



*Minnesota State Employee Group
Insurance Program*

**Biennial Report
2007-2008**



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I. Program Overview

Minnesota Management and Budget

Minnesota Management and Budget (MMB), an executive branch, cabinet-level state agency, provides financial and human information and analytical services for state government. In this capacity, MMB administers insurance benefits for state employees and other groups under the legislative authority provided in Minnesota Statutes 43A. MMB's Employee Insurance Division (EID) oversees the State Employee Group Insurance Program (SEGIP), which offers a variety of insurance benefits for eligible employees of state agencies and quasi-state agencies.

The departments of Employee Relations (DOER) and Finance were combined in June 2008 to create MMB. Before the merger, DOER housed SEGIP. This report covers calendar years 2007, during which DOER was responsible for SEGIP and 2008 when DOER was merged into MMB.

Reporting requirement

This report has been prepared in accordance with Minnesota Statutes 43A.31, which requires the commissioner of MMB to report biennially to the Legislative Commission on Employee Relations concerning MMB administration and operations of employee insurance benefits. This report covers calendar years 2007 and 2008.

In addition, the report also satisfies provisions in M.S. 43A.31 for:

- A study of local and statewide market trends regarding provider concentration, costs, and other factors as they may relate to the state's health benefits purchasing strategy, including consultation with the commissioners of the departments of Commerce and Health;
- Reporting the number, type, and disposition of complaints relating to the insurance programs offered by the MMB commissioner.

The total cost of salaries, printing, and supplies incurred in development and preparation of this report is \$5,500 (reported as required by M.S. 3.197).

State Employee Group Insurance Program (SEGIP)

SEGIP is the single largest employer group purchaser of insurance in Minnesota, covering approximately 48,300 employees as well as their dependents, for a total of approximately 122,100 covered lives. The program develops and administers coverage for all three branches of state government, including Minnesota State Colleges and Universities (MNSCU), as well as quasi-state agencies, such as the Minnesota Historical Society and the Minnesota Humanities Commission.

The state's share of premiums for insurance-related costs and administration totaled approximately \$475 million in 2007 and \$514 million in 2008. The majority of these costs, nearly 87 percent, were associated with health coverage, with the balance expended for dental, life, and disability coverage and the supporting administration fee. Insurance benefits are a significant feature of total employee compensation, accounting for 13.9 percent of state government's approximately \$3.6 billion payroll in 2008. These expenditures are also an important part of the state budget and make SEGIP an important, visible presence in the state's health care market.

SEGIP is a leader and innovator in insurance design, purchasing, and administration. It was an early adopter of managed health care, a pioneer in implementing a new model of health care market known as "managed competition," and was one of the first employers to measure and report on the

quality of health care. In 2002, it implemented an innovative, tiered health benefits design known as the Minnesota Advantage Health Plan (Advantage) that was unique in the nation. SEGIP continues to innovate and serve as a leader in the development of health plan features that help hold down costs while improving the overall health of its members.

SEGIP introduced two new measures to help employees to become informed health care consumers. It launched an employee newsletter to disseminate insurance benefit information in such areas as Open Enrollment, health and wellness, EAP and retiree information. In addition, working with the labor unions representing state employees, SEGIP implemented a health reimbursement account that rewarded employees for making cost effective health care decisions. These and other programs help employees use their benefits effectively and efficiently.

Innovative programs designed to hold down health care costs, improve the quality of care, and increase access for its members continued to be implemented and refined. These programs emphasize three key areas: targeting member's specific chronic health conditions; providing a set of diverse avenues for members to better understand their insurance benefits, conditions and other health care related questions; and improved methods of accessing and delivering health care.

Many of SEGIP's programs were the result of teaming with other stakeholder groups including the labor unions that represent state employees, the Governor's Health Care Cabinet, as well as other large health care purchasers such as other state agencies and Minnesota employers. By acting in concert with other health care purchasers, SEGIP is able to direct its programs and purchasing power in ways that provide the most return for its dollars and efforts and to help move the health care industry in a more cost effective and quality oriented direction.

Eligibility for benefits

Eligibility for insurance benefits administered by SEGIP and the amounts contributed to their costs by the employer and employee respectively are determined through a combination of statute, collectively bargained labor agreements, and compensation plans. SEGIP provides eligibility and enrollment services for approximately 48,300 employees, 63,700 dependents, 9,500 retirees and 600 COBRA participants.

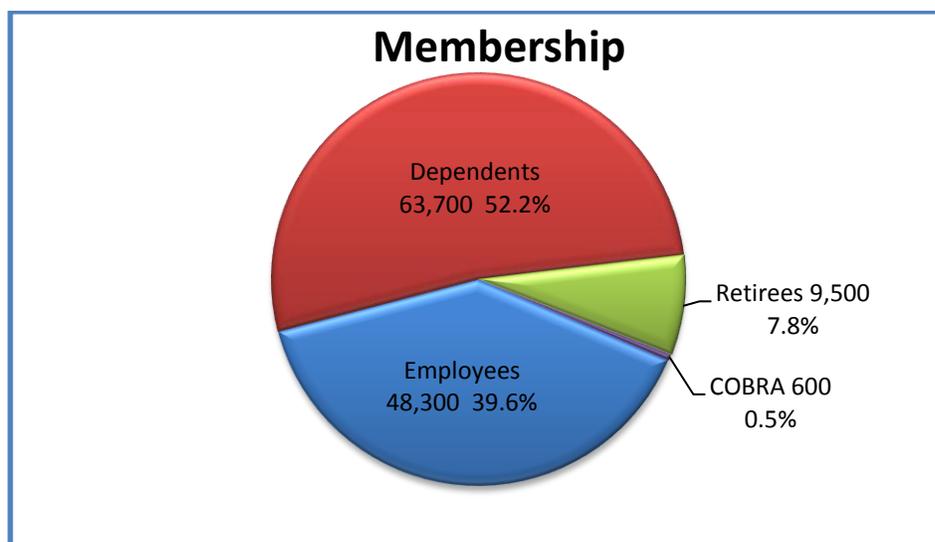


Figure 1 – Membership 2007 - 2008

Minnesota law requires that state employee health benefits be negotiated between the executive branch and the labor unions representing state employees. Approximately 83 percent of all state employees belong to a union. These labor unions represent 22 bargaining units that each negotiates a different contract with the state. However, insurance benefits are negotiated through a coalition of the labor unions and all employees, including the nearly 17 percent of employees who are not represented by unions, receive the same set of benefits.

Insurance benefits with employer contribution

During 2007 and 2008, the state contributed in whole or in part to the monthly cost of premiums for:

- Employee and dependent health insurance
- Employee and dependent dental insurance
- Employee life insurance
- Manager's income protection plan

Optional benefits

Employees could also purchase additional group life, short and long-term disability, and long-term care insurance at their own expense through programs administered by SEGIP. Also available, are pre-tax spending accounts that allow employees to set aside a portion of their compensation, on a pre-tax basis, to fund allowable health, dental, daycare, and transportation expenses.

Specialty programs

SEGIP provides assistance to members for insurance-related issues through a variety of services and programs. These include programs to help members understand their benefits and health issues, disease management programs, and programs to help manage chronic health conditions. There are also programs includes other, health risk assessments, and other services provided by the contracted health plans, other vendors, and in-house resources. Finally, SEGIP offers state agencies and employees and their family members the Employee Assistance Program that works with members to restore and strengthen the health and productivity of employees and the workplace.

Total premiums and administration fees

The total annual premiums and fees collected by SEGIP is well over a half billion dollars per year. Total premiums and administrative costs in 2007 were \$609,566,072 and \$652,337,960 in 2008. Medical premiums were \$530.7 million in 2007 while all other premiums and fees combined amounted to \$78.9 million or 13 percent of total premiums and fees contributed. In 2008, medical premiums were \$570.7 million and all other premiums and fees totaled \$81.6 million or 13 percent of total premiums and fees contributed.

Program Premiums & Fees by Product – 2007 and 2008

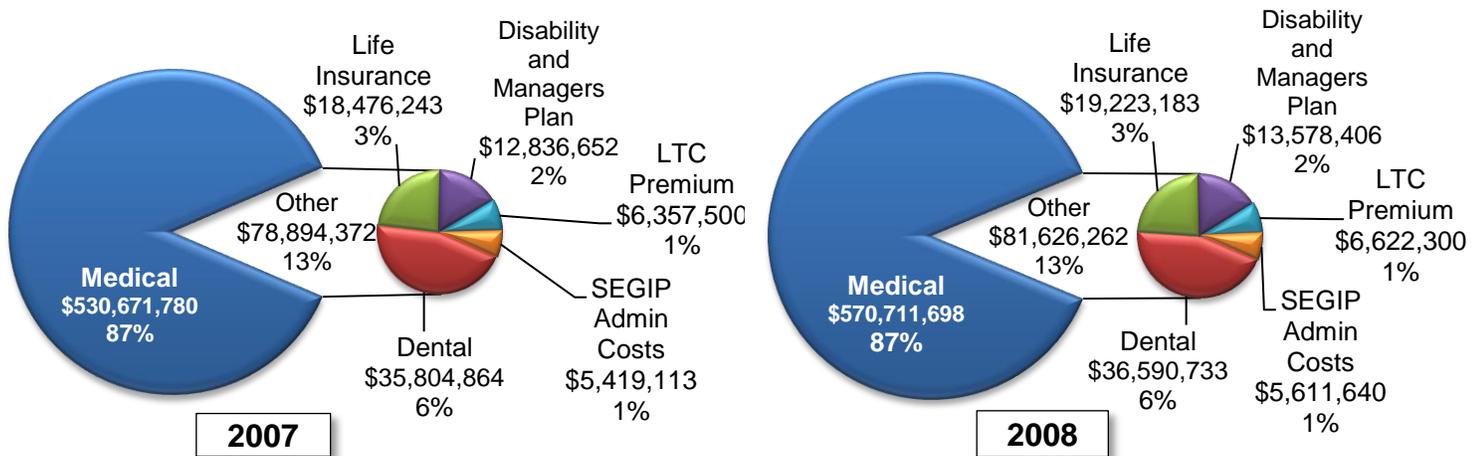


Figure 2 – Total premiums & fees by program in 2007 and 2008

In 2007, state agencies paid 78.7 percent of total premiums, while state employees and retirees paid 18.6 percent and quasi-state agencies and their employees paid 2.8 percent. During 2008, state agencies paid 79.4 percent of total premiums leaving state employees and retirees to pay 18 percent and quasi-state agencies and their employees the remaining 2.6 percent. In both 2007 and 2008, active state employees paid approximately 9.9 percent of health, dental and life total premiums. The remaining approximately 9 percent paid by state employee and retirees includes the amounts for health, dental and life paid by retirees, and optional life, disability and long-term care which are all fully paid by members. In addition to paying premiums, state agencies and quasi-state agencies also paid \$5,419,113 in administrative costs in 2007 and \$5,611,640 in 2008.

Total Premiums by Source



Figure 3 – Total premiums by source

II. Program description

Health insurance – the Minnesota Advantage Health Plan

The most costly and visible insurance benefit provided by SEGIP is health coverage. When the state first began offering “medical insurance” in 1945, the cost of health care was low and coverage was optional and paid entirely by enrollees. Since then, health coverage has evolved into an integral part of employee compensation in the United States. In 2008, 87.7 percent of private sector employees worked for an employer who offered health insurance.¹

The total cost of health insurance for state employees and their insurance eligible dependents during 2007 and 2008 was over \$1.1 billion. Of this, state agencies paid \$937.4 million, employees and retirees paid \$133.7 million, and quasi-state agencies and their employees paid \$30.2 million.

Advantage is fully self-insured meaning that the state is responsible for paying its own claims and administrative expenses. The program contracts with three health insurance carriers, Blue Cross Blue Shield of Minnesota, HealthPartners and PreferredOne. They are responsible for paying claims so the state does not have access to the protected health information of its employees or their dependents. The carriers also provide medical networks, pharmacy benefits, and disease management services. In 2008, Advantage moved its pharmacy benefit services to a single provider.

A key feature of Advantage is its tiering or cost levels. Tiering was a unique concept when it was introduced in the Minnesota Advantage Health Plan in 2002. Since then, tiering has become an industry norm. Under the Advantage tiering system, participating primary care clinic systems are placed into different tiers, or “cost levels,” based on their actual risk-adjusted costs of delivering care and as negotiated in collective bargaining. Advantage members choose a primary care clinic and pay lower copayments, deductibles, and coinsurance for choosing a more cost effective clinic system. Tiering saves money and enhances the value of health benefits for state employees in two ways:

- It gives employees and their families a choice of health care providers, as well as information and incentives to select more cost-effective providers; and,
- It provides more transparency of health care costs, creating incentives for providers to deliver value and quality at a more affordable price or risk loss of market share.

The Advantage health premium tended to increase less than the national average between 2002 and 2008. Over this seven-year period, the Advantage premium increased on average by 8.09 percent compared to the national average of 9.4 percent.

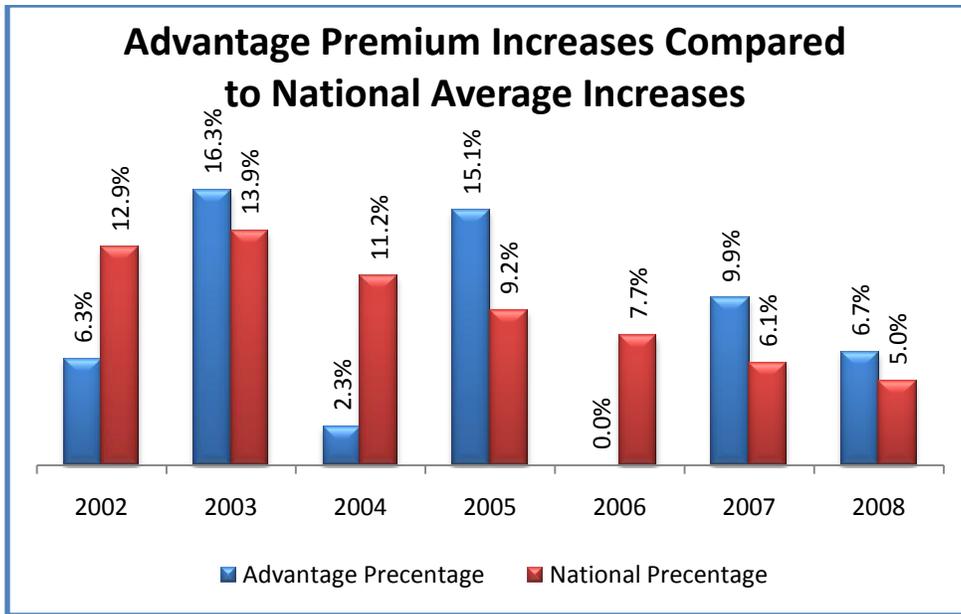


Figure 4 – Advantage premium increases compared to national average increases²
 Note: In 2008, the method for calculating the national average increase changed.³

Both the Advantage health premium and the national average premium from 2002 through 2008 rose faster than medical inflation or all item inflation. Despite two years in which the Advantage premium increased less than either medical or all item consumer price indexes, it averaged approximately 4 percent higher than the CPIs. The national health insurance averaged approximately 5 percent higher. However, in 2008, both the Advantage and the national premium increase were within 4 percentage points of the CPIs.

Advantage Premium Increases Compared to Other Indicators

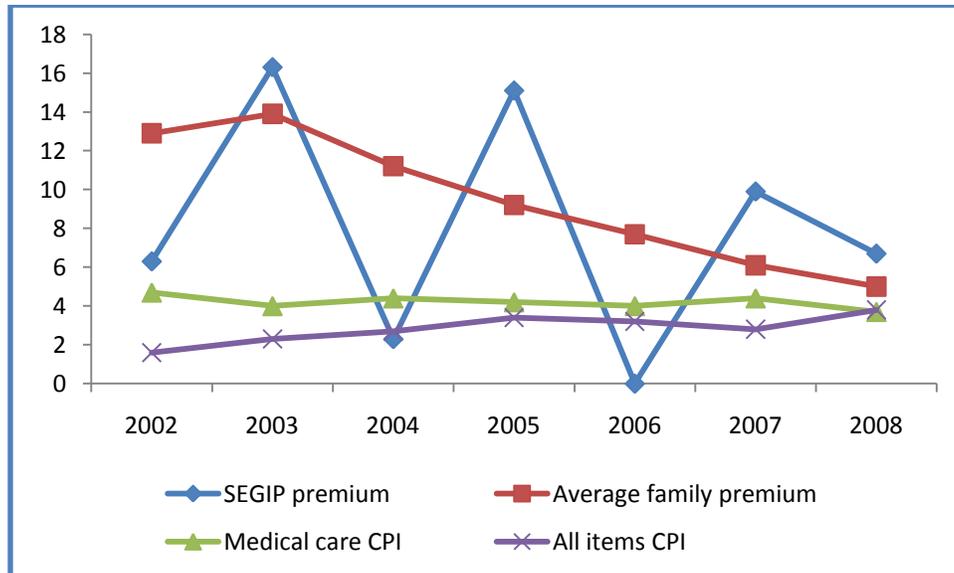


Figure 5 – Advantage premium increases compared to other indicators⁴

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Sources: Kaiser/HRET Survey of Employer-Sponsored Health Benefits and Bureau of Labor Statistics and Consumer Price Indexes (CPI).⁵

Overall, the average Advantage family health premium is growing slower than the national average family health premium. The \$12,680 national average annual family premium in 2008 was 27 percent higher than it was in 2004 and 119% higher than in 1999.⁶ Comparably, the Advantage family premium in 2008 was \$15,250, 35% higher than its family premium in 2004 and 91% higher than its 1999 premium.⁷

Advantage Health Plan income

The Advantage Health Plan generates its income through premiums paid by participating employer groups and the retention of its interest income.

Minnesota statutes authorize SEGIP to retain its interest income.⁸ During 2005, it earned interest equal to approximately one percent of total income and it rose to 1.55 percent of total income in 2006. Interest income remained strong in 2007 reaching 1.65 percent of total income. After the economic downturn began in December 2007, interest income fell in 2008 to 1.40 percent of total income.

Advantage Income by Source 2005 – 2008								
Year	2005		2006		2007		2008	
	Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent
Premiums	470,917,583	99.03	475,632,616	98.45	530,671,700	98.35	570,711,698	98.60
Interest	4,591,227	.97	7,489,989	1.55	8,905,293	1.65	8,092,692	1.40
Total	475,508,810	100.00	483,122,605	100.00	539,576,993	100.00	578,804,390	100.00

Figure 6 – Advantage income 2005 - 2008

Health premiums

State agencies pay the majority of health premiums and the percent they contribute has increased slightly. In 2004, agencies contributed 84.2 percent of total premiums and by 2008, their contribution increased to 85.4 percent. During the same period, the portion contributed by employees and retirees fell from 12.9 percent to 11.9 percent.

In 2007, a total of \$530.7 million was contributed in health premiums. Of that, state agencies paid \$449.8 million, employees and retirees contributed \$65.8 million and quasi-state agencies and their employees contributed the remaining \$15 million.

In 2008, a total of \$570.7 million was contributed in health premiums. Of that, state agencies paid \$487.6 million, employees and retirees contributed \$67.9 million and quasi-state agencies and their employees contributed the remaining \$15.2 million.

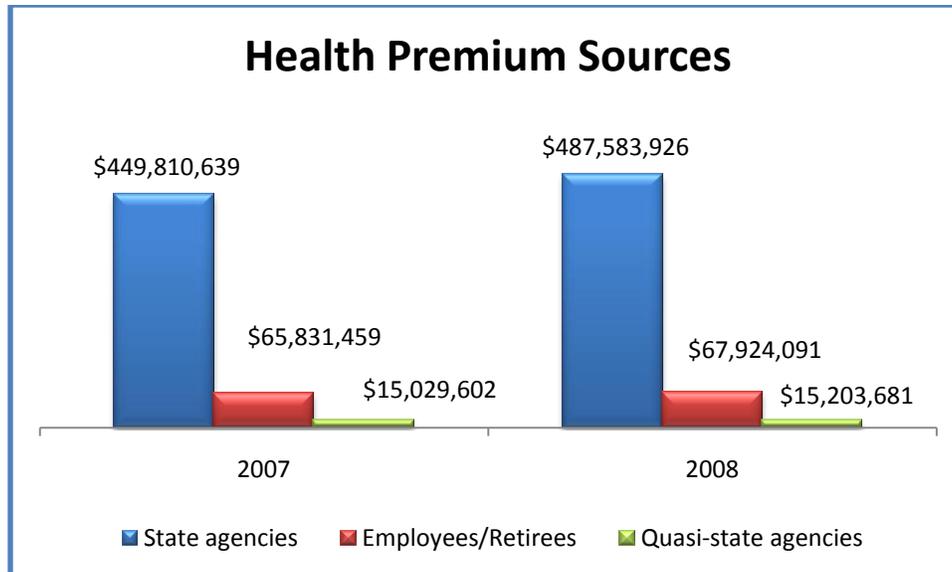


Figure 7 – Health premium sources

After two years of a steady rate, the Advantage premium increased in both 2007 and 2008. In 2007, the plan experienced a 9.9 percent increase. The monthly cost of single coverage rose to \$405.18, or by \$36.50 per month, of which the state paid the entire amount. The 2007 monthly family premium was \$1,191.50 of which the state paid \$1,073.56 while employees contributed \$117.94. This represented an increase of \$107.34 per month, of which the state’s portion increased by \$96.72 and the employee portion increased by \$10.62.

In 2008, the plan experienced a 6.7 percent increase. The cost of single coverage rose to \$432.16, or by \$26.98 per month, of which the state paid the entire amount. The monthly family premium increased to \$1,270.86 of which the state paid \$1,145.06 and the employee contributed \$125.80. This equated to a monthly increase of \$79.36, of which the state paid \$71.50 per month while the employee’s share increased by \$7.86 per month.

Advantage Health Premium 2005 – 2008									
<i>(in dollars)</i>									
	2005 - 2006			2007			2008		
	Total	State	Employee	Total	State	Employee	Total	State	Employee
Single - Monthly	368.68	368.68		405.18	405.18		432.16	432.16	
Annual	4,424	4,424		4,682	4,682		5,186	5,186	
Family - monthly	1,084.16	976.84	107.32	1,191.50	1,073.56	117.94	1,270.86	1,145.06	125.80
Annual	13,010	11,722	1,288	14,298	12,883	1,415	15,250	13,741	1,510
Percent increase				9.90%			6.70%		

Figure 8 – Advantage monthly single and family premiums

Health premium for single coverage

Single coverage in 2007⁹

In 2007, the Advantage single coverage contribution was \$405.18 per month compared to the national average of \$373 per month.¹⁰ Advantage's annual cost for single coverage in 2007 was \$4,862 compared to the national average of \$4,479.¹¹

Under Advantage, employees make no contribution for single coverage. Comparably, nationally on average workers contribute 16 percent of the premium for single coverage.¹² Workers in self-funded plans, such as Advantage, pay on average 17 percent for single coverage and workers in firms that had at least some union workers paid on average 15 percent.¹³

Nationally, nine percent of all large employers pay the full single premium and 44 percent of small firms pay the full premium.¹⁴

Single coverage in 2008

In 2008, the Advantage single coverage contribution rate was \$432.16 per month compared to the national average of \$392 per month.¹⁵

Advantage's single rate was higher than the national average but less than the national average for state and local governments. In 2008, the Advantage annual cost for single coverage was \$5,186 compared to the national average cost of premiums for single coverage of \$4,704.¹⁶ The average total single premium per employee enrolled through state and local government jobs was \$5,367.¹⁷

Under Advantage, employees make no contribution for single coverage. Nationally the average covered worker contributed \$721 per year (or \$60.08 per month).¹⁸ Comparably, state and local government employees nationally, contributed an average of \$503 annually (or 41.92 per month) in 2008.¹⁹

Less than half of all employers offered a health plan that required no contribution from employees for single coverage. Nationally, 40.7 percent of private sector employers that offered health insurance, offered at least one health insurance plan that required no contribution from the employee for single coverage.²⁰ In Minnesota, that number was 39 percent.²¹ Nationally, 39.1 percent of private sector establishments that offered at least one health insurance plan requiring no contribution from the employee for single coverage had at least some union employees.²²

Health premiums for family coverage

Family coverage in 2007

In 2007, Advantage's family rate was \$1,191.50 per month compared to the national average of \$1,009 per month.²³ Advantage's annual family premium rate was \$14,298, which was higher than the national average of \$12,106 for family coverage premium.²⁴

Under Advantage, the annual employee contribution for family coverage in 2007 was \$1,415.28 compared to a \$3,281 contribution by the average worker nationally.²⁵ Workers in large firms paid the national average of \$2,831 for family coverage.²⁶

The employee portion of the family premium contribution under Advantage was 9.9 percent of the premium compared to 28 percent paid on average by workers nationally,²⁷ 23 percent was the average for self-funded plans,²⁸ and 21 percent was the average paid by workers in firms that had at least some union workers.²⁹

Family coverage in 2008

The Advantage family premium contribution in 2008 was comparable to national averages. The Advantage monthly premium for family coverage was \$1,270.83 compared to the national average of \$1,057 per month.³⁰ Advantage's annual family premium, in 2008 was \$15,250 compared to the national average of \$12,680 per year.³¹ The average total family premium per employee enrolled through a state or local government in 2008 was \$13,183, the total for just state governments was slightly lower at \$12,850.³²

Under Advantage, like most workers nationally, employees paid a portion of the family coverage premium contribution. Nationally, 78.9 percent, and in Minnesota 79.2 percent, of private sector employers who offered health insurance offered at least one health insurance plan that required an employee contribution for family coverage in 2008.³³

Nationally, 21.1 percent of private sector firms that offered health insurance offered at least one health insurance plan that required no contribution from the employee for family coverage had at least some union employees.³⁴

Out-of-pocket costs

In addition to a premium contribution for family coverage, all members have limited out-of-pocket cost responsibilities.³⁵ The purpose of out-of-pocket cost sharing is to increase consumer cost sensitivity, encourage thoughtful utilization and highlight the relative differences in cost among providers in the four cost levels. In 2007, Advantage members paid 8.31 percent of the plan's allowable claims through cost sharing and that number increased to 9.13 percent in 2008.

These out-of-pocket costs include an annual first dollar deductible, copayments and coinsurance. The amount required for each type of cost sharing is determined by the cost level of the primary care clinic the member chooses and whether or not the employee has opted to take a health assessment. All three of these methods combine for the out-of-pocket maximum. The cost sharing methods and the amounts for both 2007 and 2008 were:

Deductible: Advantage includes a first dollar deductible that varies depending on whether the member has single or family coverage and the cost level selected. In 2007, the deductible for single coverage in cost level 1 was \$30 or \$60 for a member with family coverage. In cost level 4, a member with single coverage will pay a \$500 deductible while the family deductible was \$1000.

In 2008, the deductible for single coverage in cost level 1 was \$50 and \$100 for a member with family coverage. In cost level 4, the single coverage deductible was \$600 while the family level 4 deductible was \$1,200.

Copayment: A copayment is a fixed fee paid by members for each treatment or service. Advantage includes copayments for non-preventive care office visits, emergency services, inpatient hospital and outpatient surgery and prescription drugs. In 2007, the cost level 1 office visit copayment for single and family coverage was \$20 while the cost level 4 copayment was \$35. By taking the health risk assessment, members receive a \$5 discount on all office visit copayments for themselves and their covered dependents.

In 2008, the cost level 1 office visit copayment for single and family coverage was \$22 while the cost level 4 copayment was \$42. The \$5 reduction for taking the health risk assessment remained in effect.

The plan also features copayments for several other services. A visit to a convenience clinic entailed a \$10 copayment for 2006 through 2009. Various other copayment rates are included for emergency care, inpatient hospital and outpatient surgery.

Coinsurance: After a member pays the deductible, the plan reimburses at less than 100 percent while the member pays the remaining percent. In 2007, Advantage included coinsurance for:

- Prosthetics and durable medical equipment: 20 percent for cost levels 1 through 3 and 30 percent for cost level 4 members.
- Lab, pathology, X-rays: none for cost levels 1 and 2, 10 percent at cost level 3, and 30 percent at cost level 4.
- Certain other expenses (such as home health care and outpatient hospital services): no coinsurance for cost levels 1 and 2, 10 percent for cost level 3 and 30 percent for cost level 4.

In 2008, Advantage coinsurance rates were:

- Prosthetics and durable medical equipment: 20% for levels 1, 2 and 3; and 30 percent for level 4.
- Lab, pathology, X-rays: 5 percent coinsurance for levels 1 and 2; 10 percent for level 3, and 30 percent for level 4.
- Certain other expenses (such as home health care and outpatient hospital services): 5 percent for levels 1 and 2; 10 percent for level 3; and 30 percent for level 4.

Seventy-one percent of workers with single or family coverage, including Advantage members, are enrolled in a plan that limits the amount of cost sharing that plan enrollees may have to pay.³⁶ In 2007, Advantage members were limited to the out-of-pocket maximum of \$1,000 for single coverage and \$2,000 for family coverage. For the 2008 plan year, the out-of-pocket maximum was increased to \$1,100 for single coverage and \$2,200 for family coverage. Nationally in 2008, 29 percent of covered workers had an out-of-pocket maximum of \$1,499 or less and 6 percent had a limit of \$999 or less.³⁷

For family coverage, the majority of workers with general annual deductibles had an aggregate deductible versus a separate deductible. This means that under most plans all covered expenses from family members count toward meeting the deductible amount. Plans with a separate family deductible require each individual family member to reach the deductible. Under Advantage, an individual member never pays more than the single deductible rate and the entire family stops paying the deductible once it has been reached.

Employees enrolled in Advantage had a deductible, as did employees in many other employer based health plans. Nationally, in 2008, 50 percent of workers in point of service (POS) plans had single coverage with no general annual deductible.³⁸ In that same year, nationally 70.7 percent of all private sector employees enrolled in a health insurance plan had a deductible while only 66.3 percent of private sector employees enrolled in a health plan that had a deductible worked in a firm with union employees.³⁹ Nearly 48 percent of state and local government employees enrolled in a health insurance plan that had a deductible.⁴⁰

Advantage deductibles tended to be lower than the national average in 2008. The average individual deductible per employee enrolled with single coverage in a health insurance plan that had a deductible was \$559.⁴¹ Under Advantage, single members pay an annual deductible at level one was \$50, \$140 for level two, \$350 at level 3 and \$600 for level four clinics. Nationally, those with family

coverage averaged \$1,155.⁴² Comparably, Advantage featured level 1 clinics at \$100, level 2 at \$280, level 3 at \$700 and level 4 clinics were \$1,200.

In 2008, 77.8 percent of state and local government employees enrolled in a health plan had a copayment for a physician office visit.⁴³ Nationally, the average copayment was \$16.84 for a physician office visit, which was comparable to Advantage.⁴⁴

In 2007, 79 percent of covered workers had a copayment when they visited an in-network physician⁴⁵ and 34 percent of those members paid \$20 per visit.⁴⁶

Coinsurance is less prevalent in employer sponsored health plans. Like 12 percent of covered workers in 2007⁴⁷ and 11 percent in 2008.⁴⁸ Advantage includes a coinsurance feature.

Advantage Plan expenses

SEGIP expenditures are a combination of claims and related administrative expenses. In 2007, health claim costs comprised 87 percent of the program's total program expenditures. Those claims increased from \$435.4 million in 2006 to \$470.8 million in 2007, an increase of \$35.4 million or 8.14 percent over those paid in 2006. In 2008, health claims increased to \$570.7 million. This represented an increase of \$16.8 million or 3.58 percent increase over health claims paid in 2007.

In addition to claim costs, the Advantage Health Plan had these additional expenses:

- Administrative and Reinsurance: The carrier's administration costs and reinsurance combined was approximately 5.6 percent of total health program premiums in 2007 and 5.8 percent in 2008. SEGIP's health carrier administrative costs were lower than Minnesota's average health plan administrative cost of 8.4 percent in 2007 and 8.1 percent in 2008.⁴⁹
- Employee Health Reimbursement Account: A \$250 health reimbursement account was provided to each contract holder. The \$16.3 million includes the cost of the accounts as well as the associated administrative fees.
- Consulting, EAP, and other costs: Includes the cost of the state EAP program, the program's actuaries, attorney and other related costs.
- Federal liability on funds transfers: These dollars represent the final reimbursement to the federal government for its share of transfers from the Contingency Reserves to the General Fund. The total payment to the federal government was \$5.05 million including \$269,628 in interest. This represented approximately a 14 percent penalty on the \$11 million 2003 transfer and the \$23 million transfer in 2005.
- Prior years – settlement paid: Carrier claim settlements relating to a prior calendar year.

The Contingency Reserves are an important feature of the Advantage Health Plan. Established under Minnesota Statute 43A.30, Subd.6, the contingency reserves "...increase the controls over medical plan provisions and insurance costs for ..." members. The contingency reserves pays claims in excess of premiums and it stabilizes the premium rates by eliminating the need for large premium increases in reaction to large unexpected one-time costs.

The Reserves have grown due to lower than expected annual claim expenses. At the end of 2007, the reserves were 24 percent of the annual expenses and 31 percent at the end of 2008. The program's actuaries estimate that a Contingency Reserve equal to 16.7 percent of annual claim

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expenses will adequately ensure the solvency of the fund. To achieve this goal a five-year plan was implemented to bring reserves to this desired level. Under this plan, the annual premium increase will be set lower than anticipated as necessary to cover cost increases. It is expected that this dampening of the premium will bring the Contingency Reserves to 16.7 percent of annual claim expenses by 2013.

Advantage Health Plan – Financial Statement			
	CY 2006	CY 2007	CY 2008
Income			
Premiums	475,632,616	530,671,700	570,711,698
Interest Income	7,489,989	8,905,293	8,092,692
	<u>483,122,605</u>	<u>539,576,993</u>	<u>578,804,390</u>
Expenditures			
Claims Paid and Incurred	435,354,910	470,800,913	487,647,098
Admin & Reinsurance (Paid to Carriers)	30,923,152	30,340,823	33,664,288
Employee Health Account			16,318,750
Consulting, EAP, and Other Costs	858,284	1,025,155	432,814
Federal Liability on Fund Transfers		446,628	
Prior years -Settlements Received (Paid)	(3,069,534)	6,223,149	(4,260,598)
Premium Holiday	19,902,735		
Total Expenditures	<u>483,969,547</u>	<u>508,836,668</u>	<u>533,802,352</u>
Gain or Loss	(846,942)	30,740,325	45,002,038
Contingency Reserves - End of Plan Year	<u>91,444,263</u>	<u>122,184,588</u>	<u>167,186,626</u>

Figure 9 – Advantage Health Plan financial statement

Note: This income statement has not been independently audited. A "Statement of Net Assets," on a Plan Year Basis has not been prepared.

Dental insurance

SEGIP provides employees with optional group dental insurance for insurance eligible employees and their dependents. Three dental plans were offered: HealthPartners Dental, Blue Plus Dental Care and State Dental Plan (Delta). The rates for each program are comparable and each offers approximately the same benefit set but there are certain administrative differences among the programs. All of the plans maintain a network of dentists through which members receive care. Coverage is provided for most conditions requiring dental diagnosis and treatment, including orthodontic treatment for children. Each plan design places an emphasis on preventative services including full coverage for regular exams, x-rays and teeth cleaning.

In 2007, the SEGIP offered three different dental plans: Blue Plus Dental, State Dental Plan and HealthPartners Dental. All three of the SEGIP dental plans provided substantially the same comprehensive coverage and each offered a network of dental providers. Both employees and the state paid dental premiums.

The Blue Plus Dental program was eliminated beginning in 2008. This decision was made in part because SEGIP was the only remaining employer group in the program. This change had a minimal impact on members because the plan was very similar to the State Dental Plan. Approximately 3,300 members were required to select from the remaining two dental programs.

SEGIP 2007 - 2008 Biennial Report

2007 Dental Premium Rates – Monthly Rate						
Health Plan	Single Coverage			Family Coverage		
	Total	State	Employee	Total	State	Employee
Blue Plus Dental	25.00	20.00	5.00	72.76	45.48	27.28
State Dental plan	26.02	21.02	5.00	76.98	46.50	30.48
HealthPartners Dental	26.64	21.64	5.00	78.80	47.12	31.68

2008 Dental Premiums Rates – Monthly Rate						
Health Plan	Single Coverage			Family Coverage		
	Total	State	Employee	Total	State	Employee
State Dental plan	26.02	21.02	5.00	76.98	46.50	30.48
HealthPartners Dental	26.90	21.90	5.00	79.60	47.38	32.22

Figure 10 – Monthly dental rates 2007 and 2008

Both the state and employees pay dental premiums. Total dental premiums in 2007 were \$35,804,864. Of those dollars, state agencies paid \$19,766,803, employees paid \$15,094,818 and quasi-state agencies and their employees paid \$943,243.

In 2008, total dental premiums were \$36,590,733. Of those dollars, state agencies paid \$20,303,732, employees paid \$15,392,112 and quasi-state agencies and their employees paid the remaining \$894,889.

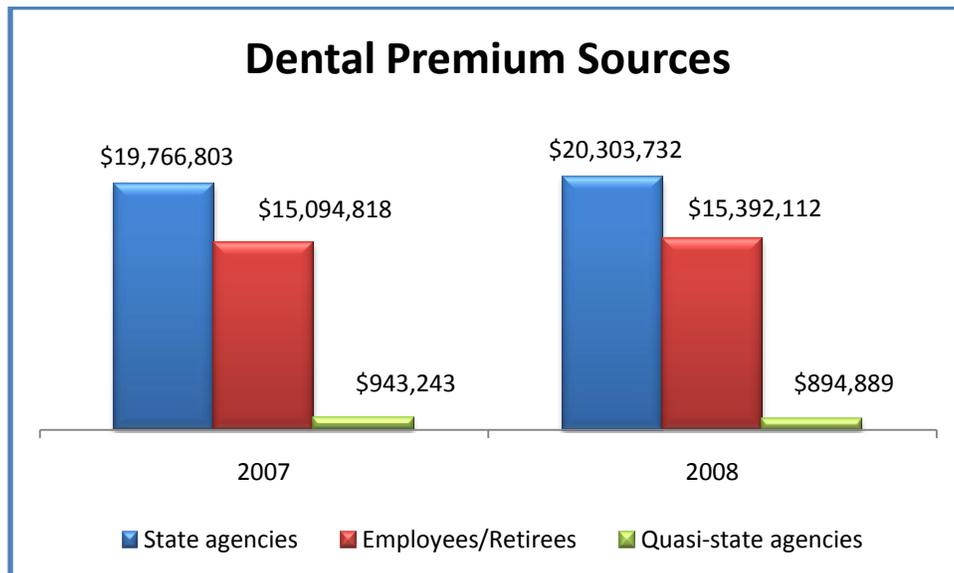


Figure 11 – Dental premium sources

Basic Life Insurance

In most cases, insurance-eligible employees participating in SEGIP receive group term life insurance paid in full by the employer. The amount of the insurance is determined by the applicable collective bargaining agreement or compensation plan and the employee's annual salary.

A total of \$5,572,537 was paid for life insurance premiums in 2007. Of that the state paid \$5,226,618, employees and retirees paid \$175,649 and the quasi-state agencies and their employees paid \$170,270.

A total of \$5,820,418 was paid for life insurance premiums in 2008. Of that the state paid \$5,496,019, employees and retirees paid \$156,184 and quasi-state agencies and their employees paid \$168,215.

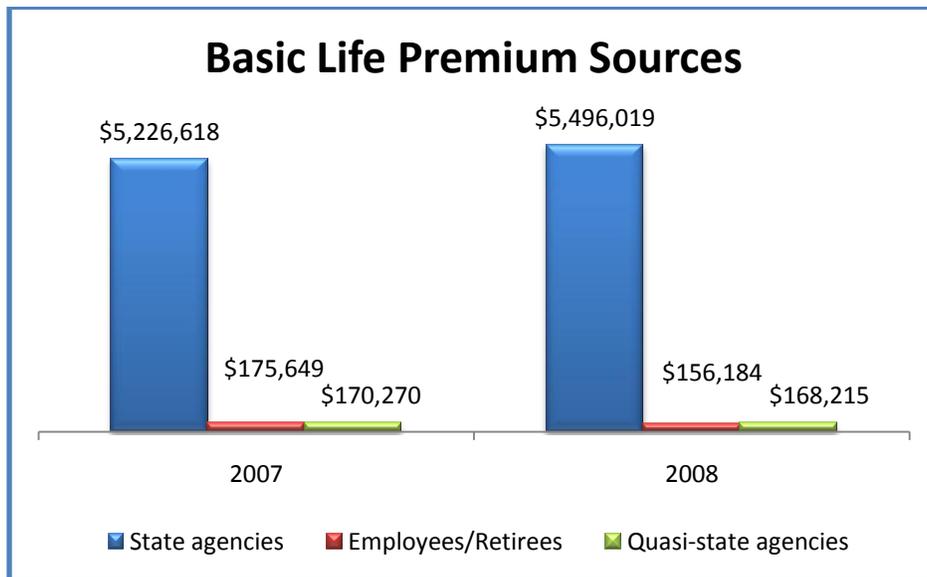


Figure 12 – Basic Life premium sources

Manager's Income Protection Plan

Manager's Income Protection Plan is part of the employer paid benefits for managers. The plan is a combination of life insurance and long-term disability insurance. Managers have two options under the plan. The first is coverage at two times the employee's salary with a waiver of employer paid long-term disability coverage. Disability coverage can still be maintained at the employee's cost. The second option provides coverage at one and one half times the employee's salary and employer paid long-term disability coverage. Employees have the option to buy down the elimination period on the long-term disability coverage.

For the Manager's Income Protection Program a total of \$490,603 was paid in 2007, of which \$379,785 was paid by the state and \$110,818 was paid by employees. In 2008, \$539,965 was paid, of which the state paid \$395,796 and employees paid 144,169.

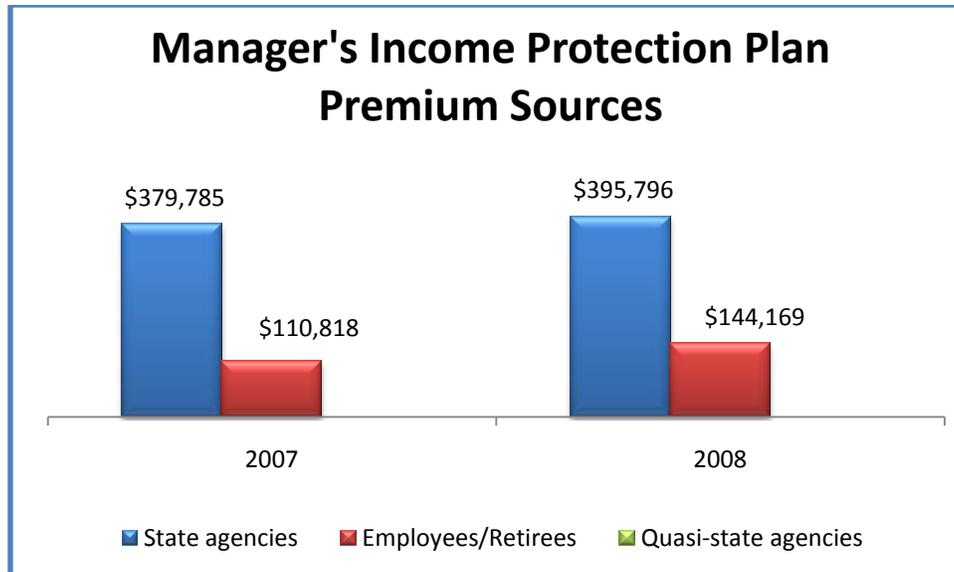


Figure 13 – Manager’s Income Protection Plan premium sources

Fully employee paid coverages

SEGIP offers eligible employees a variety of optional insurance benefits, including:

- Additional employee life, and spouse and child life
- Accidental death and dismemberment
- Short and long-term disability
- Long-term care (LTC) insurance
- Pre-tax benefit accounts

Optional life insurance

The amounts and terms of optional life insurance may vary by collective bargaining agreements and plans. Life insurance is available for spouse and children. Employees may also purchase additional life. These insurance products combined generate \$12.9 million in 2007 and \$13.4 million in 2008.

Additional employee life, spouse life, and child life insurance policies are available to employees who choose to carry this coverage. To obtain optional life insurance, applicants are usually required to provide satisfactory evidence of good health. However, evidence of good health is not required for certain policy amounts if a new employee enrolls within 35 days of employment; if a new spouse enrolls within 30 days of the marriage and a new child within 30 days of the birth or adoption. One child life insurance policy covers all of the employee’s dependent children. The value of all life insurance policies automatically doubles in the event of an accidental death.

Accidental Death and Dismemberment insurance (AD & D) provides additional coverage for death and dismemberment due to an accident. AD & D insurance is available for employees and spouses. In addition to the optional coverage, accidental death coverage is automatically included in the premium for all employee and spouse life insurance coverage, and doubles the benefit amount in the event of accidental death.

In 2007, a total of \$12,903,706 was contributed in premiums. Of that, employees and retirees paid \$12,695,488 and quasi-state agencies and their employees paid \$208,218. State employees and retirees spent \$12,412,768 on additional life insurance products while the quasi-state agencies

contributed \$202,922. State employees and retirees contributed \$282,720 in additional death and dismemberment insurance and quasi-state agencies \$5,296

In 2008, a total of \$13,402,765 was contributed in premiums. Of that, employees and retirees paid \$13,191,113 and quasi-state agencies and their employees paid \$211,652. State employee and retirees contributed \$12,887,700 on additional life products and quasi-state agencies \$206,254. Additional death and dismemberment coverage generated \$303,113 from state employees and retirees and \$5,398 from quasi-state agencies.

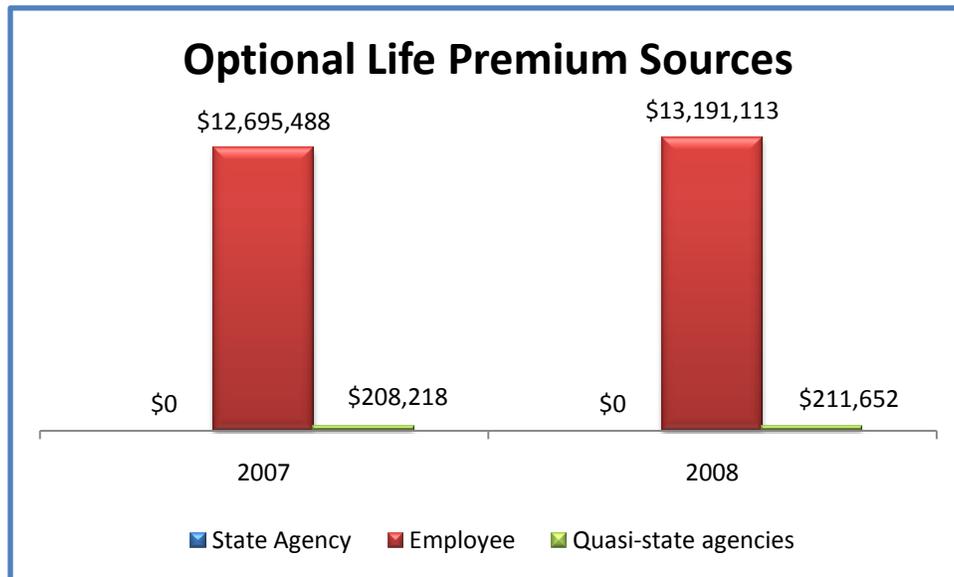


Figure 14 – Optional Life Premium Sources

Disability coverages

The program offers both short and long-term disability insurance to active state employees. Short-term disability insurance provides employees with income when injury, sickness or pregnancy results in continuous total disability. Benefits begin on the first day of disability due to accident, or the eighth day of a disability due to sickness or pregnancy. Benefits are limited to 180 days for any one incident of total disability. Evidence of good health is generally required to enroll unless an employee enrolls within 35 days of eligibility.

Long-term disability insurance provides employees with income when an injury or sickness results in continuous disability beyond 180 days. Benefits begin on the 181st day of total disability due to injury, sickness or pregnancy and are generally payable until age 65. Evidence of good health is generally required to enroll unless an employee enrolls within 35 days of eligibility.

A total of \$13,346,049 was paid in disability premiums during 2007. Of that, state employees paid \$12,035,655 and quasi-state agencies and their employees paid \$310,394. State employee contributed \$7,281,945 for short-term disability and \$4,753,710 for long-term disability.

In 2008, a total of \$13,038,441 was paid in premiums of which state employees paid \$12,712,564 and quasi-state agencies and their employees paid \$325,877. State employees contributed \$7,662,033 for short-term disability and \$5,050,531 for long-term disability.

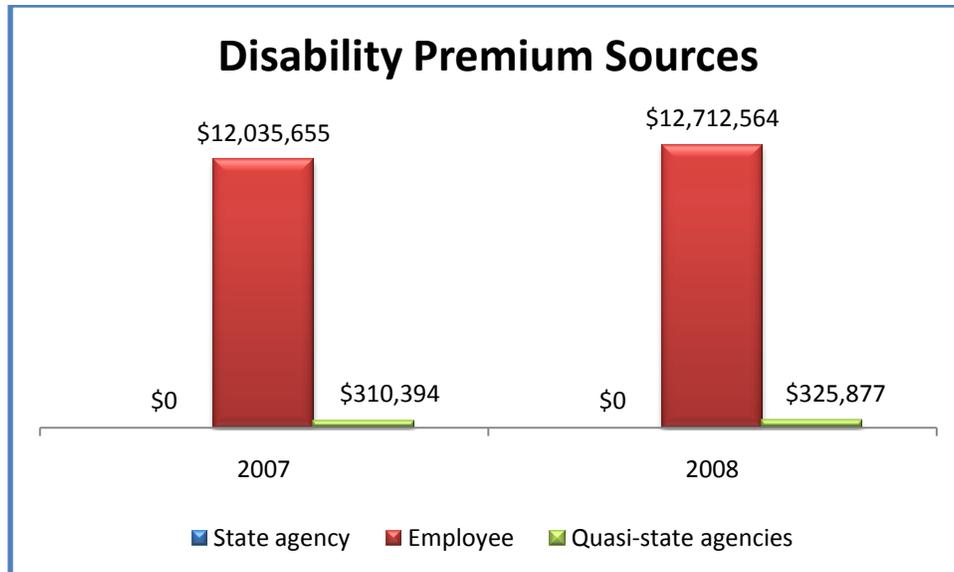


Figure 15 – Disability premium sources

Long-term care insurance

Long-term care insurance (LTCi) provides a variety of services for individuals who are unable to care for themselves due to an injury, chronic illness, an acute episode, or a cognitive impairment. Long-term care services may include assistance in a home, adult day care center, an assisted living facility, or nursing home.

By industry standards, the state’s LTCi plan is a large group. It is one of the 10 largest groups of the nearly 700 groups served by the state’s vendor, on a nation-wide basis. The industry average enrollment is between 5 and 8 percent compared to the state’s nearly 20 percent enrollment.

In 2007, the LTCi had 9,630 members, of which 6,321 were employees, 1,754 were spouses, 1,239 were former employees, 251 were retirees and 65 were parents. LTCi is a fully member paid program, and those members contributed \$6,357,500 in LTCi premiums.

In 2008, the LTCi program had 9,468 members of which 5,949 were employees, 1,746 were spouses, 1,382 were former employees, 328 were retirees and 63 were parents. These members contributed a total of \$6,622,300 in premiums.

Pre-tax accounts

Pre-tax accounts, or flexible spending accounts, are an important feature of SEGIP benefits. These accounts enable employees to set aside a portion of their pre-tax compensation for qualified expenses. These programs are fully employee paid. SEGIP offers three accounts:

- Medical-Dental Expense: covers medical expenses not paid for by insurance, including deductible, copayments, and coinsurance as well as dental, vision, prescription drugs and over the counter medications.
- Dependent Care Expense: covers certain expenses to care for dependents that live with the employee while the employee is at work. This includes both child and elder care.
- Transit Expense: covers certain expenses associated with an employee’s commute to work including parking and bus and vanpool costs.

These dollars result in substantial tax savings, as they are not subject to payroll taxes for either the employee or the employer. In 2007, 16,798 members participated in the pre-tax programs and contributed \$23.1 million. This represented nearly a 6 percent increase in usage over 2006. In 2008, 17,062 members contributed \$24.2 million. In both years, members saved approximately 28 percent from income tax payments and the state saved more than 7.5 percent in employment related taxes.

Employee Assistance Program

SEGIP offers a comprehensive Employee Assistance Program (EAP) to individual employees, their families, state managers, supervisors, human resource professionals and union leaders. The EAP seeks to provide concrete, practical solutions to state employees' personal, family and workplace problems that result in improved productivity and reduced poor quality work, absenteeism and morale problems.

Through the EAP vendor, employees and their families have 24/7 confidential access to EAP counselors both telephonically and face-to-face. The EAP is designed to assist in the identification and resolution of personal, family, and workplace problems faced by state employees and organizations. In addition, with strong confidentiality measures, EAP services are free-of-charge helping ensure there are no barriers to accessing this care. EAP provides services that help state workers balance their work and personal lives, thereby increasing job satisfaction and productivity.

The state's internal EAP consultants provide confidential consultation to state agency managers, supervisors, human resource staff and union leaders. These organization services are integrated with labor relations, health promotion, safety, training, benefits administration, and disability management. Offering both an internal and external EAP services allows employees, families, and state agencies to receive the services they need to ensure that employees are healthy, productive, and have job satisfaction.

During 2007 and 2008, 3,096 cases were opened through the state's EAP vendor, which equaled a use rate of 2.75% of the total employee population.⁵⁰ In 2007, 1,574 cases were opened, equaling a use rate of 2.8%. In 2008, 1,522 cases were opened, equaling a use rate of 2.7%. These cases cost approximately \$270 over both 2007 and 2008. Total program costs, including the state's internal EAP, were \$559,284 in 2007 and \$550,311 in 2008.

Utilization by employee / family member:

	2007		2008	
State Employee	1399	88.88%	1340	88.04%
Family Member	174	11.05%	182	11.96%
Unknown	1	0.06%	0	0.00%
Total	1574	99.99%	1522	100.00%

Services provided:

	2007		2008	
Assessment & counseling	163	10.36%	122	8.02%
Assessment & referral	306	19.44%	322	21.16%
Assessment, counsel & referral	993	63.09%	998	65.57%
Unknown	112	7.12%	80	5.26%
Total	1574	100.01%	1522	100.01%

Figure 16 – EAP utilization and services provided in 2007 and 2008

Program administration

SEGIP administers all its insurance benefits in part through a combination of its own staff and contracted vendors. SEGIP is comprised of three primary areas: Contracts and Networks, Benefits Administration, and Health Risk Management.

Contracts and Networks manages SEGIP's purchasing functions by negotiating contracts with vendors and monitoring them for compliance with collective bargaining agreements, plan contracts, and federal and state requirements. Annually, they renew contracts with each carrier including medical, dental, life and the optional coverages. Every two years the unit prepares labor contract proposals for management and cost estimates for labor negotiations. During the legislative session, they provide information for legislative initiatives. The unit also manages medical and dental provider networks.

Benefits Administration is responsible for enrollment and billing services for the nearly 118,000 participants. The unit's primary task is processing transactions for the program, including the enrollment of newly eligible employees and changes to existing coverage. During 2007, the unit processed over 77,215 transactions and another 59,787 during 2008. To accomplish this task the unit provides support for the information system insurance application and supporting software tools.

Benefit Services has the primary responsibility for Open Enrollment but the entire division is actively involved. During the annual Open Enrollment, members are allowed to make certain changes to their benefit set.

During the 2007 Open Enrollment, 27,954 elections were made of which 99.5 percent were made electronically while SEGIP staff manually entered the remaining half percent. SEGIP staff also answered 3,443 phone calls, conducted 32 training sessions for state employees and four trainings for state agency human resource staff. During the 2008 Open Enrollment, 25,330 elections were made of which 99.6 percent were electronic. SEGIP staff answered 4,743 phone calls, conducted 34 trainings for state employees and 4 training sessions for state agency human resource staff. Typically, approximately nine staff handle Open Enrollment.

Health Risk Management provides programs and benefits that focus on helping members achieve healthy and productive lifestyles. In doing so, the unit focuses on strategies and interventions that reduce employee absenteeism, increase employee health and productivity, reduce claims costs and other factors that influence plan costs within all Minnesota state agencies.

SEGIP's administrative fee covers the cost of its administrative operations. State and quasi-state agencies are charged \$8.02 per employee per month and members directly paying premiums are assessed a two percent administration fee. SEGIP administrative fees are approximately one percent of total premiums per year while the administrative fees of the carriers (not including long-term care) are approximately six percent. The combined total of SEGIP and carrier administration costs was 6.3 percent in 2007 and 6.5 percent in 2008. This was down from approximately seven percent in both 2005 and 2006.

SEGIP continues to control successfully its administrative fees. Its administrative fees were significantly below the national average of between 10 percent and 15% in both 2007 and 2008.⁵¹ Its administration fees were also below the Minnesota average of 8.4% in 2007 and 8.1% in 2008.⁵² SEGIP's administrative fee has not increased since January 1999.

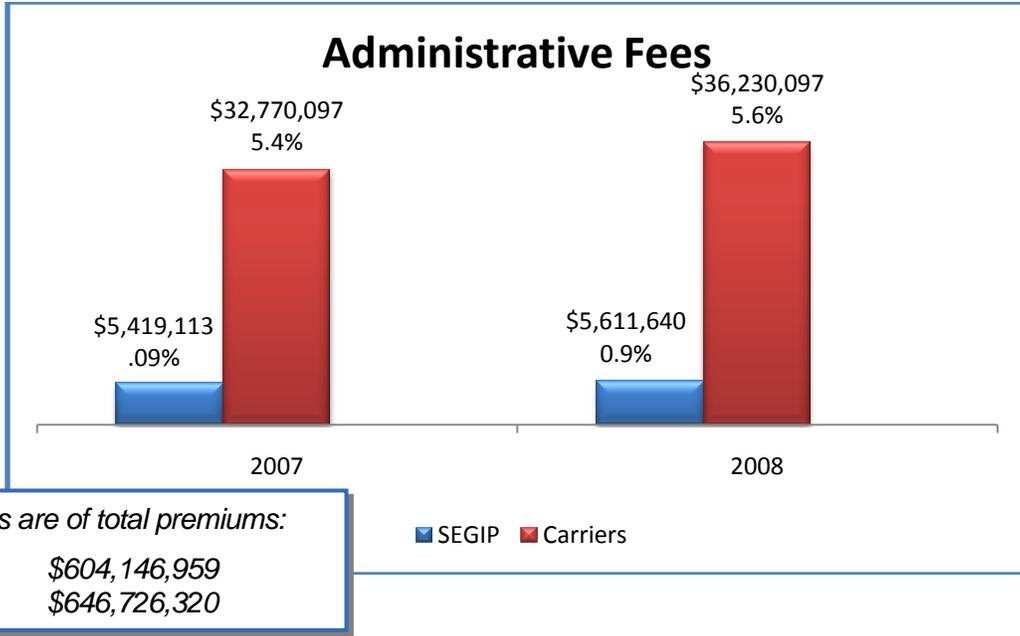


Figure 17 – SEGIP administration fees in 2007 and 2008

III. A brief history of SEGIP

1945 State began to offer optional, member-paid “medical insurance” during WWII to recruit and retain workers. Oversight was provided by a board of elected officials and agency commissioners.

1957 SEGIP began to promote use of managed care by offering coverage through one of the first health maintenance organizations, Group Health.

1966 State began to contribute toward the cost of employee coverage.

1967 University of Minnesota employees joined SEGIP.

1973 Public Employees Labor Relations Act was passed, allowing employees to unionize and to bargain benefits. State began to contribute toward the cost of dependent coverage.

1986 SEGIP created the Joint Labor Management Committee on Health Plans to explore various approaches to health care cost containment outside the formal collective bargaining environment. State self-insured one of its health plans.

1987 SEGIP began to contribute only toward the lowest-cost plan in employee’s county to promote competition among health plans and to encourage employees to be more cost-conscious.

1990 SEGIP phased out the last of its indemnity plans so that all SEGIP members were enrolled in managed care plans.

1991 SEGIP began to survey members to assess satisfaction and quality.

1995 SEGIP joined a coalition of employers, the Buyers’ Health Care Action Group (BHCAG), to explore strategies to contain health care costs.

1997 SEGIP began a thorough study of better models for purchasing health care benefits

2000 SEGIP self-insured all of its health plans. SEGIP began to build data warehouse to compile information so that health care costs across all provider groups could be analyzed.

2001 Employees went on strike, in part due to a larger share of insurance costs being shifted to employees. Advantage tiered health plan introduced during bargaining.

2002 SEGIP implemented Minnesota Advantage Health Care Plan to address rapidly rising health care costs and to maintain access to as many healthcare providers for state employees as possible. University of Minnesota left SEGIP.

2003 SEGIP began disease management programs.

2004 Advantage won the 2004 Innovations in State Government Award from the Council of State Governments.

2005 SEGIP implemented programs geared to help contain costs by empowering members to take control of their health and become better-informed health care purchasers.

2008 SEGIP moved to a single pharmacy benefit manager.

IV. Important program innovations and developments

Throughout 2007 and 2008, SEGIP introduced programs to help employees better understand and utilize their benefits and further developed and expanded several health risk management programs that it had implemented during the previous two years. Its new programs and features addressed a wide variety of insurance related issues from programs that helped members better understand their benefits to programs designed to help members better manage their chronic health conditions.

Innovative programs designed to hold down health care costs, improve the quality of care, and increase access for its members continued to be implemented and refined. These programs emphasize three key areas: targeting member's specific chronic health conditions; providing a set of diverse avenues for members to better understand their insurance benefits, conditions and other health care related questions; and improved methods of accessing and delivering health care. These programs provide a variety of avenues for employees to deal with health issues in a cost effective manner that increases the quality of care the member receives and helps them to take control of their health.

Many of SEGIP's programs were the result of teaming with other stakeholder groups including the labor unions that represent state employees, the Governor's Health Care Cabinet, as well as other large health care purchasers such as other state agencies and Minnesota employers. By acting in concert with other health care purchasers, SEGIP is able to direct its programs and purchasing power in ways that provide the most return for its dollars and efforts and to help move the health care industry in a more cost effective and quality oriented direction.

Health Reimbursement Account

Employees enrolled in the Advantage Health Plan received a \$250 Health Reimbursement Account (HRA) in 2009. This included quasi-state agency employees and retirees who receive an employer contribution.

The dollars were available to members because of better than anticipated claim costs resulting in a reserve level higher than the program requires. The decision was made to return these funds to employees as a reward for the wise health care decisions made by Advantage members. It was those decisions that resulted in lower than forecasted claims costs. By providing this reward, it is anticipated that members will be able to understand better how their consumption of health care directly relates to the cost of the program. This reward is intended to help control future costs.

An HRA was chosen as the vehicle to provide this reward to members because it provides the most flexible and pointed method for expending these funds. An HRA is tax advantaged and regulated by the federal government. Expenditures are limited to health care related items and so members experience a real life exercise in managing their health care dollars. Unlike the Medical Dental Expense Account (MDEA) that employees already have access to, HRA dollars are able to carry over from year-to-year. This carry-forward ability prevented employees from being forced to use-or-lose the funds, reinforcing the message of planful health care spending.

Confirmation Statements

Confirmation Statements were introduced in 2008. These printed statements of each member's individualized benefit set selected during Open Enrollment for the upcoming year is mailed to the member's mailing address. This document confirms the member has received the benefit set they elected and allows the opportunity to correct documented errors that may have occurred during the

Open Enrollment process. This new feature is part of SEGIP's secure and seamless Open Enrollment process.

Pharmacy Benefit Manager (PBM)

SEGIP added a pharmacy benefit manager (PBM) in 2008 to better ensure the program's prescription drug costs are controlled to the extent possible. Previously, each of the three Advantage Health Plan carriers provided their own PBM services. Moving to a single PBM model was determined through the bargaining process between the state and the labor unions representing state employees.

Navitus Health Solutions, was selected through a request for proposal process. They serve as the administrator of the prescription drug program and adjudicate pharmacy claims, administer the pharmacy network, and oversee the formulary.

SEGIP estimated that it saved \$5 million during 2008 from what it would have spent under its previous multi-PBM model.

COBRA Subsidy

The American Recovery and Reinvestment Act of 2009 (ARRA) provided a subsidy of 65 percent of the cost of COBRA coverage for certain qualified beneficiaries who lost coverage due to an involuntary termination of employment. Under this program, the federal government will pay 65 percent of the cost leaving the employee to pay the remaining 35 percent. The program will pay this subsidy for up to nine months. Passed in early 2009, the legislation included a look-back feature that reached employees laid-off beginning September 1, 2008.

COBRA gives workers and their families who lose their health benefits the right to purchase group health coverage provided by the plan under certain circumstances. If an employer continues to offer a group health plan, the employee and his/her family can retain their group health coverage for up to 18 months by paying group health rates.

During 2008 and into early 2009, 186 employees qualified and received a federal subsidy under this program. In addition to the federal program, the state of Minnesota implemented a program that paid the employee share of their COBRA payment if certain income guidelines were met. Approximately 16 employees also qualified for the related state subsidy.

Work Well

Work Well is SEGIP's worksite health promotion benefit. The focus is creating state workplaces that support and encourage healthy behaviors, with the outcome of a measurably healthier, more productive workforce. Work Well's strategy is to build policy, systems and environmental supports under each state agencies' wellness initiatives so they might be effective and sustainable.

The program is lead by SEGIP staff and a committee of Agency Wellness Champions (AWC), which includes representation from each state agency. This committee meets monthly to strategize on new initiatives, build skills, partner and share tools and resources.

Work Well was initiated by the Minnesota Department of Health in 2005 to create a healthier worksite for employees, and to serve as a pilot program for other public and private entities. Although initially implemented within a division of Health, it was transferred to SEGIP in 2008 to be coordinated as a statewide resource to promote the health of all state employees.

During 2008, the program began to lay the foundation for its future work. An assessment was conducted of wellness benefits that were already in place and could be maximized. These included items such as wellness benefits offered by the health insurance carriers, the health assessment and individual on-line and telephonic coaching programs, Advantage Health Advisors, the Employee Assistance Program, access to convenience clinics, and existing wellness committees, and classes. The program also invited agencies to conduct an environment assessment of their worksites and began to address risk management concerns around safety and liability.

SEGIP Report

The SEGIP Report was first published in October 2008. This quarterly newsletter provides information to members about their insurance benefits so that they receive up-to-date information and understand what is available. It is intended to introduce and explain changes to the insurance programs and help employees understand their options so that they can choose a benefit that best meets their needs. The articles also address important but low profile program features such as a program to save prescription drug costs by pill splitting and the travel benefits embedded in the life insurance policy. It features a wellness section comprised of Work Well, Employee Assistance and general wellness. In response to the aging workforce, a retiree feature is included to help employees understand their retirement related options. Three editions are provided electronically while the annual open enrollment edition is mailed to each employee's mailing address.

Diabetes MTM Pilot

The diabetes Medication Therapy Management (MTM) pilot was initiated in 2007. The goal was to provide better care for diabetic patients through medication management. In addition to the conventional care of diabetes through physician-patient interactions, pharmacists trained and certified in MTM worked directly with patients.

The Fairview Pharmacy and HealthPartners Pharmacy pharmacists conducted the pilot. Patient participation in the pilot was voluntary. Members with diabetes who were enrolled in the pilot clinics received a letter of invitation to participate. Recruitment lasted for six months from July 1, 2007 through December 31, 2007. Four hundred and six patients chose to participate.

The majority of patients with diabetes take multiple drugs to manage their condition and the volunteers in this pilot averaged 11 prescribed drugs. The intervention offered in this program dealt with issues related to the medications including drug therapy problems such as dose too low, dose too high, need for additional drugs, medications changes, compliance, and adverse drug reactions.

Data collected in 2008 indicated that patients involved in an MTM program complied with the drug therapies prescribed by their doctors and has been cost effective. The percentage of patients who reached the goals almost doubled compared with that before the pilot began. The majority of patients were satisfied with the services they received from the pharmacists and continued in the pilot.

Convenience clinics

SEGIP added convenience clinics to its list of providers in 2006. Since then, convenience clinics have continued to build their presence in the health care industry. As SEGIP plan administrators credential and add them to their networks, Advantage members have enjoyed increased access.

This option provides members with quality and reasonably priced service at a convenient time and location. They are usually located in a shopping center or retail store. Convenience clinics are staffed by a nurse practitioner or physician assistant who are qualified to evaluate, diagnose, and prescribe medications for simple illnesses and are able to provide certain types of vaccinations and screenings.

Under the Advantage Plan, convenience clinics are available to members at a reduced co-payment of \$10 per visit for all cost levels. The plan also waives the first dollar deductible and the copayment for preventive care including vaccinations and some screenings.

The state saves both directly and indirectly when members use a convenience clinic rather than scheduling an office visit. A study conducted of HealthPartners' claims data found that convenience clinic treatment versus that offered by physician offices, urgent care centers and emergency departments was on average \$110 less costly.⁵³

In addition to the direct savings, the use of convenience clinics also provides indirect savings. Employees are typically able to visit a convenience clinic at a location and hour better suited to their family needs and work schedule. The flexibility of hours and locations combined with the no appointment requirement results in visits taking less time than for traditional medical venues and employee miss less work. Employees using this health care delivery method save the state an estimated average of two hours of time away from work per visit.

MinuteClinic in the Centennial Office Building

Advantage offers a MinuteClinic in the Centennial Office Building, on the State Capitol campus, in an effort to provide quality medical care for minor illnesses. A certified physician assistant who is qualified to evaluate, diagnose, and prescribe medications for simple illnesses, and to provide certain types of vaccinations and screenings staffs the MinuteClinic. Services are available to state employees, their families and the public at \$10 per visit, with no charge for preventive care.

Over an eight-month period in 2007, the Centennial Office MinuteClinic provided 1,100 visits. During 2007, the state paid \$59,000 to maintain the site. During 2008, the state paid \$92,000 and the site provided 1,600 visits over an eleven-month period.

Advantage Health Advisors (AHA!)

AHA!, a Minnesota Advantage Health Plan program, was an outcome of the 2005 negotiated agreement between the state and the employee unions. It offers state employees and their family members the opportunity to consult with licensed nurses to help make informed health care decisions.

The service helps members get the most from Advantage. It provides access to information about provider and facility selection, health conditions, treatment options, health plan coverage and cost sharing. The program operated the last four months of 2006 and during that period received approximately 1,040 inquiries.

The program continues to provide valuable services for members. In 2007, it has 4,619 inbound calls and 5,666 out bound calls. In 2008, there were 4,384 inbound calls and 1,713 outbound calls.

Worksite Flu Vaccination

SEGIP provides annual on-site flu vaccination clinics for state employees enrolled in Advantage. Onsite clinics make it quicker and easier for employees to receive a vaccination. Vaccinating employees helps to reduce the spread of the flu thereby saving the expense of sick leave usage for flu related illnesses. Experts estimate that three to four workdays are lost due to the flu and productivity is compromised when sick employees come to work and their performance is impaired due the illness.

State employee vaccination clinics are offered each year from late October through late November. Flu vaccinations are a preventive service included within the plan design and so employees enrolled in Advantage receive the service at no cost to them. Employees not enrolled in Advantage may participate but are required to pay a fee. Approximately 15,700 flu shots are dispensed at about 185 sites each year covering approximately 29 percent of all state employees.

Chronic Disease Management

Advantage features a disease management program to improve the health of members, hold down claim costs, and reduce employee absenteeism and increase productivity. These goals are accomplished by targeting members with chronic illnesses and educating them about their disease, suggesting treatment options, and assessing the treatment process and outcomes. Each of Advantage's three carriers (Blue Cross Blue Shield of Minnesota, HealthPartners, and PreferredOne) provides disease management services to their enrolled Advantage members.

Chronic disease management programs target the small portion of SEGIP's membership who consume a large portion of its total medical claims. In any given year, approximately five percent of members produce 50 percent of medical claims. By targeting those with chronic diseases, Advantage has the opportunity to reduce the claim costs of its most expensive members.

The carriers invite SEGIP members to participate in a disease management program based on the presence of one or more of these programs:

- Diabetes
- Cardiovascular diseases
- Depression
- Low back pain
- Asthma
- Cancer
- Chronic obstructive pulmonary disease
- Rare diseases and specialty drugs

Members in this program receive regular calls from a carrier representative, usually a registered nurse. The nurse seeks to ensure the member is successfully managing their condition and provides additional services as necessary. These services are designed to promote the member's understanding of the disease, behavior modifications, medication compliance, and support for self-monitoring techniques used to track the disease. Higher risk members receive more services than those with lower risk. Participants who achieve a certain level of control over their condition "graduate" from the program.

Health Risk Assessments

The Health Risk Assessment (HRA), implemented in 2005, is a benefit negotiated between the executive branch and the unions representing state employees. An HRA is a series of questions about health, lifestyle and health history that, based on an individual's responses, measures the individual's current health status and readiness to make a lifestyle behavior change. The assessments only identify health conditions that are addressable through behavior change.

Initially, each of the three health carriers provided their own HRA to members enrolled in their system. In 2008, the state moved to a single provider so that members would experience comparable results no matter which health carrier they chose. The new vendor also provides related online wellness programs.

The personal health assessment is completed annually, creating an opportunity for individuals to assess progress, update their current health status and identify areas of improvement to a modifiable lifestyle (such as quitting tobacco use, eating better, and managing stress). The wellness programs offer tools, resources and support needed to make healthy choices.

By choosing to take the assessment employees are rewarded with both a monetary savings and information about their personal health. Employees who take the assessment receive a \$5 discount on office visit copayments for both themselves and their dependents.

Members taking the assessment may be also eligible for a variety of programs offered to them at no charge. Three online wellness programs are available: 10,000 Steps, Healthy Weight, and Balancing Stress. It offers phone coaching for: back health, blood pressure management, chemical health, cholesterol management, emotional health, nutrition, healthy pregnancy, physical activity, stress management, tobacco cessation and weight management. Another available service is “Ask a Health Coach” in which member may ask health professionals questions on health topics by phone or secure email.

In both 2007 and 2008, approximately 70 percent of employees took the assessment. The table below, shows data from 2008, and illustrates the risk factors employees face. The four leading modifiable conditions are weight, pre-hypertension, second hand smoke and high cholesterol. This data is used to ensure that SEGIP programs are targeted to the conditions that most affect employees.

Prevalence of modifiable risk factors 2008	
Risk factors	Prevalence percent
Pre-diabetes	7.6
Pre-hypertension	39.8
High cholesterol	18.2
Overweight	38.4
Obesity	28.4
Sedentary	2.6
Use tobacco	10.6
Secondhand smoke	20.0
Alcohol (hazardous and harmful drinking)	1.8
Depression (history of)	18.0
Stress (unhealthy)	5.9

Figure 18 – Chronic Disease – prevalence of modifiable risk factors in 2008

MN Community Measurement

MN Community Measurement (MNCM) is a non-profit organization with representatives from Minnesota hospitals, physician groups, consumers, employers and health plans. MNCM’s mission is to improve the health of the community by publicly reporting information on health care cost and quality.

As part of its annual Open Enrollment, SEGIP encourages its members to use this resource to help select a health care provider. Members are provided a link to the organization’s annual Health Care Quality Report that can be found at www.mnhealthscores.org. This report provides members comparative data on provider group performance in the areas of preventive care screenings and

immunizations, basic ambulatory care tests and treatments, and treatment of selected chronic conditions, as well as cost, locations and past history. By combining both the clinic tiering information alongside the MNMCM quality rankings, SEGIP provides multiple sources of efficiency and quality for members to consider when enrolling in the program. SEGIP provides more referrals to MNMCM than any other employer or website in Minnesota or the nation.

DIAMOND Project

DIAMOND changes the way depression care is delivered and paid for in Minnesota. The roles of care manager and consulting psychiatrist were not previously reimbursable. Under this program, health plans make a monthly payment to participating medical groups for a bundle of services. Bundles services include all aspects of depression related care including the case manager, psychiatric and nursing services. Approximately 85 clinics offered DIAMOND in 2008. As of December 2008, 1,154 patients entered the program. Of those contacted after six months of active participation in DIAMOND, 55 percent had a 50 percent or greater reduction in the severity of depression symptoms and 44 percent were in remission.

Bridges to Excellence

Bridges to Excellence (BTE) is a national employer driven pay for performance effort that pays doctors for effective and efficient care. SEGIP, as a member of BHCAG, joined other large Minnesota employers in implementing this program. The Buyers Health Care Action Group (BHCAG) manages the program and SEGIP participates as a member of that group.

The national BTE program was modified to take advantage of certain aspects of the infrastructure that exists in Minnesota. Known as Minnesota Bridges to Excellence (MNBTE), the program rewards doctors for meeting care standards in the treatment of selected conditions. When initially implemented the program targeted diabetic care by following the standard of optimal care developed by the Institute for Clinical Systems Improvement (ICSI) and utilizing Minnesota Community Measurement (MNMCM) to measure performance. In 2004, less than 6 percent of patients in Minnesota were receiving diabetic treatment that met the ICSI standard.

When SEGIP began participation in April 2006, the MNBTE goal was for 10 percent of patients within a medical group to receive optimal diabetic care. MNMCM determined the rewards through the analysis of an annual health quality study. After reviewing approximately 700 clinics, MNMCM found that nine medical groups achieved the goal. SEGIP awarded those medical groups a total of \$55,000. SEGIP estimated that for every dollar it spent on provider rewards and program administration it saved \$5.60. Each year, the features of BTE are reassessed and enhanced, building upon the outcomes and experience of previous years.

Desiring a more granular level of quality transparency, MNBTE worked with MNMCM to accelerate their implementation of direct data submission (DDS). Through DDS, medical groups submit clinical data for each of their clinic sites to MNMCM. MNBTE began to pay rewards for optimal care at the clinic-level instead of the medical group level. Also in 2007, MNBTE added coronary artery disease as their second condition eligible for performance rewards. The performance goal for diabetes was increased to 20 percent of the clinic's patients with diabetes receiving optimal care and the goal established for coronary artery disease was set at 50 percent. Thirty-nine clinics were rewarded for diabetes and sixty-four clinics were rewarded for coronary artery disease. SEGIP paid \$34,000 in rewards for diabetes and \$83,000 in rewards for coronary artery disease.

In 2008, Optimal Vascular Care replaced coronary artery disease as the second condition in MNBTE. Three tiers of performance rewards were established. The minimum performance goal for diabetes was increased to 25 percent. The initial performance goal for Optimal Vascular Care was set at 40

percent of patients with the condition receiving optimal care. SEGIP paid \$89,000 in rewards for diabetes and \$30,000 for rewards for vascular care.

Centers of Excellence

SEGIP, in partnership with the state employee labor unions, Blue Cross Blue Shield Minnesota, HealthPartners and PreferredOne developed the Centers of Excellence (COE) program. This program identifies health care providers and facilities with the best patient care and outcomes and provides members with information to help make wise decisions about their individual health care providers.

The program brings together “best-in-class” providers and facilities to manage effectively and efficiently the care of patients with select costly disease states or procedures that require highly specialized, technical care. COEs have been established in the areas of bariatric surgery and transplants. Networks for the treatment of lower back pain and cardiac conditions are on the immediate horizon.

The underlying principle behind this program is that the best quality care translates into fewer complications and future lower costs. In other words, doing it right the first time is cheaper and more effective than doing it twice. Providers and facilities must demonstrate competence, superior outcomes, and a coordinated service approach to meet COE criteria. Programs are reevaluated each year to assure they continue to meet the standards by which they were originally selected.

Participation is voluntary. However, as the networks become more established SEIGP may begin to incent financially members to choose COE providers and facilities. Employees who use a COE understand that they will receive high quality care. For providers participation means an enhanced reputation and special referrals.

This program informs Advantage members of which providers meet the strict COE criteria. The COE network is listed on the SEGIP website and is available by calling *AHA!*

Medication Therapy Management (MTM)

SEGIP implemented a pilot diabetes MTM program in 2007. Under this MTM program, participants were closely monitored by their physicians and they received waivers for copays for their office visit to MTM pharmacists, lab tests ordered by pharmacists, and copays of drugs to treat diabetes, high cholesterol, and hypertension. Five targets were set for enrollees to meet including no tobacco use, aspirin use, as well as appropriate blood pressure, LDL level, and A1c level. In comparing the pilot participants to non-participants, 40.4 percent of participants reached all five targets over a 30-month period while only 25.5 percent of non-participants reached all five targets. The success of this program is likely to lead to an expansion of the MTM concept for SEGIP members.

eValue8

eValue8 is a nationally recognized health care purchasing and quality improvement assessment process. Using a standardized request for information, eValue8 asks health plans to submit information about clinical quality and administrative efficiency so that purchasers of health care can compare health plans against one another and against national benchmarks. It provides the information necessary to select health plans based on quality, not just price. The results can also be used in on-going health plan performance management.

eValue8 is sponsored by the National Business Coalition on Health (NBCH) and managed by regional health care coalitions on behalf of their members. SEGIP participates in this program

through its membership in the Buyers Health Care Action Group (BHCAG). The evidence-based content in eValue8 is reviewed and updated each year and is informed through the collaboration with national experts, such as the Centers for Disease Control and Prevention (CDC), the federal Agency for Healthcare Research and Quality (AHRQ), the American Board of Internal Medicine and George Washington and Pennsylvania State universities.

From January through April each year, the eValue8 process is conducted by BHCAG. All three of Advantage's health carriers participated in the eValue8 process conducted by BHCAG. These carriers, as well as others across the country, responded to a standard request for information that included questions about clinical quality and administrative efficiency. The responses were verified and a report was produced.

Once the review of the health carriers was completed, meetings were held with the carrier leaders and BHCAG members to discuss each plan's eValue8 results and identify areas for improvement and collaboration. These discussions helped develop community-wide collaboration to improve the health outcomes associated with chronic illnesses such as diabetes, coronary heart disease and asthma. They also created a basis for performance guarantees and provided leverage for rate negotiations. The content in eValue8 results in benchmarks for improving value and quality for all stakeholders in Minnesota.

Governor's Health Cabinet

Governor Tim Pawlenty created the Governor's Health Cabinet to develop solutions to rising health care costs and deliver more value for health care spending. The Health Cabinet is comprised of the state agency heads from five state agencies: the departments of MMB, Health, Human Services, Commerce, and Labor and Industry. The members work together to find solutions to health care issues often collaborating with other political divisions, non-profits and private industry to develop new health care reform ideas. Through this collaborative approach, SEGIP has another avenue to develop methods to hold down and even reduce health care costs. It was through the cabinet that many pilot project and new programs were developed.

V. Complaints

Number of complaints

Members may file a complaint, or appeal, if they believe an insurance coverage decision or transaction was made in error. Appeals range from a member's claim that she/he did not receive an enrollment packet and were unable to enroll to a transaction was erroneously processed.

The number of complaints remains low. In both 2005 and 2006, approximately .003 percent of members filed an appeal with SEGIP. Of the appeals filed in 2007, 41 percent were approved while 59% were denied. In 2008, 34 percent of all appeals were approved and 66 percent were denied. New to the Open Enrollment process in 2008, was the confirmation statement that provided members the opportunity to correct documented errors. The introduction of the statements resulted in fewer approved Open Enrollment appeals because they enabled the correction of mistakes before an appeal was filed. It also increased the number of denials because it caused some members remember to realize they failed to complete their Open Enrollment and use the confirmation process as an attempt to continue Open Enrollment.

Open Enrollment Appeals

Year	Approved	Denied	Total
1999 - 2000	215	74	289
2000 - 2001	154	50	204
2001 - 2002	207	57	264
2002 - 2003	84	38	122
2003 - 2004	na	na	na
2004 - 2005	93	47	140
2005 - 2006	53	58	111
2006 - 2007	43	25	68
2007 - 2008	72	104	176
2008 - 2009	37	177	214

Non-Open Enrollment Appeals

Year	Approved	Denied	Total
1999 - 2000	8	4	12
2000 - 2001	3	0	3
2001 - 2002	50	32	82
2002 - 2003	16	35	51
2003 - 2004	97	111	208
2004 - 2005	104	112	216
2005 - 2006	15	21	36
2006 - 2007	53	110	163
2007 - 2008	93	138	231
2008 - 2009	110	103	213

Figure 19 – Appeals

VI. End Notes

¹ Crimmel, B.L. *Trends in Employer-Sponsored Health Insurance offers and Enrollment, Private Sector by Firm Size, 1998-2008*. Statistical Brief #266. Agency for Healthcare Research and Quality, Rockville, MD. www.meps.ahrq.gov/mepsweb/data_files/publications/st266/stat266.pdf, Accessed on October 6, 2010.

² Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2007 Annual Survey*, page 14. This is publication #7672 and is available at www.kff.org.

[Hereinafter Kaiser 2007]

Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2008 Annual Survey*, page 14. This is publication #7790 and is available at www.kff.org.

[Hereinafter Kaiser 2008].

SEGIP percentage increases were developed by SEGIP staff.

³ For more information about the change in reporting method, see Kaiser 2008, *supra* note 2, at 14.

⁴ The Advantage premium increased 3.5 percent in 2009 and had no increase in 2010.

⁵ Kaiser 2007, *supra* note 2, at 13.

Bureau of Labor Statistics, Consumer Price Index. U.S. City Average. Medical care inflation. Not seasonally adjusted.

http://data.bls.gov/PDQ/servlet/SurveyOutputServlet?data_tool=latest_numbers&series_id=CUUR000SAM&output_view=pct_12mths. Accessed on 10/26/10.

Bureau of Labor Statistics, Consumer Price Index. U.S. City Average. Inflation. Not seasonally adjusted.

http://data.bls.gov/PDQ/servlet/SurveyOutputServlet?data_tool=latest_numbers&series_id=CUUR000SA0&output_view=pct_12mths. Accessed on 10/26/2010.

⁶ Kaiser 2008, *supra* note 2, at 16.

⁷ In 1999, the state the state offered its employees a choice between six different health plans. Its lowest costing 1999 family health plan had a monthly premium of \$816.80. The plan cited is most comparable to the current Advantage Health Plan.

⁸ Minnesota Statutes 43A.30 subdivision 4.

⁹ In this report, an attempt is made to compare Minnesota state employee insurance benefits to those afforded workers on a state and national basis. One tool used is the Medical Expenditure Panel Survey. MEPS did not collect 2007 data. For more information, see www.meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp.

¹⁰ Kaiser 2007, *supra* note 2, at 11.

¹¹ *Id.* at 11.

¹² *Id.* at 66.

¹³ *Id.* at 79.

¹⁴ *Id.* at 67.

¹⁵ Kaiser 2008, *supra* note 2, at 14.

¹⁶ *Id.* at 14.

¹⁷ U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey (MEPS) [Hereinafter MEPS].
www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2008/tiic1.htm

¹⁸ Kaiser 2008 *supra* note 2, at 72.

¹⁹ MEPS *supra* note 17 at
www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2008/tiic2.pdf
at accessed on October 8, 2010.

²⁰ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tia2b.pdf
accessed on October 12, 2010.

²¹ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tia2b.pdf
accessed on October 12, 2010.

²² *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tia2b.pdf
accessed on October 14, 2010.

²³ Kaiser 2007, *supra* note 2, at 11.

²⁴ *Id.* at 11.

²⁵ *Id.* at 66.

²⁶ *Id.* at 66.

²⁷ *Id.* at 66.

²⁸ *Id.* at 80.

²⁹ *Id.* at 80.

³⁰ *Id.* at 14.

³¹ Kaiser 2008, *supra* note 2, at 14.

³² MEPS *supra* note 17 at
www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2008/tiic1.htm
accessed on November 4, 2010.

³³ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tia2c.pdf
accessed on October 12, 2010.

³⁴ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tia2c.pdf
accessed on October 15, 2010.

³⁵ Out-of-pocket costs are collected at the point of service and the balance of the claim is billed by the carrier to SEGIP. Consequently, out-of-pocket costs are not displayed or reported on income statements as a separate line. This is an industry wide practice.

³⁶ Kaiser 2007, *supra* note 2, at 90.

³⁷ Kaiser 2008, *supra* note 2, at 127.

³⁸ *Id.* at 96.

³⁹ MEPS *supra* note 17 at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tif1.pdf accessed on October 19, 2010.

⁴⁰ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2008/tiif1.pdf accessed on October 19, 2010.

⁴¹ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2008/tiif2.pdf accessed on October 18, 2010.

⁴² *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2008/tiif3.pdf accessed on October 19, 2010.

⁴³ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2008/tiif4.pdf accessed on October 19, 2010.

⁴⁴ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2008/tiif5.pdf accessed on October 19, 2010.

⁴⁵ Kaiser 2007, *supra* note 2, at 89.

⁴⁶ *Id.* at 112.

⁴⁷ *Id.* at 89.

⁴⁸ Kaiser 2008, *supra* note 2, at 98.

⁴⁹ Administrative Costs at Minnesota Health Plans in 2008, Minnesota Department of Health. June, 2010. <http://www.health.state.mn.us/health/economics> Accessed on October 7, 2010

⁵⁰ The EAP serves the entire employee population, not just the insurance eligible. This includes those in all three branches of state government as well as both full and part-time employees of the Minnesota State Colleges and Universities (MnSCU). In 2007, there were 56,201 employees and 56,405 in 2008.

⁵¹ Julia Philips, actuary, Minnesota Department of Commerce, e-mail to SEGIP, St Paul, Minnesota October 21, 2010.

⁵² Administrative Costs at Minnesota Health Plans in 2008, Minnesota Department of Health. June, 2010. <http://www.health.state.mn.us/health/economics> Accessed on October 7, 2010.

⁵³ Mehrotra, A., H. Liu, J. L. Adams, M. C. Wang, J. R. Lave, N. M. Thygeson, L. I. Solberg, and E. A. McGlynn, "Comparing Costs and Quality of Care at Retail Clinics with That of Other Medical Settings for 3 Common Illnesses," *Ann Intern Med*, Vol. 151, No. 5, September 1, 2009, pp. 321–328. Found in *Policy Implications of the Use of Retail Clinics*. Robin M. Weinick, Craig Evan Pollack, Michael P. Fisher, Emily Meredith Gillen, Ateev Mehrotra. Prepared for the Department of Health and Human Services (2010) http://www.rand.org/pubs/technical_reports/2010/RAND_TR810.pdf . viewed on October 11, 2010.