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.

---

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]

---

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

---

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.**

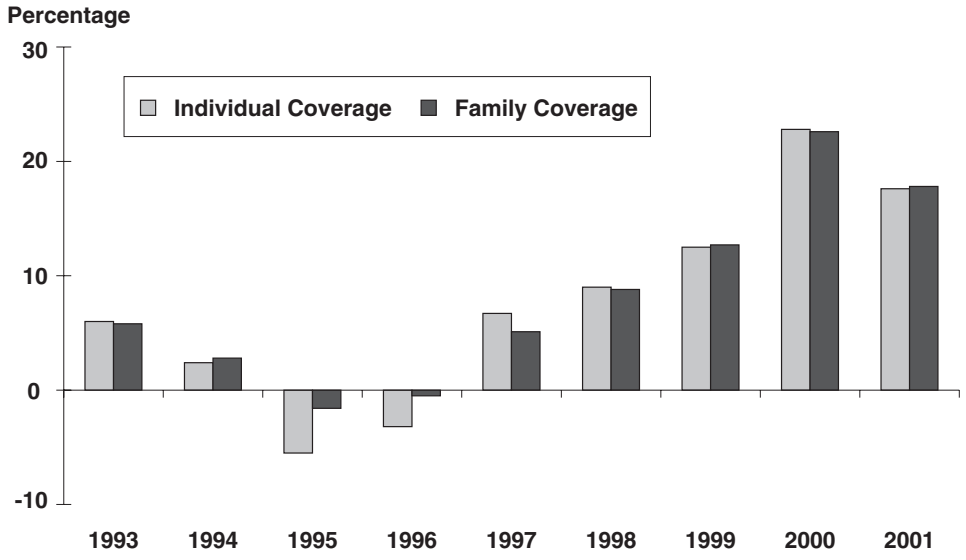
Figure 2.1 shows changes in average weighted premiums from 1992 through 2001. Average annual growth was low through the mid-1990s, actually declining in 1995 and 1996. But premiums began to rise sharply in 1998, increasing 9 percent over the previous year. Since that time, overall premiums for individual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

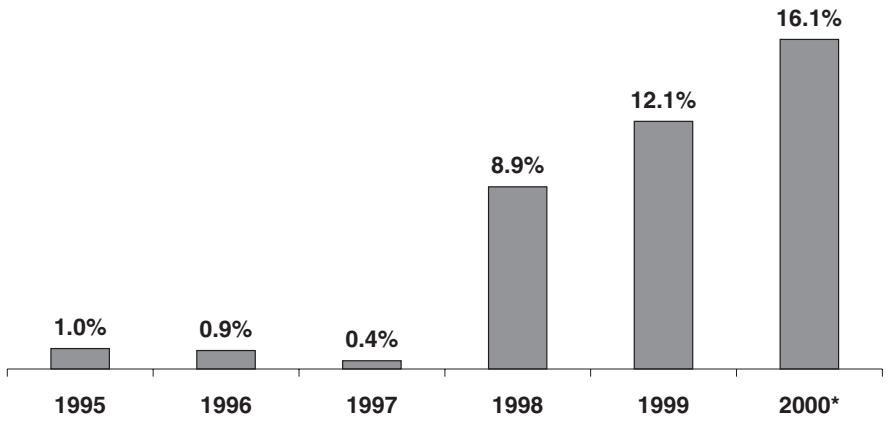
show that growth in health insurance premiums nationwide was low in the mid-1990s, but have accelerated in recent years—similar to the trend for Minnesota state government. For example, nationwide surveys by the Kaiser Family Foundation found that the average annual growth rate of insurance premiums 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.

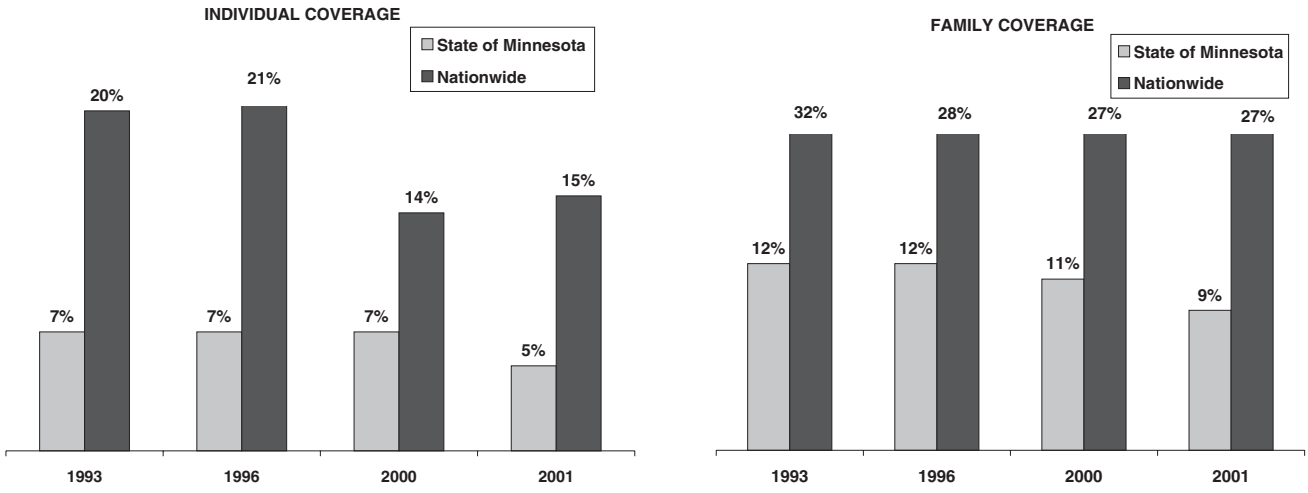
Finally, data from a small sample of 14 public and 8 private employers in the Twin Cities metropolitan area show that public employers generally contributed anywhere from 92 to 100 percent of the premium for individual coverage in their lowest cost plan in 2001 and from 68 to 93 percent of the family 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,

---

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.

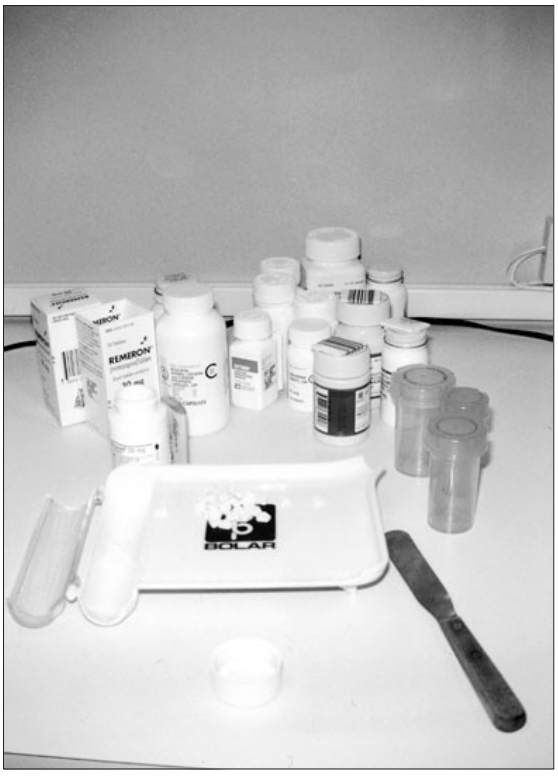
administrative and physician services increased 7.8 and 7.4 percent respectively, and inpatient services increased 5.6 percent.

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.**

---

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.

---

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]

---

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.