1. **Program Name**

Minnesota Advantage Health Plan

2. **Administering Agency**

Minnesota Department of Employee Relations

3. **Contact Person (Name and Title)**

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9. **Please provide a two-sentence description of the program.**

The Minnesota Advantage Health Benefits Plan is an innovative, cost-tiered employee health benefits plan serving 120,000+ members of the State Employee Group Insurance Program (SEGIP) that has saved the state and employees millions of dollars, while creating new levels of competition and incentives for efficiency in the health care market. Advantage’s unique design places primary care clinics available to SEGIP members into one of four cost levels based on their risk-adjusted costs of delivering care and as
negotiated in collective bargaining; members may choose any primary care clinic, but pay higher copays, deductible, and coinsurance for more costly choices.

10. How long has this program been operational (month and year)? Note: the program must be between 9 months and 5 years old on May 1, 2004 to be considered.

The program became operational January 1, 2002.

11. Why was the program created? (What problem[s] or issue[s] was it designed to address?)

Advantage was created because the previous employee health benefits program was rapidly becoming unaffordable. By the end of the 1990’s, the State was experiencing annual rates of health care increases approaching 20% per year. Moreover, because of adverse selection among the health plan offerings of the previous health benefits arrangement, it appeared that several health plan options would no longer be able to attract enough members to be viable. Their loss would result in restricted choices and access to health care providers for employees and their families, and lead to further cost escalation.

Advantage was designed to meet this crisis, and to help address fundamental health care cost, quality, and access issues confronting many employers and states. In particular, Advantage was designed to:

- Help the State transition away from providing nearly “first dollar” levels of comprehensive health coverage with low out of pocket costs in a heavily unionized state workforce, toward greater employee out of pocket cost sharing in the form of copays, deductible, and coinsurance;

- Respond to increasing health care provider and health plan consolidation in the market, which had led to corresponding reductions in meaningful competition and choices, and reduced leverage for the state as a major health care purchaser;

- Provide SEGIP members with new levels of information about health care provider costs of delivering care, as well as incentives to choose more cost-effective sources of care. This strategy was fundamental in addressing significant variation in provider costs found at the level of the clinic system or “care system” most directly involved in patient care decisions. The significant cost differences remained even after employing a sophisticated risk adjustment tool developed at Johns Hopkins University and used widely around the country;

- Create new incentives for health care providers to justify their costs and become more cost-effective, or risk loss of market share;
Retain as many options and choices of health care providers for employees and their families as possible, while providing for greater accountability for the costs of those choices.

12. Describe the specific activities and operations of the program in chronological order.

The basic structure of Advantage is negotiated biennially with the unions representing over 90% of state employees. Collective bargaining on health benefits is conducted in a coalition format that brings together all state bargaining units in the odd numbered years. Results of the bargaining for health benefits then apply to all unions and to non-union employees as well. Health benefits bargaining is conducted for the State by DOER’s Labor Relations Division, with support from the Employee Insurance Division, which administers SEGIP and Advantage.

Under Advantage, primary care clinic systems available to state employees are ranked according to their risk adjusted costs of delivering health care. Those with the lowest risk-adjusted costs are place in “cost level one”, those with higher costs in levels two, three or four (for the highest cost clinic systems). Employees are free to choose the primary care clinic of their choice and may change their selection throughout the year. However, their copays, deductible, and coinsurance will vary according to the cost level of their primary care clinic. For example, employees selecting a “level one” primary care clinic pay a $15 doctor’s office visit copay, while those choosing “level two” or “level three” pay a $20 office visit copay, and those selecting a level four clinic (the highest cost level) pay 30% coinsurance for their office visit. Similar differentials exist across a number of types of health care services.

The collective bargaining process determines the number of provider cost levels, employee cost sharing at each cost level, and employer and employee premium contribution levels. In addition, the unions have historically bargained for access statewide by all employees to health care providers at a designated cost level.

Most recently, as a result of the 2003 round of collective bargaining, Advantage has four cost levels. In addition, the bargained agreement included provisions for guaranteed access to at least “cost level two” primary care providers within 30 miles or 30 minutes of the employees’ work location or place of residence. This is significant because in some areas of the State outside the Minneapolis-St. Paul metropolitan area, there are no naturally occurring level one or level two health care providers. In order to meet the terms of the bargained agreement on geographic access, the State selectively makes other higher cost level providers available at the lower cost level. This represents a subsidy of a limited number of clinic locations, and a cost to the State.

Each spring, the DOER Employee Insurance Division, with its consulting actuaries, reviews risk-adjusted claims data on clinic systems throughout the state in order to assign them to Advantage cost levels. The clinic systems are informed of their ranking and
given time to respond or to request additional information. In several instances, clinic systems placed in higher cost levels have voluntarily negotiated financial concessions with the state in the form of lowered rates of reimbursement in order to be available at lower cost sharing levels to state employees. The clinic system cost level configuration of Advantage is reviewed and agreed to with the unions in non-bargaining years through a meet and confer process held in early summer.

Materials and communications summarizing Advantage are then prepared to make available to employees in preparation for the annual open enrollment in the fall of each year. A website is established with a special tool that allows employees to determine locations, cost levels, and other information of primary care clinic sites of possible interest.

During open enrollment, employees and their family members select a primary care clinic with its corresponding cost level. Family members may select different clinics, in different cost levels, and may change cost levels up to twice a year. General information and related links regarding Advantage can be found at the DOER website, http://www.doer.state.mn.us/ei-segip/health.htm. The clinic look-up tool can be found at http://www.doer.state.mn.us/insdir/provider_directory.asp.

13. **Why is the program a new and creative approach or method?**

While there are other examples of tiered benefit plan or health care purchasing arrangements, Advantage is new and innovative for:

- **Creating a new health care purchasing focus based on smaller, local “clinic systems” rather than large regional or national health plans.**

Advantage shifts the traditional health care purchasing focus from the conventional health plan (HMO) level to a more useful, more actionable “clinic systems” level [also known as “care systems”, or “accountable provider networks”, and including Physician Hospital Organizations (PHOs) and other delivery systems]. Conventional health plans typically contract with clinic systems to provide health care to their enrollees. Clinic systems, including primary care clinics, are where health care decisions are typically made and where consumers most strongly identify the source of their health care. Until the advent of the Advantage cost-tiered concept however, employees and their families lacked information on the differences in clinic system costs and had no incentives to use more cost-effective clinic systems. Focusing at the level of the clinic system has: provided greater transparency of health care costs, and greater awareness by both employees and health care providers of cost differences among providers; bolstered competition among health care providers for market share; and, resulted in greater negotiating leverage for the state as some clinic systems have negotiated substantially lowered rates of reimbursement in order to be available to employees at a lower cost-sharing level under Advantage.

- **Cost-tiering based on all health care services and costs.**
Some tiered benefit designs focus on just a single component of health care service delivery and costs, such as inpatient hospital services. Advantage captures comprehensive, risk-adjusted claims data from a claims data warehouse to accurately compile and compare the costs of delivering all services to our population, including pharmacy, physician, inpatient, outpatient, specialty, and ancillary care. The risk-adjusted cost data on all services are assigned to the appropriate primary care delivery system as the essential unit of analysis, and as the source of referrals and the subsequent cascades of care resulting from decisions made at the primary care level. This provides for meaningful overall comparisons of the relative efficiencies of primary care-based clinic systems in caring for our population.

- **The introduction of risk adjustment**

Advantage uses a risk adjustment tool developed at Johns Hopkins University known as Adjusted Clinical Groups (ACGs). Risk adjustment is key to any competitive health care purchasing strategy, to ensure apples-apples comparisons and to adjust for differences in patient mix that might otherwise lead to false conclusions about the underlying costs of care providers.

- **Use of out of pocket cost sharing at the point of service to differentiate among provider cost levels**

While some other tiered models have used premium pricing to differentiate between tiers, the Advantage model employs uniform premium rates (one rate for single coverage, and one rate for family coverage) that are the same regardless of the cost level of the primary care clinic chosen by the employee. Advantage’s method of differentiating provider cost levels by varying copays, deductibles, and coinsurance was chosen for the following reasons:

  - *Usefulness in collective bargaining and in transitioning to greater employee cost sharing at the point of service.* Advantage’s signature concept of variable levels of out of pocket cost sharing was advanced at least in part to help ease the transition to a benefit plan design with more copays, deductibles, and coinsurance. Under Advantage, employees can enroll with a health care provider available at a lower cost sharing level if they want to minimize their copays, etc. This option helped provide a useful transition to a new health benefits design with point of service enrollee cost sharing.

  - *Continual reinforcement of underlying cost differences and their consequences.* Paying a differential rate in the form of higher premiums does not continually reinforce the consequences of provider selection and care seeking behaviors. Paying higher copays, deductibles, and coinsurance with each service reinforces the consequences of choosing higher cost providers each time the service is provided.
- **More affordable monthly premiums.** The point of service cost sharing associated with each cost level kept premiums more affordable while also retaining the full complement of health care providers that had been available previously.

- **Ease of administration and communication.** Advantage was less complicated and difficult to implement and administer than a premium-differentiated alternative. This was particularly important as the state was committed, at the time, to an extensive upgrade of its overall HR-payroll-benefits computer system using the PeopleSoft platform.

Advantage’s new design was also easier to communicate to employees and more readily understood than a premium differentiated approach. For most employees, the key message was simply that their share of premiums continued to be low – roughly the same level that had been in place under the previous health benefits plan. If employees were willing to choose a “cost level one” (low cost) primary care clinic, their additional out of pocket costs would be low as well. Evidence of Advantage’s relative simplicity can be found in the speed with which the program was implemented following resolution of bargaining in 2001. Negotiations with the unions regarding Advantage were not completed until mid-October, 2001. A successful open enrollment for Advantage for the more than 120,000 SEGIP members was held shortly thereafter during the first two weeks of December, 2001, and the new plan year commenced on January 1, 2002. Despite the short timeframe to prepare for and conduct the open enrollment, it was one of the most successful ever.

- **More flexibility with regard to mid-year changes.** Federal laws regarding the pre-tax status of health coverage expenditures require that the employee essentially be locked in at a certain premium level for the plan year. In a premium differentiated arrangement, once employees chooses a cost tier with its associated premium cost, they cannot move “up” to a more expensive tier during the year. With the Advantage design, employees can change to different clinics in different cost tiers during the year. Employees’ premium costs remain the same regardless of the cost level of the clinic they select – what changes are their copays, deductibles, and coinsurance.

- Development of a comprehensive claims data warehouse and related analytic capabilities

A significant development in the design and preparation of Advantage was the construction of a comprehensive claims data warehouse, including pharmacy claims. The data warehouse has also figured prominently in a new risk management initiative to more effectively target and utilize disease management, prevention, and wellness programs to improve the health of the SEGIP population and reduce claims costs. In 2002, data from the warehouse was analyzed to determine the key burdens of illness and their corresponding costs in the population. As a result of the analysis, a number of key target conditions such heart disease, diabetes, and asthma were identified for interventions.
DOER negotiated contracts for 2003 and 2004 with the health plan administrators of the Advantage program that included new levels of performance incentives and guarantees for meeting performance standards for the target conditions. In the future, we anticipate exploring whether similar outcome and quality indicators can be discerned at the primary care system level. We believe the optimum Advantage design may be one which incorporates both risk-adjusted claims costs as well as quality indicators in configuring the Advantage cost tiers and benefits design. The Advantage plan design, claims data warehouse, and lessons learned to date in designing, bargaining, and implementing Advantage, have positioned us to take the next important step to improved health care purchasing and benefit plan administration.

14. What were the program’s start-up costs? (Provide details about specific purchases for this program, staffing needs and other financial expenditures, as well as existing materials, technology and staff already in place.)

Total start-up costs were $1.2 million. Start-up costs included initial actuarial consulting, risk-adjusting claims data, and use of additional actuarial consulting and costing models during extensive collective bargaining. All other related start-up work was performed by existing staff using existing capabilities.

15. What are the program’s annual operational costs?

Annual operational costs are $346,000, primarily for use of a claims data warehouse, and risk-adjusting claims data.

16. How is the program funded?

The program is funded through employee and employer contributions that are established in collective bargaining with the unions. The bargained outcome also applies to nonbargained state employee as well.

17. Did this program require the passage of legislation, executive order or regulations? If YES, please indicate the citation number.

No.

18. What equipment, technology and software are used to operate and administer this program?

The principal resource needed for Advantage is a claims data warehouse and related analytic capabilities with which to establish risk-adjusted costs of health care providers and to place them in appropriate cost-levels. The data warehouse is currently maintained and used under contract to support Advantage by SEGIP’s consulting actuaries, Deloitte and Touche, LLP.
In addition, the state has designed special web-based communication features to help employees locate health care providers by cost level, location, health plan affiliation, and other information.

Finally, during the period that Advantage was being developed, implemented, and refined, the State has also made a major change in its benefits administration computer system with the implementation of the “PeopleSoft” benefits administration capabilities. While this change was not necessitated by Advantage, it has been undertaken to be fully integrated with Advantage’s features.

19. To the best of your knowledge, did this program originate in your state? If YES, please indicate the innovator’s name, present address, telephone number and e-mail address.

Yes. Advantage was created by the State of Minnesota. We know of no other example of its kind.

20. Are you aware of similar programs in other states? If YES, which ones and how does this program differ?

No.

21. Has the program been fully implemented? If NO, what actions remain to be taken?

Yes.

22. Briefly evaluate (pro and con) the program’s effectiveness in addressing the defined problem[s] or issue[s]. Provide tangible examples.

As further described below, Advantage has been tremendously effective in a number of areas, leading to: immediate and long term cost savings; changes in the health care market for sustained improvements in health care value; greater consumer engagement in health care decisions; and flexibility, adaptability, and options for the future.

- **Cost savings**

Advantage resulted in significant, immediate cost savings to the State and its employees, with premium savings totaling more than a projected $33 million during the first two years alone compared with maintaining the previous health benefits plan.

In addition, the projected rate of increase in the state's share of costs for the Advantage employee health insurance program for 2004 was 9.98%, compared with national average projected rates of increase for other employers of 14% or more. Advantage's lower rate of increase resulted in savings to the state of $23.9 million over the FY 2004-05 biennium. Moreover, changes in employee cost sharing and other modifications to
Advantage were negotiated during the most recent round of collective bargaining. These changes saved the state an estimated additional $55 million over the FY 2004-05 biennium compared with continuing the Advantage status quo unchanged.

- **Heightened competition and accountability among health care providers**

Prior to Advantage, the State purchased health benefits from three large health plans which together accounted for approximately 80% of the market share in Minnesota. At the time, the State was presented an overall health plan price, which averaged the costs of the health plan’s component clinic systems, making it virtually impossible to know which clinic systems were more or less costly on a risk-adjusted basis than others. The State had lost significant purchasing leverage, options, and flexibility as the health plan market consolidated.

With the advent of Advantage, the focus shifted largely away from the health plan level and to the level of nearly 50 clinic systems around the state. Because clinic systems are smaller and more localized than large health plans, shifts in local enrollment of SEGIP members among competing clinic systems is felt more strongly at the clinic system level than it is at the health plan level. With new levels of risk-adjusted cost information provided on all the clinic systems, and increased market pressures, competition has often intensified among these provider groups. With Advantage, the clinic systems are under heightened pressures to justify or change their underlying costs. In a number of cases, clinic systems have negotiated lower rates of reimbursement for their services in order to be available to SEGIP members at a lower Advantage cost level, saving state taxpayers and employees millions of dollars.

- **New information and incentives, leading to greater engagement of SEGIP members in health care decisions**

As described below, Advantage aided the transition from first dollar coverage to a tiered benefit plan with copays, deductible, and coinsurance. State employees and their family members now have new levels of information and incentives to be more mindful of health care costs and to make sound health care decisions. At the same time, they retain options to choose among providers that are available, and the ability to change providers.

- **Help in transitioning away from “first dollar coverage” to greater point of service cost sharing**

The State of Minnesota is a highly unionized workforce. SEGIP had historically provided comprehensive, nearly “first dollar” coverage with high employer contributions to monthly premium costs and very little out of pocket cost sharing. As bargained with the unions, Advantage provides all employees with access to health care providers at lower cost-sharing levels, while retaining other choices, but with corresponding higher copays, deductible, and coinsurance. The introduction of greater out of pocket cost sharing at the point of service helped reduce premium increases. The continued availability of lower cost sharing options, while retaining the full complement of providers that were previously available (but in many cases now at higher cost sharing.
levels) also provided important options to union members. As a result, Advantage provided the means by which to successfully transition from nearly first dollar coverage, to the introduction of copays, deductibles, and coinsurance, in a highly unionized, collectively bargained environment.

- A useful, easily adaptable platform for further modifications and enhancements in response to changing market and financial conditions

This advantage became evident in the most recent round of collective bargaining in 2003, in response to the budget pressures created by a projected $4.2 billion deficit for the FY2004-05 biennium, the largest in state history. As a result of the budget pressures, changes in Advantage were negotiated with the unions, including the addition of an additional provider cost level and greater cost sharing for employees at each level. The flexibility of the model allowed it to be readily adapted to meet needs expressed in collective bargaining. A voluntary settlement was reached with unions following some benefit plan design changes which reduced the financial exposure of employees who used low cost providers, while increasing the expense for those using higher cost level providers.

23. How has the program grown and/or changed since its inception?

The program has become increasingly more sophisticated in placing providers in cost tiers, and has become more effective in distinguishing among various cost levels of providers for consumers with greater cost sharing at each level.

The program is receiving significant attention and inquiries about possible adoption or adaptation from other Minnesota local units of government and other states.

24. What limitations or obstacles might other states expect to encounter if they attempt to adopt this program?

Adequate, reliable claims data with which to analyze and risk-adjust clinic system costs is essential. The data warehouse created by the State and leading to the development, implementation, and continued refinement of Advantage was a significant investment, and could be an obstacle if states do not have such a resource. However, the payback for having access to a data warehouse is great, as it provides unparalleled information for planning, decision making, and bringing about greater accountability.

States may face significant opposition from health care providers and/or insurers and health plans as the Advantage approach radically redefines established relationships and accountabilities.

State employees and benefit plan members may be opposed to many changes in health benefits. However, Advantage is designed to be as targeted, rational, and flexible a tool as possible to aid in addressing health benefit tradeoffs. In this regard, it may offer many advantages over other alternatives to health care cost containment such as increasing
premiums and other out of pocket costs, eliminating health carriers, reducing provider networks and access to providers, or reducing other forms of employee compensation.

Advantage was not available in the insured health plan market at the time SEGIP participated in it. The State transitioned from a partially self-funded program to fully self-funded in 2000, in order to acquire the necessary data and flexibility to design and implement programs such as Advantage. However, we recognize that the transition to a completely self-funded program may result in costs and financial exposure that could conceivably be an obstacle for some states. (However, to the extent that Advantage-type designs also become prevalent in the insured market, the transition to self-insurance would not be necessary.)

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