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Minnesota State Employee Group Insurance Plan (SEGIP)
Advantage Tiered Network Model

Group Insurance Board Presentation

Deloitte Consulting LLP

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Agenda

- State of Minnesota Advantage Plan Description
  - –Background
  - –Comparison to Wisconsin arrangement
  - –How does the plan work?
  - –Plan design
- Risk Adjustment in a Tiered Network Program
  - –Assessing provider efficiency
  - –Provider placement process
- Results/Outcomes
- Questions/Answers

Why Minnesota Advantage?

- Until 2002 the State Employee Group Insurance Program (SEGIP) had been employing a “Managed Competition model”
  - Successful for many years, the employer contribution was based on the Lowest Qualified Plan by County
  - At one time, there were 12 plans, but consolidation and attrition reduced the number to three
- SEGIP health plans had been experiencing significant healthcare cost increases.
- Member cost share was based on differences in plan premiums.
  - As healthier members switched to low cost plans, the premium differentials increased, causing more members to switch plans.
  - Low cost plans may not have been the most efficient, causing increases in overall costs when more members moved into these plans.
- Result was a reduction in competition among plans and affordable access to all providers

Why Minnesota Advantage?

- Healthcare provider groups had traditionally been rewarded based on a pure cost basis
  - The existing plans arrangements “masked” the impact of inefficient or high cost provider groups
- Low costs may be due to healthier members rather than *efficient* healthcare delivery
- Directing members to low cost but *inefficient* providers will increase costs as their overall plan population becomes unhealthier
- Need to be able to assess and reward *efficiency*
- The introduction of cost sharing provisions at the point of care will reinforce value of provider choice decision elected by members
- Competition introduced among provider groups rather than plans

Advantage – How it Works

- In 2000 SEGIP self-insured all plans primarily to be able to maintain and own their data
  - Captured data for 2000 plan year which helped formulate plan design and network strategy in 2001 for 2002
  - Able to track members (scrambled IDs) by provider group utilization
  - Deloitte Consulting provides the data warehouse
- Network
  - Plan administrators are responsible for contract negotiations and reimbursements which are based on their most favorable contracts
    - Initially, the administrators each had different subsets of the entire provider group population
    - Today, administrators essentially have all provider groups
      - HealthPartners Medical Group (staff model) is only available through HealthPartners

Advantage – How it Works

- Determining Cost Level (Tier) Placement
  - Health care providers grouped into provider groups on statewide basis
    - Provider groups consist of primary care physician clinics and ancillary services
    - Each clinic has own referral, prescribing, and hospital admission characteristics
    - Grouped by recognized care systems
      - Broken into sub-groups where needed
      - Independent clinics grouped regionally to develop credible risk-score
  - Provider groups are assigned to one of four levels based on analysis of historical risk adjusted cost
  - Employer, with the support of the Unions, has control (working with plan administrators) over level and network composition
- Plan Design
  - Cost sharing (copays, deductibles, etc.) is greater for less efficient provider groups
  - Employer has considerable control over benefit plan design
  - Employees and dependents each choose their own provider group which determines their cost level
  - "Gatekeeper" model—participants choose their primary care physician

Advantage – How it Works

- Administration
  - Multiple health plan administrators are used to:
    - Negotiate contracts and manage network
    - Perform core functions such as claims adjudication, disease management
    - Three medical and one PBM
      - BCBS, HealthPartners, and PreferredOne
      - Navitus
  - Public Employees Insurance Plan (PEIP)
    - Uses same arrangements with three plan design options
      - Leverages the administrative and network cost advantages
    - Pooled separately
      - Each participating entity has its own rate

Advantage – How it Works

- Cost
  - Premium and employee contribution is the same for all provider groups and plan administrators
    - Selection of plans based on employee preference or in some cases better access to a provider group
  - When members elect a higher cost level, they pay greater cost sharing each time they receive services
  - Theoretically plan design can be set up so the plan sponsor's cost is constant across all levels (i.e., the higher employee cost sharing is set such that it is equal to the higher provider costs)
    - Advantage was subject to collective bargaining so final plan design did not reflect a "cost neutral" design

Theoretical Advantage Plan Concept
- Member Cost Share Example -

Level	Risk Adjusted Provider Cost	Member Cost Share	Cost to Plan
1	87%	4%	83%
2	96%	6%	90%
3	104%	14%	90%
4	111%	21%	90%

- Differences in risk-adjusted provider cost directly reflected in the cost-sharing for levels 3 and 4
  - Access is “guaranteed” at level 2
- Member movement between levels 2-4 theoretically cost-neutral
- SEGIP was unable to raise member cost share to fully reflect the cost difference in levels 3 & 4 due to collective bargaining agreements

Advantage – 2014-15 Benefit Plan Design

Benefit Provision	Level 1	Level 2	Level 3	Level 4
First $$ Deductible for ALL Services (except drugs and preventive) (S/F)	$75/$150	$180/$360	$400/$800	$1000/$2000
Office Visit Copay (waived for preventive)	$18	$23	$36	$55
Convenience Clinic Office Visit Copay (not subject to deductible)	$10	$10	$10	$10
Emergency Room Copay	$100	$100	$100	25% coinsurance annual deductible applies
Per Admission Copay	$100	$200	$500	25% coinsurance annual deductible applies
Per Outpatient Surgery Copay	$60	$120	$250	
Participant Responsibility Coinsurance for MRI/CT Scan Services	5% after deductible	10% after deductible	20% after deductible	25% after deductible
Participant Responsibility Coinsurance for Services NOT Subject to Copays	5% after deductible	5% after deductible	20% after deductible	25% after deductible
Copay for Prescription Drug Plan (30 day supply)	$12 Tier 1/ $18 Tier 2/ $38 Tier 3			
Maximum Drug Out-of-Pocket Limit (S/F)	$800/$1600			
Maximum Non-Drug Out-of–Pocket Limit (S/F)	$1100/$2200	$1100/$2200	$1500,$3000	$2500/$5000

Advantage CDHP Background

- Effective in 2010, the State Legislature required the State of Minnesota to add a Qualified High Deductible Health Plan (QHDHP) option alongside its current plan offerings for members of the Commissioners and Managers Plan
- Employee payroll contributions are the same for the traditional Advantage Plan and the Advantage CDHP
  - $0 contribution for single coverage
- Although the legislation did not require the State to contribute to the HSA, they initially elected to make contributions in the following amounts: $700 for single coverage / $1,400 for family coverage.
- From 2011 forward, the base contributions to HSAs were $500 single/ $1,000 family and increased to $800 single/ $1,600 family with completion biometric screenings and health assessment
- Enrollment in the initial offering was relatively low with 54 employees selecting the option out of more than 5,000 eligible and has not increased significantly.
  - 2010 enrolled employees: 54
  - 2013 enrolled employees: 60

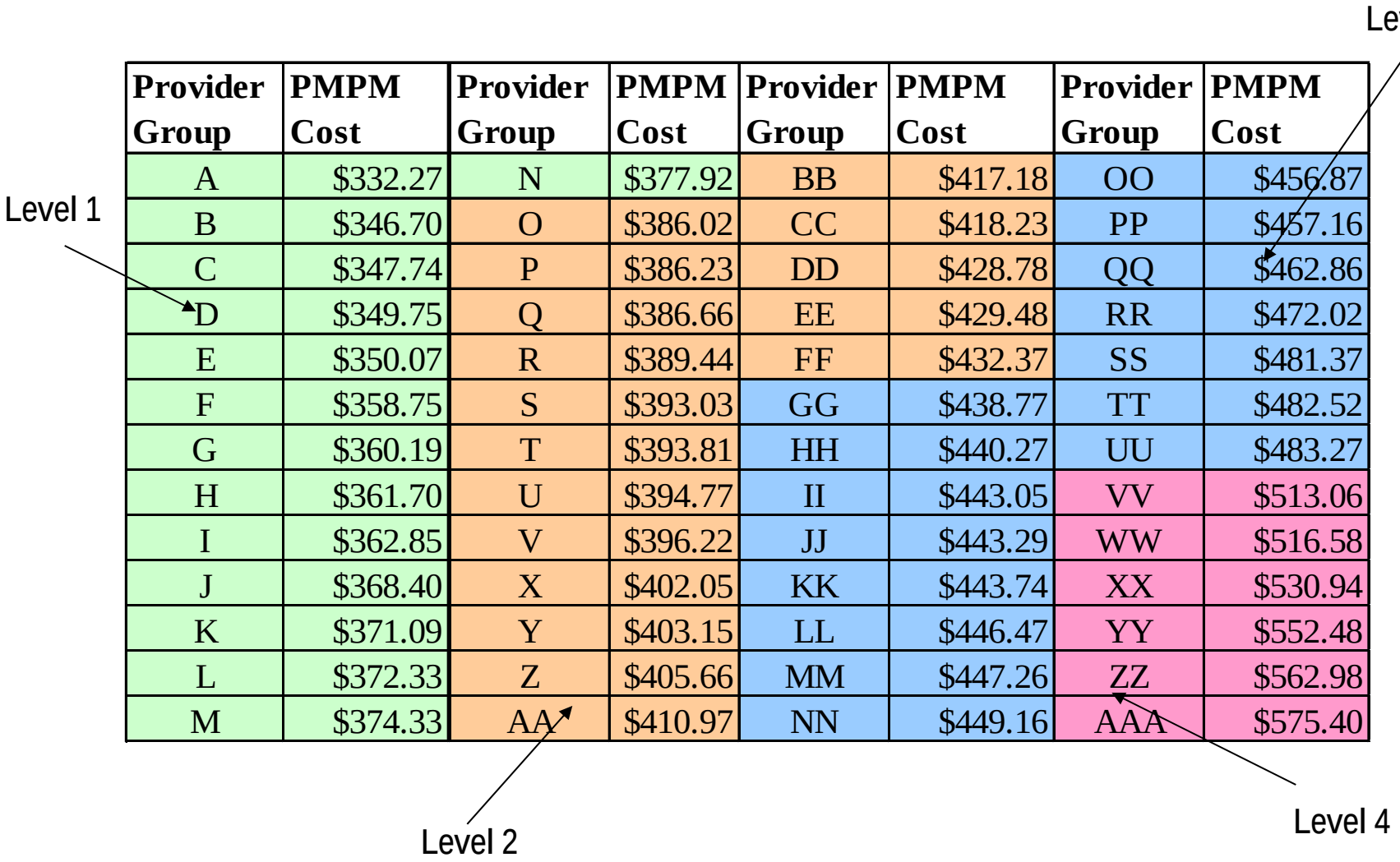
Advantage CDHP – 2014-15 Benefit Plan Design

Benefit Provision	Level 1	Level 2	Level 3	Level 4
Preventive Care Services	Plan Pays 100% of Covered Services			
HSA Contribution	$500/$1,000 base contribution – $800/$1,600 w/ wellness screening & health assessment			
Annual Deductible (S/F)	$1,500/$3,000			
Annual Out-of-Pocket Maximum (includes deductible)	$3,000/$6,000			
Office Visits*	5% after deductible	10% after deductible	15% after deductible	25% after deductible
Convenience Clinics	5% after deductible	10% after deductible	15% after deductible	25% after deductible
Emergency Room	5% after deductible	10% after deductible	15% after deductible	25% after deductible
Inpatient Hospital	5% after deductible	10% after deductible	15% after deductible	25% after deductible
Outpatient Surgery	5% after deductible	10% after deductible	15% after deductible	25% after deductible
Prosthetics and Durable Medical Equipment; Lab, Pathology, and X-ray; MRI/CT Scans; Other (e.g., Ambulance, Home Health Care, Outpatient Hospital (non-surgical))	5% after deductible	10% after deductible	15% after deductible	25% after deductible
Prescription Drugs**	After deductible is met, $12 Tier 1 / $18 Tier 2 / $38 Tier 3			

Assessing Provider Efficiency

- Deloitte maintains a data warehouse of Advantage plan claims data
- Utilize the Johns Hopkins Adjusted Clinical Groups (ACG) System to assess the relative illness burden of the members enrolled in different provider groups
  - The ACG System measures the illness burden of patient populations based on disease patterns, age and gender
- Illness burden is used to risk adjust the claims levels of each provider group and rank them on their relative efficiency into four cost levels
- Provider groups receive a letter notifying them of their initial cost level placement including a ranking by component cost (inpatient, outpatient, professional, Rx) and the additional discounts required to move to a lower cost level
- Provider groups negotiate deals with the plan administrators to improve their final cost level placement

Advantage – Sample Risk Adjusted PMPM Distribution



Provider Group	PMPM Cost	Provider Group	PMPM Cost	Provider Group	PMPM Cost	Provider Group	PMPM Cost
A	$332.27	N	$377.92	BB	$417.18	OO	$456.87
B	$346.70	O	$386.02	CC	$418.23	PP	$457.16
C	$347.74	P	$386.23	DD	$428.78	QQ	$462.86
D	$349.75	Q	$386.66	EE	$429.48	RR	$472.02
E	$350.07	R	$389.44	FF	$432.37	SS	$481.37
F	$358.75	S	$393.03	GG	$438.77	TT	$482.52
G	$360.19	T	$393.81	HH	$440.27	UU	$483.27
H	$361.70	U	$394.77	II	$443.05	VV	$513.06
I	$362.85	V	$396.22	JJ	$443.29	WW	$516.58
J	$368.40	X	$402.05	KK	$443.74	XX	$530.94
K	$371.09	Y	$403.15	LL	$446.47	YY	$552.48
L	$372.33	Z	$405.66	MM	$447.26	ZZ	$562.98
M	$374.33	AA	$410.97	NN	$449.16	AAA	$575.40

Additional Negotiated Discounts

- Prior to final tier assignment, providers are notified of their preliminary placement and the necessary cost reductions
- A provider may switch tiers if they reduce reimbursement levels sufficiently to bring their risk-adjusted costs to the “average” level of their new tier
  - Reduction must be sufficient to offset tier cost-share differential
- Plan administrators translate necessary aggregate cost reductions to necessary fee schedule reductions
- Alliances between PCP groups and hospitals have resulted in tier movement with less cost reduction absorbed by PCPs

Final Placement of Provider Groups

- After provider groups have negotiated any discounts to move tiers, MMB analyzes the access to Tiers 1 & 2
  - Collective bargaining agreements require access to a qualified provider group within 30 miles of worksite
  - MMB will determine if a clinic site needs to be artificially placed in Tier 2 to meet access needs
    - Clinics will be moved without moving the entire provider group

Multiple Administrators

- Having multiple administrators has been beneficial to SEGIP
  - Maintains competition among the plans
    - Impact on administrative expenses and other fees
    - Provider contracting
    - Plan design, disease management, care innovation
    - Risk sharing arrangements and performance guarantees

SEGIP Achievements

- Advantage program received Council of State Governments 2004 Innovation Award
- Stabilized premium contributions
  - Employee contributions reduced overall at inception
- Lower trend than corporate trends of participating plans
- Offers wider choice of provider flexibility
  - All providers are “affordable”
  - More than 85% select Tier 1 or Tier 2 provider groups
- Flexible platform for future modifications and collective bargaining sessions
- Realized additional savings during implementation
  - Certain large provider groups re-negotiated to change benefit level assignment

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