SUMMARY

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

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

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

- What are the advantages and disadvantages of each option?

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

As we described in Chapters 2 and 3, the department has implemented many cost-control features related to managed care and managed competition principles. Table 4.1 summarizes several structural alternatives for cost control and identifies the alternatives that the state has not implemented. Overall:
The Department of Employee Relations has already incorporated many of the structural features that the literature identifies as potentially promoting cost control, such as self-insurance, managed care plans, and employee co-pays, deductibles, and co-insurance.

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

PRESCRIPTION DRUG CO-PAYS

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

A formulary drug is included in a list of drugs that are covered by a health plan at the least cost to the employee. A non-formulary drug may be covered at a greater cost to the employee or not at all.

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

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


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

<table>
<thead>
<tr>
<th>Level of Co-Pay</th>
<th>Prescription Drug Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>$$$</td>
<td>Brand name drugs—generic substitute available</td>
</tr>
<tr>
<td>$$</td>
<td>Brand name drugs—no generic substitute available</td>
</tr>
<tr>
<td>$</td>
<td>Generic drugs</td>
</tr>
</tbody>
</table>

SOURCE: Compiled by the Office of the Legislative Auditor.

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

2 Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2001 Annual Survey (Menlo Park, CA and Chicago, IL, 2001), 118.
because drug manufacturers have increased the price of generic drugs in recent years, thereby minimizing the price difference between generic and brand name drugs.¹ Others suggest that the approach has failed to substantially increase consumer use of less expensive drugs because co-pays are low relative to the actual costs of the drugs.⁴

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

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

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

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

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⁵ Perlstein, “Four-Tier Approach.”

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

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

RECOMMENDATION

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

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

SEPARATE CONTRACTS FOR SPECIFIC SERVICES

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

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7 Kreling, *Cost Control for Prescription Drug Programs*, 6-7.
8 Dalzell, “Pharmacy Copayments: A Double-Edged Sword.”
services. These arrangements, often referred to as “carve-outs” or “carve-ins,” are described in Table 4.4. They are used because an employer or health plan carrier believes that a specialized contract can better manage the cost and quality of specific services.

Table 4.4: Typical “Carve-Out” and “Carve-In” Provisions

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

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


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

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

### Table 4.5: Share of Insured Workers Receiving Benefits Through Carve-Outs, 2001

<table>
<thead>
<tr>
<th>Type of Carve-Out</th>
<th>All Firms</th>
<th>Very Large Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drug</td>
<td>32%</td>
<td>52%</td>
</tr>
<tr>
<td>Mental Health/ Substance Abuse</td>
<td>22</td>
<td>37</td>
</tr>
</tbody>
</table>

*aPercentages represent insured workers nationwide and includes carve-outs established through direct employer contracts or health plan subcontracts.

bEmployers with more than 5,000 employees.

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

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

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

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

Overall, we think that:

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

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

The Department of Employee Relations considered implementing a pharmacy carve-out a few years ago and indicated that it might evaluate this alternative again in the near future. If the department were to pursue a separate contract for pharmacy services, it could eliminate the current variation in practices across plans or could identify one vendor that is more efficient than others. Because the department has not identified adverse selection as a problem that is specific to pharmacy benefits, we do not believe that there would be significant gains from simply eliminating variation across plans. Therefore, the primary benefit of evaluating this option would be to assess the relative efficiency of the specialized management offered by the existing plans and other potential contractors. If the state identifies a single contractor that is significantly more efficient in providing pharmacy benefits than the existing plans, the potential cost savings would need to outweigh the disadvantages associated with contract carve-outs. Based on our interviews with industry experts, the problems associated with data sharing and coordination of care may be the most difficult obstacles for the state to address.
Health plans with defined contribution options involve an employer committing a specific dollar amount toward employees’ health care benefits instead of providing a package of benefits with open-ended costs. These approaches typically shift the risk and responsibility of managing those dollars to employees. As shown in Table 4.6, defined contribution approaches fall along a continuum, depending on how much control employees have over spending. They range from group plans, which give employers the most direct control over how dollars are spent, to individual health benefit accounts, which significantly increase employees’ control.

We found that:

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

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

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

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

As shown in Table 4.7, many of the new approaches to defined contribution try to maintain the advantages of group insurance while introducing some of the advantages of individual accounts. For example, one of the plan choices available
### Table 4.6: Defined Contribution Options

<table>
<thead>
<tr>
<th>Option</th>
<th>Status Under the State’s Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer-Sponsored Group Benefits with a Defined Contribution</td>
<td></td>
<td><strong>Fixed-Dollar Contribution from the Employer</strong></td>
</tr>
<tr>
<td>Cafeateria Plans or Flexible Benefits (Section 125 of the Internal Revenue Code)</td>
<td>Not available</td>
<td>Cafeateria plans are tax-preferred plans that allow an employee to choose between cash and directing a portion of dollars to &quot;qualified benefits.&quot; Allowable benefits include, but are not limited to, health coverage (group medical, dental, or vision), group term life insurance (up to $50,000), accidental death insurance, short or long-term disability insurance, dependent care expense reimbursement, and medical expense reimbursement. They are used to allow the employee share of health insurance premiums to be paid on a pre-tax basis. Employees must make benefit elections prior to the beginning of each plan year.</td>
</tr>
<tr>
<td>Individual Health Benefit Accounts with a Defined Contribution</td>
<td></td>
<td><strong>Health Care Reimbursement Accounts or Flexible Spending Accounts</strong></td>
</tr>
<tr>
<td>Personal Health Accounts</td>
<td>Not available</td>
<td>These are personal accounts funded with tax-free contributions that can be used to buy health insurance or pay for medical expenses not otherwise covered by insurance. Unused amounts are being rolled over and accumulated from year to year. The accounts only include employer contributions.</td>
</tr>
<tr>
<td>Medical Savings Accounts</td>
<td>Not available to large employers</td>
<td>These are personal accounts funded by tax-free contributions. Under current federal laws, the accounts are only available to employees of firms with fewer than 50 employees, the self-employed, or the uninsured. The funds can be used to pay itemized health care bills; can be accumulated for use in future years; and can be withdrawn for other purposes after paying taxes and fees. These accounts can include both employer contributions and employee contributions, but cannot be used to purchase insurance.</td>
</tr>
<tr>
<td>Stipend for Health Care Purchases—Higher Wages in Lieu of Health Insurance</td>
<td>Not available</td>
<td>A stipend for health care purchases increases salaries and removes the employer entirely from the role of providing health benefits. This approach is often referred to as the most &quot;pure&quot; form of defined contribution. Under this approach, employees and the employer lose the current tax advantages of health insurance purchasing. This option is not feasible due to loss of tax preferred status for health insurance payments.</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Table 4.7: Comparison of Group and Individual Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td>Pooling of sicker and healthier people so cross subsidies can occur</td>
</tr>
<tr>
<td>Economies of scale in administration</td>
</tr>
<tr>
<td>Lower health care prices due to clout from group purchasing</td>
</tr>
<tr>
<td>Better information on the quality of care due to the role of the employer</td>
</tr>
<tr>
<td>Tax benefits</td>
</tr>
<tr>
<td>Greater individual choice with respect to providers and covered services</td>
</tr>
<tr>
<td>Less intrusion into the physician-patient relationship</td>
</tr>
<tr>
<td>Less inefficiency due to over-utilization (if an individual is allowed to keep account surpluses)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Individual Insurance</strong></th>
<th><strong>Group Insurance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Segmentation of the insurance market, leaving sicker people in traditional plans with higher premiums</td>
<td></td>
</tr>
<tr>
<td>Higher administrative costs</td>
<td></td>
</tr>
<tr>
<td>Higher health care prices due to less purchasing clout</td>
<td></td>
</tr>
<tr>
<td>Poorer information on the quality of care</td>
<td></td>
</tr>
<tr>
<td>Potential to neglect preventive care</td>
<td></td>
</tr>
</tbody>
</table>

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

**Personal Health Accounts With a Group Insurance Plan**

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

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

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

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

We discuss each of these considerations below.

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

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15 Expanding the use of cafeteria plans would require the state to either increase the total dollar contribution for benefits or allow employees to decrease the dollars contributed to an existing benefit, such as salaries, in order to increase the dollars for an alternative benefit. Evaluating this option is beyond the scope of the report.
Expanded choice may be particularly attractive to employees who previously had only a single plan offered or a limited choice of providers or who have a strong interest in expanding coverage. For example, the University of Minnesota is using a personal health account and high deductible insurance plan offered by Definity Health as one way to address employee desires to expand access to alternative health care providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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**RECOMMENDATION**

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

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

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**DISTRIBUTION OF COSTS**

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

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**Relationship Between Individual and Family Premiums**

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

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

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

Table 4.8: Comparison of Different Ratios of Individual to Family Premiums

<table>
<thead>
<tr>
<th></th>
<th>2.5 Ratio</th>
<th>2.7 Ratio</th>
<th>2.9 Ratio</th>
<th>3.2 Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Premium</td>
<td>$279</td>
<td>$262</td>
<td>$247</td>
<td>$226</td>
</tr>
<tr>
<td>Employee Share</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Employer Share</td>
<td>279</td>
<td>262</td>
<td>247</td>
<td>226</td>
</tr>
<tr>
<td>Family Premium</td>
<td>698</td>
<td>709</td>
<td>718</td>
<td>732</td>
</tr>
<tr>
<td>Employee Share</td>
<td>42</td>
<td>45</td>
<td>47</td>
<td>51</td>
</tr>
<tr>
<td>Employer Share</td>
<td>656</td>
<td>664</td>
<td>671</td>
<td>681</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

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

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

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

\footnote{21} Recent data on the employer share of premiums in Minnesota are not available. However, a 1997 survey conducted in conjunction with the Robert Woods Johnson Foundation indicates that the employer share of family coverage in Minnesota for all employers averaged 70 percent. National statistics from 1996 to 2001 indicate that for all size employers, the average employer contribution to family coverage has been relatively stable and very comparable to the contribution rates in Minnesota—approximately 72 percent. Kaiser Family Foundation, Employer Health Benefits 2001, 87; and Minnesota Department of Health, Employer-Based Health Insurance in Minnesota (St. Paul, February 2000), 42.
Table 4.9: Hypothetical Comparison of Employee Cost-Sharing Requirements for Family Coverage, 2002

<table>
<thead>
<tr>
<th>Cost-Sharing</th>
<th>State Plan</th>
<th>Spouse’s Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Share of Monthly Premium</td>
<td>$51</td>
<td>$187&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Employee Share of Annual Premium</td>
<td>609</td>
<td>2,243</td>
</tr>
<tr>
<td>Annual Deductibles&lt;sup&gt;b&lt;/sup&gt;</td>
<td>200–600</td>
<td>406</td>
</tr>
<tr>
<td>Office Visit Co-Pays&lt;sup&gt;c&lt;/sup&gt;</td>
<td>5–20</td>
<td>5–15</td>
</tr>
<tr>
<td>Co-insurance Rates&lt;sup&gt;d&lt;/sup&gt;</td>
<td>0–10%</td>
<td>0–40%</td>
</tr>
</tbody>
</table>

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

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

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

<sup>d</sup>The co-insurance rates for the state plan reflect the range of co-insurance required across cost levels. The co-insurance rates for the spouse’s plan reflect the range of 2001 co-insurance rates required in PPO plans.

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

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

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

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

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

**Required Participation in the State Health Insurance Program**

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

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

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**Note:** Kaiser Family Foundation, *Employer Health Benefits 2001*, 87.