THE MINNESOTA HMO

Profile

1997 IN REVIEW:
a descriptive analysis of
Minnesota HMO Performance

published by the
ECONOMICS PROGRAM
Minnesota Department of Health

December 1998

INTRODUCTION

Purpose

This profile presents performance information about Minnesota's Health Maintenance Organizations (HMOs). It is intended to do three things: 1) provide a descriptive overview of the industry's activity; 2) link HMO plan performance with statewide public health objectives set to improve the health of all Minnesotans; and 3) report HMOs' progress toward these objectives.

Information Reported

HMO operations in the state are certified by the Managed Care Systems (MCS) section of the Minnesota Department of Health (MDH). HMOs are required by law to file an annual report detailing financial performance, enrolled population descriptions, utilization statistics, and quality of care information with the Commissioner of Health. In several sections of the annual report, these data are displayed by HMO product lines, i.e. fully-insured commercial, Medicare risk, Medicare Part B supplemental (cost or HCPP), Prepaid Medical Assistance Program (PMAP), General Assistance Medical Care (GAMC), and MinnesotaCare (MNCare). Information presented in this summary is compiled from these annual HMO filings.

The Health Economics Program

The 1997 HMO Profile is published by the MDH Health Economics Program (HEP) in collaboration with the Managed Care Systems section and the Performance Measurement and Quality Improvement Division of the Department of Human Services. HEP conducts research and policy analysis to monitor and report changes in the state's health care market. It also provides information to policy-makers, purchasers, health plans, providers and consumers to increase their understanding of the complex factors influencing health care costs, access and quality.

The Minnesota HMOs

Altru 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
651.456.8000

First Plan of Minnesota
1010 Fourth Street
Two Harbors, MN 55616
218.834.7202

Health Partners Group Health Plan
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 #210S
St. Paul, MN 55114
651.647.2632

For More Information

This profile summarizes only a portion of the data reported to the Minnesota Commissioner of Health by the HMOs. We hope you find it useful.

If you have suggestions or comments about this profile, please call our office at 651.282.6367 or e-mail us at HEP@health.state.mn.us

You can locate the data in this report on our Internet website which is located at:
www.health.state.mn.us/divs/hpsc/hep/miscpubs/hmoprof.htm

ENROLLMENT

Table 1, Fully-Insured HMO Enrollment

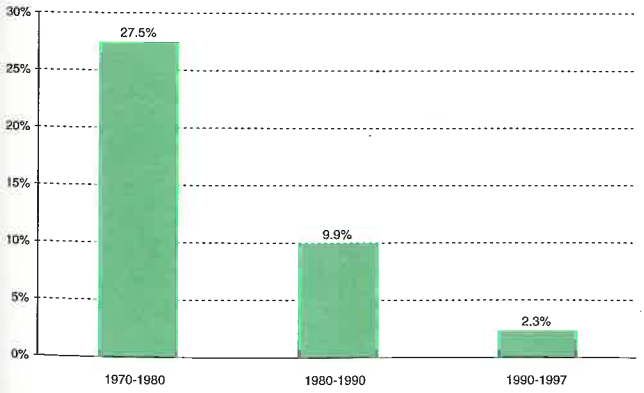
HMO	Commercial 1996	Commercial 1997	Medicare Risk 1996	Medicare Risk 1997	Medicare Non-Risk 1996	Medicare Non-Risk 1997	PMAP & GAMC 1996	PMAP & GAMC 1997	MinnesotaCare 1996	MinnesotaCare 1997	TOTAL 1996	TOTAL 1997	% Change 1996-1997
Altru*	463	563	0	0	0	0	0	0	0	0	463	563	22%
Blue Plus	56,361	73,590	805	969	9,236	8,170	10,134	14,229	51,063	57,296	127,599	154,254	21%
First Plan	9,566	9,999	0	0	978	1,533	3,133	3,325	1,077	1,165	14,754	16,022	9%
Group Health	97,541	69,510	17,513	18,597	0	0	0	0	0	0	115,054	88,107	-23%
HealthPartners	307,262	338,064	0	0	16,361	16,293	25,015	24,327	10,827	13,755	359,465	392,439	9%
MHP**	6,617	6,949	0	0	0	315	23,021	20,124	717	1,405	30,355	28,793	-5%
Mayo	4,651	4,669	0	0	559	536	0	0	0	0	5,210	5,205	0%
Medica***	521,867	472,970	37,567	35,617	37,887	38,457	71,592	74,364	4,179	5,350	673,092	626,758	-7%
UCare	0	0	0	0	0	0	42,184	40,170	16,005	19,103	58,189	59,273	2%
Total	1,004,328	976,314	55,885	55,183	65,021	65,304	175,079	176,539	83,868	98,074	1,384,181	1,371,414	-1%

* formerly Northern Plains Health Plan ** Metropolitan Health Plan *** 1996 data have been revised

Fully-insured HMO enrollment in Minnesota declined by less than 1 percent during 1997, from 1,384,181 members in 1996 to 1,371,414. By comparison, 1996 enrollment grew 12.3 percent. The higher growth rate in 1996 was due largely to enrolling MNCare, PMAP and other public beneficiaries in managed care plans.

As shown in Figure 1 below, growth in fully-insured HMO enrollment has slowed substantially in the 1990s relative to earlier periods. From 1970 to 1980, enrollment grew by an average of 28 percent per year. During the 1980s, HMO enrollment grew by about 10 percent per year. For 1990 to 1997, enrollment growth slowed to just 2 percent per year.

Figure 1, Average Annual Growth of Fully-Insured HMO Enrollment

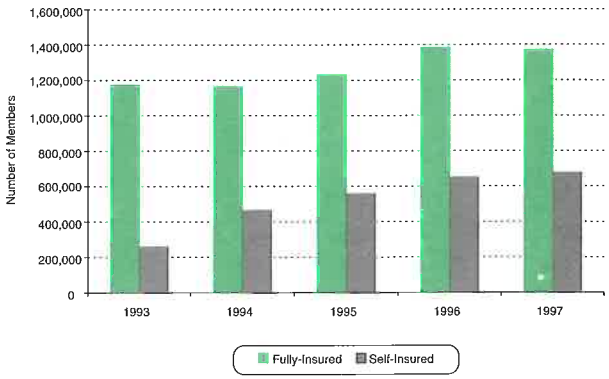


Growth in public program enrollment, such as PMAP, GAMC and MNCare, has been the primary driver behind gains in fully-insured HMO enrollment throughout the 1990s. Public program enrollment in HMOs grew by 4.0 percent in 1997, compared to a decline of 2.8 percent for commercial enrollment. While commercial enrollment has fluctuated somewhat during the 1990s, the total increase between 1990 and 1997 was only about 7,000 members. In comparison, public program enrollment in HMOs increased by about 200,000 members during the same period.

In contrast to the overall growth in public program enrollment, Medicare HMO risk product enrollment declined for the third consecutive year, to be partly offset by increases in Medicare non-risk enrollment. Over 98 percent of Medicare HMO risk enrollment and about two-thirds of non-risk enrollment is in the Twin Cities metro area, which is perhaps a reflection of the fact that federal per capita premium payments to HMOs are higher in the Twin Cities urban counties.

Of the state's four largest HMOs, Blue Plus experienced a 20.9 percent increase in enrollment during 1997, with about two-thirds of the uplift occurring in its commercial products. Medica, the state's largest HMO, saw enrollment drop by 6.9 percent, primarily due to a fluctuation in its commercial product line. Enrollment in HealthPartners and Group Health combined grew by 1.3 percent. The changes in fully-insured HMO enrollment are shown separately by HMO and product type in Table 1.

Figure 2, Trends in Fully-Insured and Self-Insured HMO Enrollment



Enrollment in HMO self-insured products continued to increase, growing by 4.2 percent in 1997. As shown in Figure 2, self-insured HMO enrollment increased from about 260,000 members in 1993 to nearly 680,000 in 1997 as employers continued the trend toward self-insuring to gain employee health benefit cost reductions. Currently, about 13 percent of Minnesota's population is enrolled in self-insured HMO products. About 29 percent of the population is enrolled in a fully-insured HMO product, including both commercial and public program enrollment.

Table 2 shows the variation in HMO enrollment by state-defined Regional Coordinating Board (RCB) areas. Fully-insured HMO enrollment continues to be concentrated in the Twin Cities metro area, which accounts for over three-fourths of statewide enrollment. Enrollment as a percentage of the population is also highest in the Twin Cities metro, at 41.3 percent. However, enrollment growth is much stronger in Greater Minnesota than the metropolitan area. In 1997, fully-insured HMO enrollment in the metro area declined by 4.8 percent while enrollment in Greater Minnesota increased by 14.6 percent. Enrollment growth was particularly strong in the regions with the lowest HMO penetration rates – RCB regions 5 and 6 in the southern part of the state.

Combining fully-insured and self-insured HMO products, the proportion of Minnesota's population enrolled in HMO products decreased only slightly in 1997, from 41.9 percent to 41.7 percent. In the Twin Cities metro area, enrollment as a percentage of the population declined from 60.4 percent to 58.7 percent. In Greater Minnesota, total HMO enrollment as a share of the population increased from 21.0 percent in 1996 to 22.5 percent in 1997.

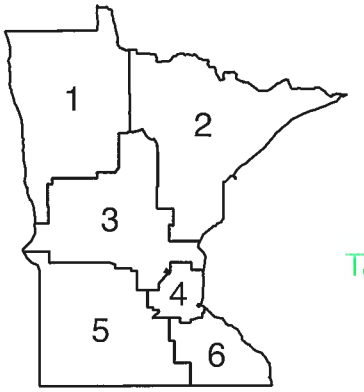


Table 2, Total 1997 HMO Enrollment by RCB Regions*

HMO	RCB 1	RCB 2	RCB 3	RCB 4	RCB 5	RCB 6	Total in MN
Altru	524	0	1	0	0	0	525
Blue Plus	10,074	25,723	26,644	50,708	21,497	15,703	150,349
First Plan	0	15,540	0	0	0	0	15,540
Group Health	19	218	7,312	78,370	89	637	86,645
HealthPartners	4,262	750	21,292	340,380	6,135	9,200	382,019
MHP	3	17	196	28,500	21	17	28,754
Mayo	5	2	5	14	112	4,808	4,946
Medica	9,514	29,775	67,182	483,263	14,651	9,280	613,665
UCare	323	2,391	4,541	47,245	3,844	929	59,273
TOTAL, FULLY-INSURED HMO:	24,724	74,416	127,173	1,028,480	46,349	40,574	1,341,716**
% of RCB population	9.8%	21.1%	19.5%	41.3%	9.2%	9.3%	28.6%
SELF-INSURED HMO:	14,655	34,017	66,775	432,871	33,145	31,222	612,685***
% of RCB population	5.8%	9.7%	10.2%	17.4%	6.6%	7.1%	13.1%
TOTAL HMO % of RCB population	15.7%	30.8%	29.7%	58.7%	15.8%	16.4%	41.7%

* The Regional Coordinating Boards, or RCBs, were established by the 1992 MinnesotaCare legislation to advise the Commissioner of Health on health care policy issues.
** Excludes 29,698 members living outside of MN.
***Excludes 66,536 members living outside of MN

Table 3, 1997 HMO Revenue, Expense and Net Income Overview

	Revenue	Expenditure	Net Income
Blue Plus	203,351,756	201,002,232	2,349,524
First Plan	32,528,610	32,227,192	301,418
Group Health	268,324,000	272,075,000	(3,751,000)
HealthPartners	652,268,000	654,436,000	(2,168,000)
Mayo	8,414,811	8,375,764	39,047
Medica	1,287,574,815	1,287,372,047	202,768
MHP	71,091,136	74,571,231	(3,480,095)
Altru	896,341	864,947	31,394
UCare	117,832,513	119,397,028	(1,564,515)
TOTAL	**2,642,281,982**	**2,650,321,441**	(8,039,459)

HMO revenue for 1997 totaled over $2.64 billion (Table 3). This includes premiums, fee-for-service payments, government payments for Medicare and Medicaid, investment income, administrative fees and other miscellaneous income. Total expenditures for 1997 were over $2.65 billion. Total expenditures include hospital and medical costs, taxes and administrative costs. Because expenses exceeded revenue in 1997, the industry as a whole experienced a loss of about $8 million.

Figure 3, Total HMO Revenues & Expenditures

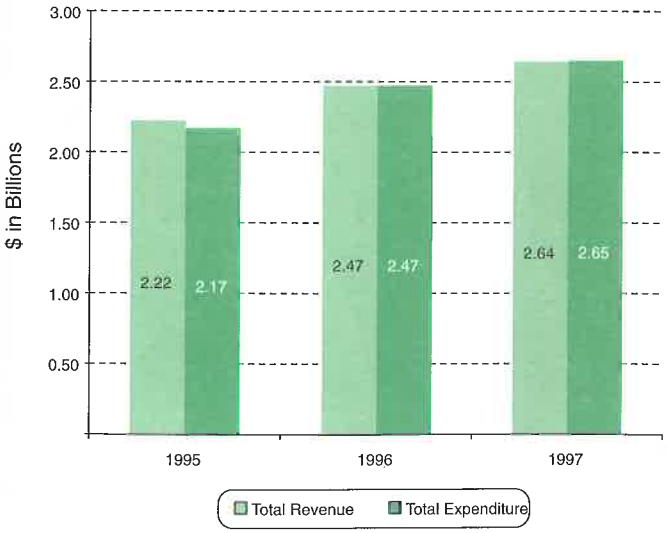
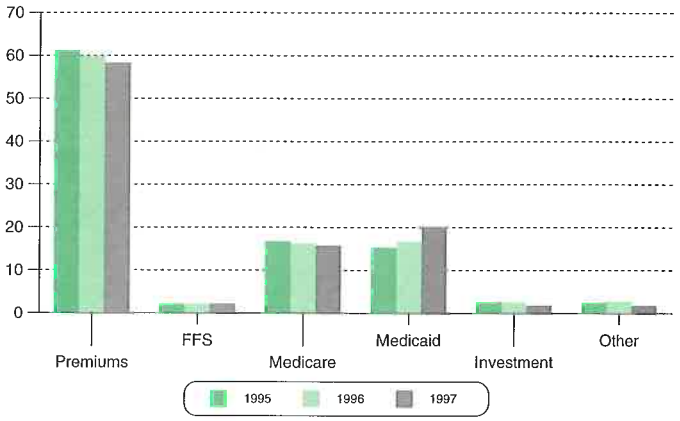


Figure 3 indicates that HMO total revenue grew 6.9 percent in 1997 compared to 11.2 percent in 1996. Total expenditures increased 7.4 percent during 1997 versus 13.7 percent during 1996. This resulted in a decline in net income due largely to rising medical-hospital expenditures. Four of the state's HMOs saw a decline in net income in 1997. Group Health, HealthPartners, Metropolitan Health Plan (MHP) and UCare ended the year with losses.

Figure 4, HMO Revenue Mix 1995-1997

% of Total Revenue by Source



While total revenue grew in 1997, its source has been slowly shifting over the three year period in concert with changes in enrollment. As shown in Figure 4, commercial premiums have been declining as a proportion of total revenue, as have Medicare payments and investments. Medicaid payments as a proportion of total revenue increased, thus reflecting the enrollment growth in the Prepaid Medical Assistance Program.

Figure 5, Total HMO Expenditure Categories

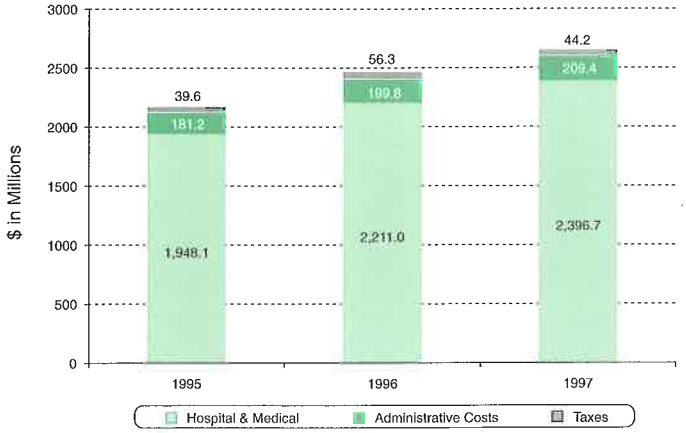
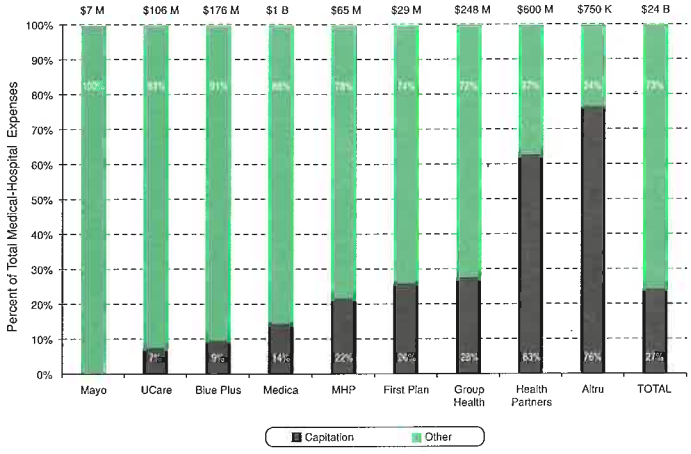


Figure 5 shows that medical-hospital expenses constituted almost 90 percent of total expenditures by HMOs. Administrative costs added approximately 8 percent to total expenditures between 1995 to 1997. Overall, approximately 27 percent of all Minnesota HMO medical-hospital expenditures were disbursed to provider organizations in the form of capitation payments. Capitation is a method of payment for health services in which individual providers, provider groups or institutional providers are paid a fixed amount for each HMO member served, without regard to the number or type of services delivered within a specified period of time. Figure 6 shows that the proportion of capitation prepayment varies widely among Minnesota's HMOs, from none at Mayo Health Plan to as much as 76 percent of total medical-hospital expense at Altru Health Plan.

Figure 6, How 1997 HMO Medical-Hospital Expenses Were Paid



The National Committee for Quality Assurance (NCQA) has developed the Health Plan Employer Data and Information Set (HEDIS®), now in its third revision. A subset of HEDIS, the clinical care measures, was designed to help purchasers of health benefits to evaluate health plan quality of care improvements over time. Clinical HEDIS measures collected by the Minnesota Department of Health are used to monitor targeted aspects of HMOs' clinical performance with the goal of improving member health through prevention, screening and early intervention. The performance targets on which HMOs are evaluated and their relevance for the health of Minnesotans are documented in two MDH publications, *Minnesota Public Health Goals* (March 1995) and *Healthy Minnesotans 2004: Public Health Improvement Goals* (September 1998).

A word of caution to the reader is warranted before interpreting the following results. Because NCQA data collection guidelines permit HMOs to choose among three different ways to collect data for each specific measure, this practice renders comparisons between plans invalid should they employ different methods. As long as each HMO uses the same method over time, within the plan, only then can evaluations be made as to whether a plan's quality of care has improved. Due to these data collection differences, HEP discourages HMO performance comparisons between product lines within an HMO company (ex. commercial versus PMAP) or between HMO companies (ex. Medica versus HealthPartners). Even if similar collection methods are used, differences among enrolled populations, program benefits, provider networks, and amounts of out-of-pocket member payments can make comparisons difficult to realize.

All HMOs do not serve the same populations, nor do they all offer the same benefit sets. Because of differences in populations served, products offered, small numbers of enrollees, changes in or use of non-standard data collection methods, some HMOs' or HMO product line results may not be represented in the following graphs or tables. The Minnesota Department of Health continues to encourage HMOs to use standard HEDIS data collection methods so that significant progress toward statewide population health objectives can be documented and acknowledged. Given these data comparability issues for 1996 and 1997, MDH has elected to report HMO product line progress toward health improvement targets set for the year 2000.

Figure 7, Childhood Immunizations

% Two year olds with vaccination series complete

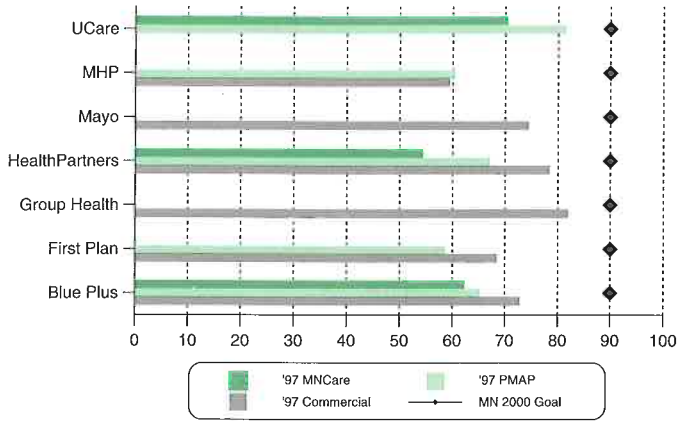


Figure 8, Breast Cancer Screening

% Women (ages 52-69) receiving mammogram

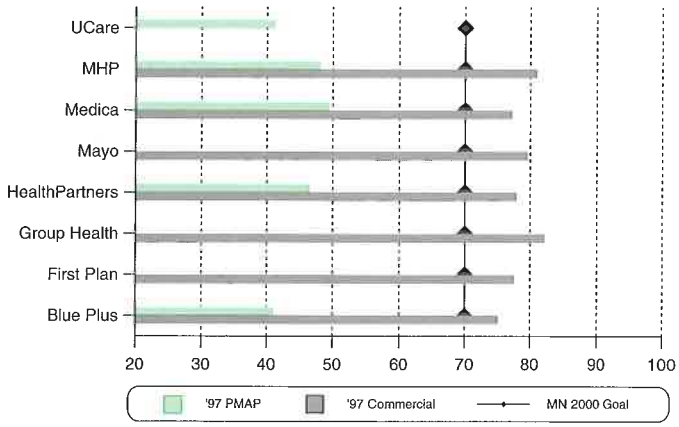


Figure 7 shows the percentage of PMAP, MNCare and commercially covered children turning two years old during 1997, who were continuously enrolled for twelve months immediately preceding their second birthday, and received all of the following immunizations: four diphtheria-tetanus-pertussis; three polio; one measles-mumps-rubella; one H influenza type B; and two hepatitis B vaccinations. The MDH Year 2000 target for childhood immunizations is that 90 percent of all children be up to date with their vaccinations.

The completed immunization rate for children covered by commercial, PMAP and MNCare products falls short of the year 2000 target. However, since these data report only 1997 immunization rates, there is a reasonable chance many HMOs will hit the target by the year 2000. This optimism is reflected in Table 4 which shows that several HMOs made significant improvements in their 1997 plan-specific immunization rates when compared with 1996 rates. This is very good news for children covered by fully-insured HMO plans. Some HMO product lines exhibiting no change on this measure have small enrollments which make it difficult for the statistical tests employed to show significant improvement. UCare, which serves only the public program populations, and Group Health, which serves only a commercial population, are setting the pace toward achieving the state-wide target.

Figure 8 reflects good news for many Minnesota women between the ages of 52 and 69 years, who were enrolled in some fully-insured HMO commercial plans. All of the HMO commercial plans represented have already reached and exceeded the MDH Year 2000 target of a 70 percent mammography rate. Group Health and Medica made further statistically significant improvement in their rates between 1996 and 1997 while the other plans evaluated reported no change (Table 4). Considerable room for improvement exists for HMOs serving the PMAP membership to increase their mammography rates. MDH has observed that as use of mammography has increased, the death rate for breast cancer in Minnesota has dropped at an average annual rate of 1.8 percent between 1988 and 1995. Detection of cancer in its early stages allows for simpler treatment with fewer side-effects than treatments for later-stage cancer. The mammography target rate for the year 2004 is now set at 90 percent.

Table 4, HMO Quality Improvement 1996 - 1997

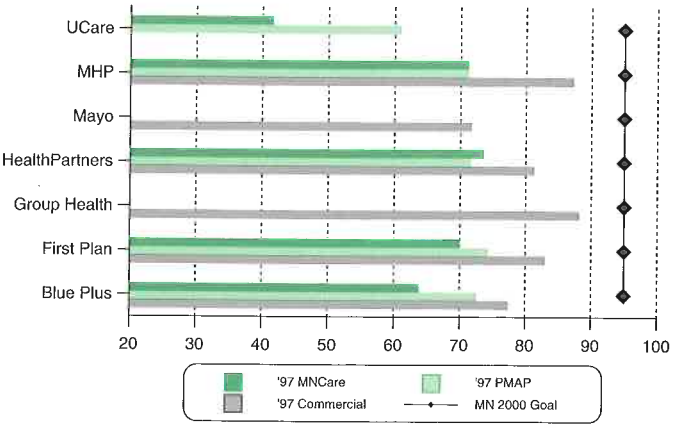
	Childhood Immunizations		Breast Cancer Screening		Cevical Cancer Screening	
HMO	1996 - 97 Change?	Yr 2000 Target 90%	1996 - 97 Change?	Yr 2000 Target 70%	1996 - 97 Change?	Yr 2000 Target 95%
Blue Plus						
Commercial	Improved	Off	None	On	None	Off
PMAP	Improved	Off	None	Off	None	Off
First Plan						
Commercial	None	Off	None	On	None	Off
Group Health						
Commercial	Improved	Off	Improved	On	None	Off
HealthPartners						
Commercial	None	Off	None	On	None	Off
PMAP	Improved	Off	None	Off	None	Off
Mayo						
Commercial	None	Off				
Medica						
Commercial			Improved	On		
PMAP			None	Off		
MHP						
Commercial	None	Off			Improved	Off
PMAP	Improved	Off			None	Off
UCare						
Commercial						
PMAP	Improved	Off	None	Off	None	Off

Improved means a statistically significant change in rates from 1996 to 1997.
Statistical tests for improvement were made at the 5% level of significance.

According to Figure 9, there is room for progress toward the Year 2000 cervical cancer screening target rate of 95 percent, especially for plans serving the PMAP and MNCare members. Table 4 shows that of the plans with internally comparable standard data, the fully-insured commercial members in Metropolitan Health Plan (MHP) received Pap smears at a statistically significant higher rate than in 1996. All other HMO plans displayed reported no significant change. MDH data reveal that death rates from cervical cancer, which dropped dramatically beginning in the 1950s as Pap smear testing increased, have leveled off in Minnesota. In order to redouble the effort to realize further reductions in cervical cancer death rate, the Year 2004 Pap smear rate target is now set at 99 percent.

Figure 9, Cervical Cancer Screening

% Women (ages 21-64) receiving Pap smear

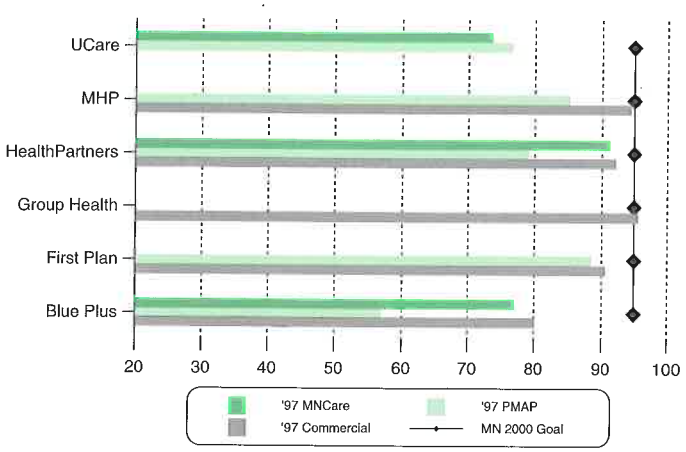


Prenatal care in the first trimester is a new addition to the Minnesota HEDIS measures collected for the first time in the 1997 HMO annual reports. Health research continues to show that timely and adequate prenatal care greatly enhances chances for positive birth outcomes. Early evaluation and intervention can often prevent many problems in the developing fetus and identify mothers with the risk of a pre-term delivery. *Healthy Minnesotans 2004* states that although Minnesota ranks among the top 10 healthiest states in the U.S., it ranks 23rd in the nation in providing adequate prenatal care. Figure 10 displays the rates at which Minnesota's HMOs provide prenatal care in relation to the overall Year 2000 target rate of 95 percent. Since 1997 was the first year of data collection, MDH has no 1996 measure against which to assess HMO plan performance. It is clear from the graph, however, that members in Group Health's commercial plans

receive prenatal care at a rate slightly exceeding the Year 2000 target with Metropolitan Health Plan very close to the target at 94.4 percent. Considerable room for improvement in prenatal care rates exist for women enrolled in some HMO plans serving PMAP members (Table 4). This diverse population is of special interest to MDH because of the birth outcome disparities found to exist among PMAP's population of color. MDH has made eliminating health status disparities a top priority for 2004 and beyond.

Figure 10, Prenatal Care in the First Trimester

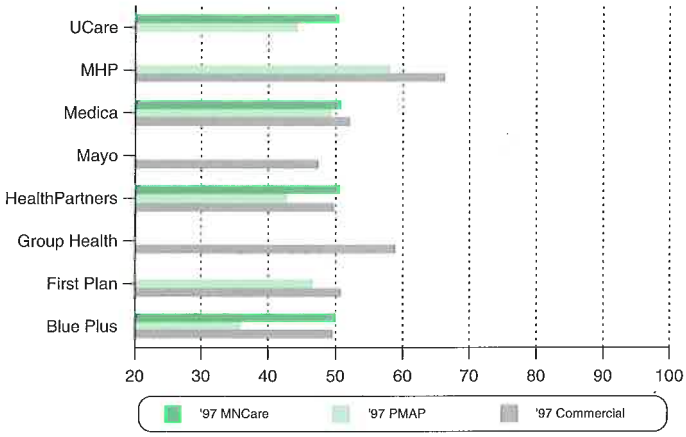
% Women with live newborn receiving care



Diabetes is a major cause of blindness, kidney failure, and lower-extremity amputation. Cardiovascular disease is two to four times more common in people with diabetes. It is the seventh-leading cause of death in Minnesota and the third-most-common cause listed anywhere on death certificates. There are at least 2,700 estimated cases of diabetes-related blindness in the state and the number of Minnesotans with diabetes is increasing. As part of a comprehensive diabetes management strategy, MDH measures the rate of retinal exams for specific populations with diabetes. Results of the 1997 HMO measurement appear in Figure 11. The chart shows that, on average, the rate for eye exams for persons with diabetes hovered around 50 percent in 1997 among Minnesota's HMO plans. There is considerable room for improvement in these rates as annual eye exams become a standard of care for persons with both Type I and Type II diabetes. No Year 2000 rate target has been set for this component of diabetes care.

Figure 11, Eye Exams for Persons with Diabetes

% 31 yrs and older receiving retinal exam



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