3 Minnesota Advantage Health Plan

SUMMARY

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

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

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

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

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

DESCRIPTION OF MINNESOTA ADVANTAGE

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

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

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

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

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

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

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

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

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

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

Risk Adjustment

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

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

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

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

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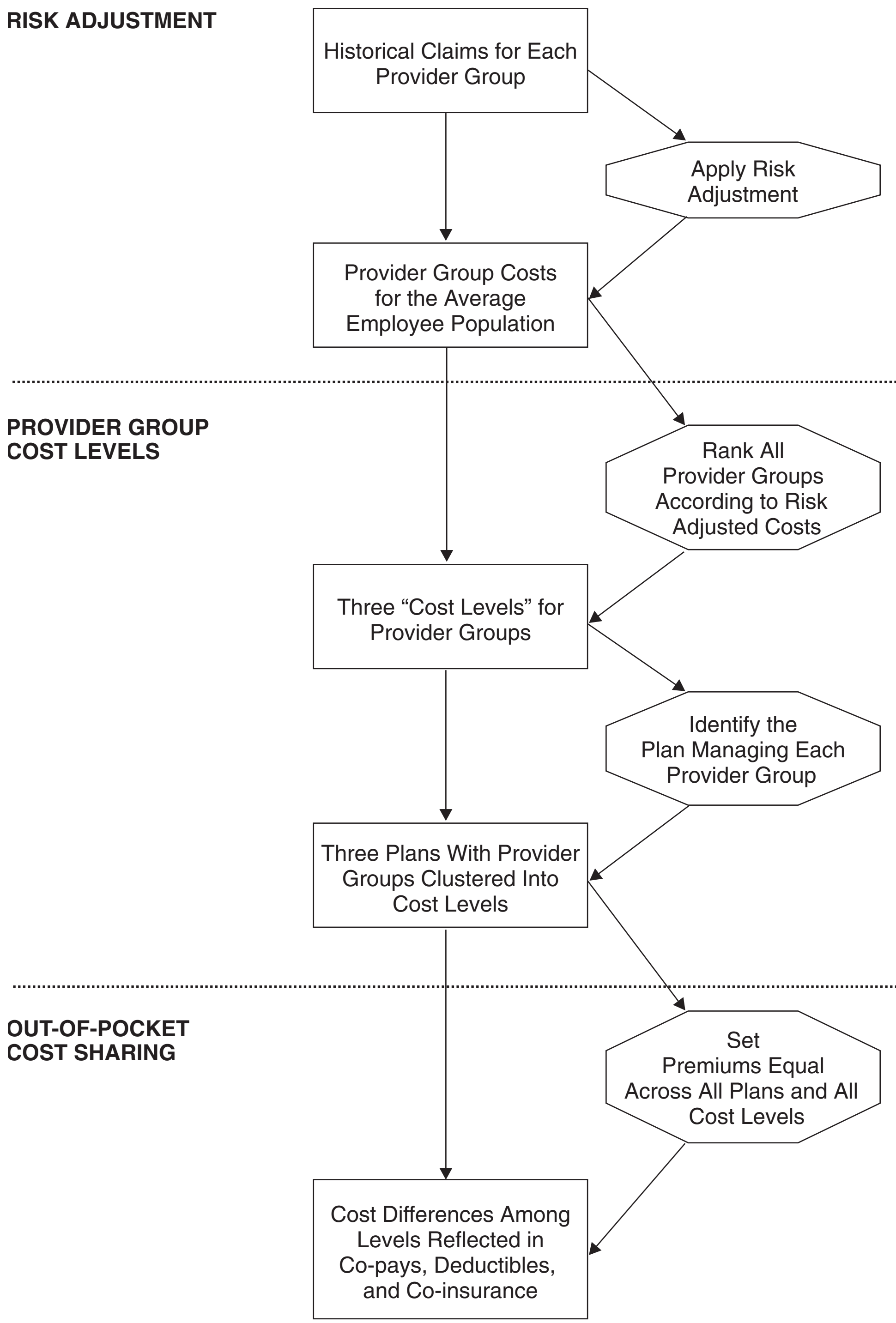
2 Deloitte and Touche, *State Employees Group Insurance Plan (SEGIP): Benefits at the Crossing* (Minneapolis, undated October 2001 version), 38. These projections assumed that employees would not switch to lower cost health plans in response to higher premiums.

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

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

Figure 3.1: The Minnesota Advantage Health Plan Structure



SOURCE: Created by the Office of the Legislative Auditor.

Table 3.2: Risk Adjustment

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

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

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

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

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

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

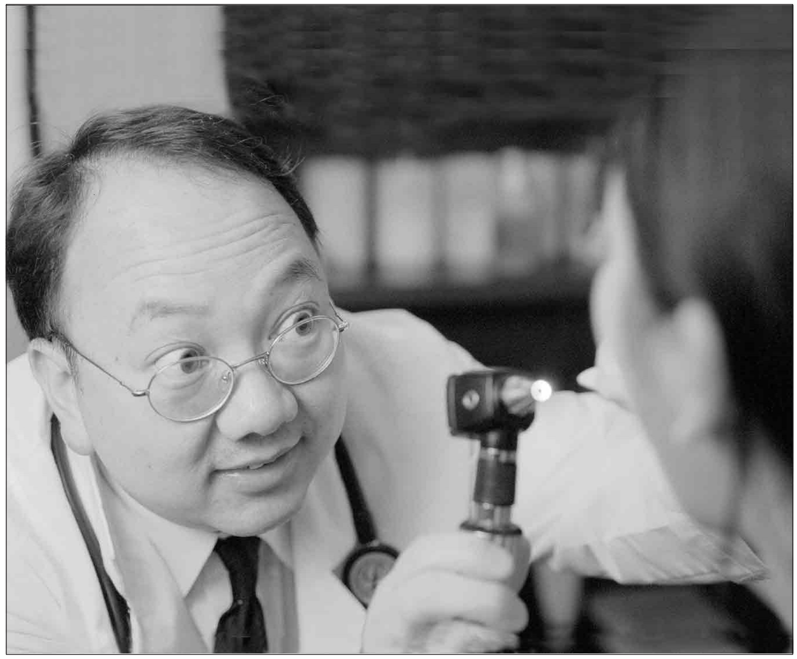
- **The department's practice of risk adjustment could help limit cost increases that occur simply because the most costly employees are concentrated in one or two health plans.**

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

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

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

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



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

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

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

Provider Group Cost Levels

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

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

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

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

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

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

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

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

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

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

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

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

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

In addition:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 Haugen, memorandum, December 21, 2001.

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

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

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

Out-of-Pocket Cost Sharing

Minnesota Advantage increases employee costs at the point of service.

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

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

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

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

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

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

Table 3.4: Minnesota Advantage Health Plan Premiums, 2002

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

SOURCE: Department of Employee Relations.

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

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

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

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

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

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

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

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

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

Shading identifies items where employee costs differ across levels.

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

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

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

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

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

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

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

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

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

18 Haugen, memorandum, December 21, 2001.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan members have some costs at the point of service.

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

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

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

BUDGET IMPACT OF THE MINNESOTA ADVANTAGE HEALTH PLAN

The department projects modest savings from Minnesota Advantage.

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

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

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

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

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

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

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

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

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

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

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

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

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

Overall, we think that:

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

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

Second, how employees and providers respond to Minnesota Advantage's incentives to control costs will affect potential cost savings. According to the department, two provider groups have recently negotiated new financial arrangements with their health plan carriers for 2002 that should increase savings to the state beyond what is shown in its estimate.[22] But, as discussed previously, several factors may weaken the new plan's incentives for providers and employees to control costs further, including local market conditions and the high concentration of providers and employees already in the lowest cost level.

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

RECOMMENDATION

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

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

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