two years old during 1996 who were continuously enrolled for twelve months immediately preceding their second birthday, and received all of the following immunizations: four diphtheria-tetanus-pertussis; three polio; one measles-mumps-rubella; one H influenza type B; and two hepatitis B.

The completed immunization rate for children in PMAP is considerably lower than commercial plans. The Commissioner of Health has suggested that if Minnesota is to do an adequate job of protecting children against disease, a significant investment in public health infrastructure is needed, including the development of a Minnesota immunization registry. By the year 2000, a Minnesota public health goal is to create a system ensuring 90% vaccination rates for children in all geographic areas, racial and ethnic groups, and socioeconomic levels.

The breast cancer screening graph on the next page shows the percentage of women ages 52 to 69 enrolled in PMAP, GAMC, and commercial plans who were continuously enrolled during 1995 and 1996, and who had a mammogram within the last two years. It shows that women enrolled in PMAP and GAMC managed care programs receive fewer mammograms than women in commercial plans. While all of the commercial plans exceed the Minnesota 2000 goal of 70%, PMAP plans approach 60% and GAMC plans are at less than 50%.

Breast Cancer Screening

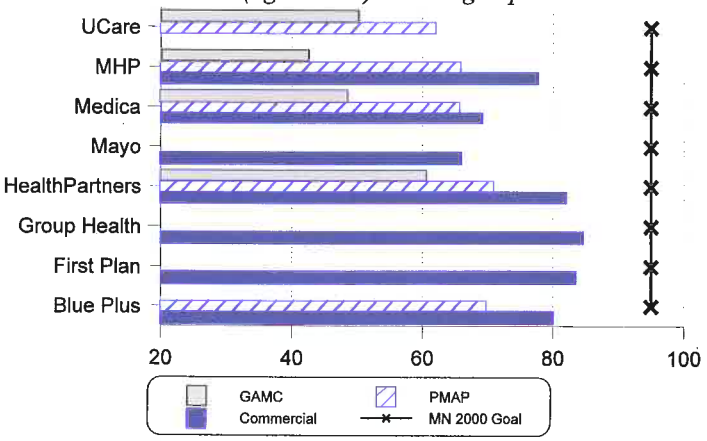
% Women (ages 52-69) receiving Mammogram



Shown in the cervical cancer screening (pap tests) graph below is the percentage of women ages 21 through 64 years who were continuously enrolled in commercial, Prepaid Medical Assistance, and General Assistance Medical Care plans during 1996; and who received one or more pap tests during 1996 or two years prior. PMAP members received pap tests, as noted below, at rates approaching that of commercial enrollees, while GAMC members tended to receive pap tests at rates below PMAP levels. None of the plans have yet reached the public health goal of 95%.

Cervical Cancer Screening

% Women (ages 21-64) receiving Pap Test

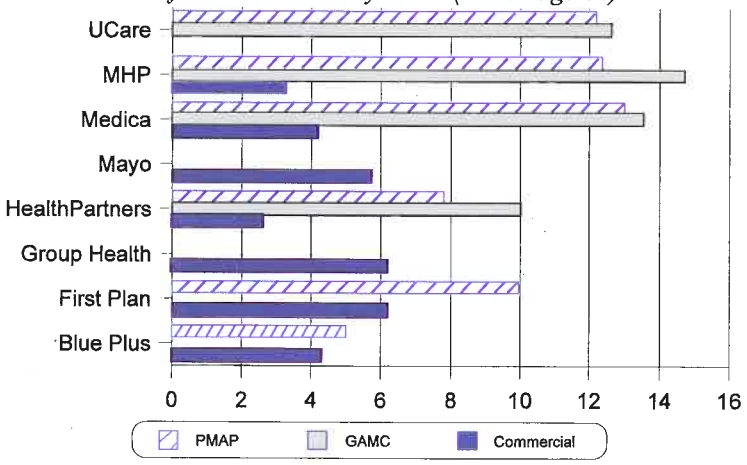


The emergency room visits graph below shows the percent of total ambulatory emergency room visits for PMAP, GAMC, and commercial populations. Data reported by managed care plans show that individuals enrolled in commercial benefit health plans used the hospital emergency room substantially less than those enrolled in PMAP or GAMC, and that the percentage of hospital emergency room visits was higher for GAMC members than for those enrolled in PMAP.

Research has shown that having a regular source of medical services with a designated primary care provider directly influences individual decisions of whether or not to seek care. The lack of a primary care relationship can result in the use of hospital emergency rooms for non-emergency health problems. As PMAP enrollees establish regular sources of care, the number of emergency room visits is expected to decline.

Emergency Room Visits

% of Total Ambulatory Visits (birth - age 64)



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The HEALTH ECONOMICS PROGRAM
of the MN Department of Health appreciates the cooperation of the MN Department of Human Services and many others who made this profile possible.

Questions? call 612.282.6367

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