



*Minnesota State Employee Group
Insurance Program*

**Biennial Report
2009-2010**



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I. Program Overview

Minnesota Management & Budget

Minnesota Management & 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.

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 2009 and 2010.

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 \$6,500.¹

State Employee Group Insurance Program (SEGIP)

SEGIP is the single largest employer group purchaser of insurance in Minnesota, covering approximately 48,700 employees as well as their dependents, for a total of approximately 123,100 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 \$542.6 million in 2009 and \$543.9 million in 2010. The majority of these costs, approximately 94 percent, were associated with health coverage, with the balance expended for dental, life, and disability coverage and the supporting administration fee.

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 health care model 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.

Innovative programs designed to hold down health care costs, improve the quality of care, and increase access for its members continue 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, as well as other large health care purchasers including 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 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 48,700 employees, 64,300 dependents, 9,500 retirees and 600 COBRA participants.

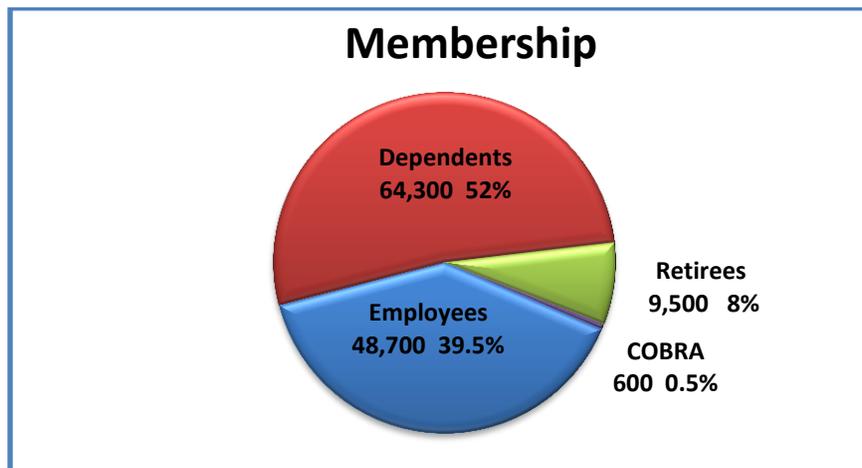


Figure 1 – Membership 2009 - 2010

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 which bargain separate contracts. 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 2009 and 2010, 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 medical (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 disease management programs and programs to help manage chronic health conditions, a health risk assessment program that features programs to help improve health, as well as other services provided by the contracted health administrators, other vendors, and in-house resources. 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 annual premiums and fees collected by SEGIP total well over a half billion dollars per year. Total premiums and administrative costs in 2009 were \$681,085,468 and \$684,770,650 in 2010. Medical premiums were \$597 million in 2009 while all other premiums and fees combined amounted to \$84 million or 12.3 percent of total premiums and fees contributed. In 2010, medical premiums were \$599.5 million and all other premiums and fees totaled \$85.3 million or 12.5 percent of total premiums and fees contributed.

Program Premiums & Fees by Product – 2009 and 2010

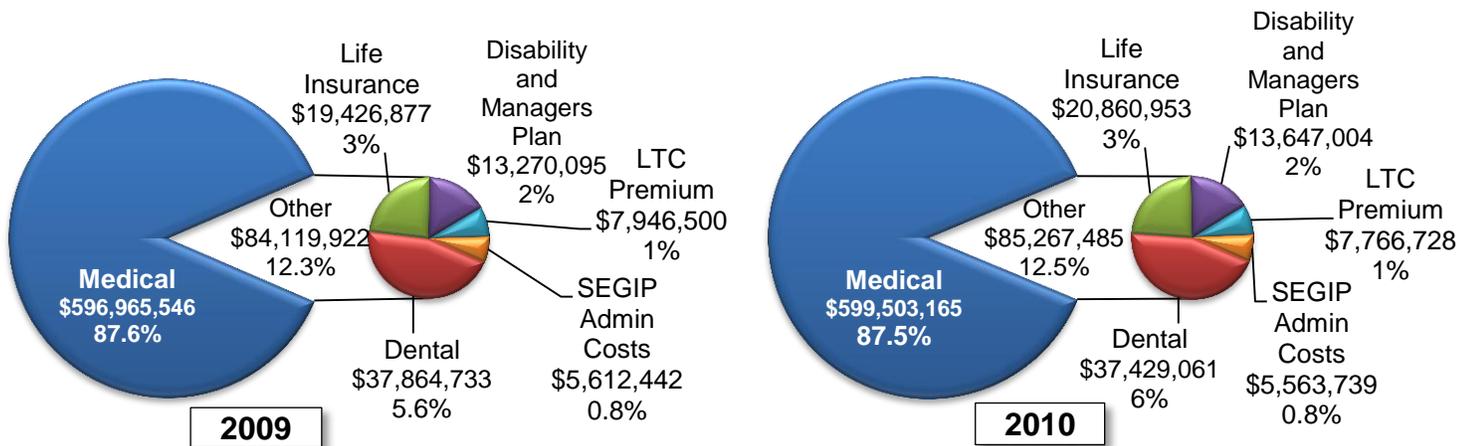


Figure 2 – Total premiums & fees by program in 2009 and 2010

Total Premiums by Source

State agencies pay the majority of employee insurance benefits costs. State employees and retirees paid proximately 17.9% of premium costs in 2009 and 18.2% in 2010. The participating quasi-state agencies and their employees paid 2.6% of all costs in both 2009 and 2010. State agencies paid 79% of all premiums in both 2009 and 2010 as well as most of the administrative costs.

Total Premiums by Source

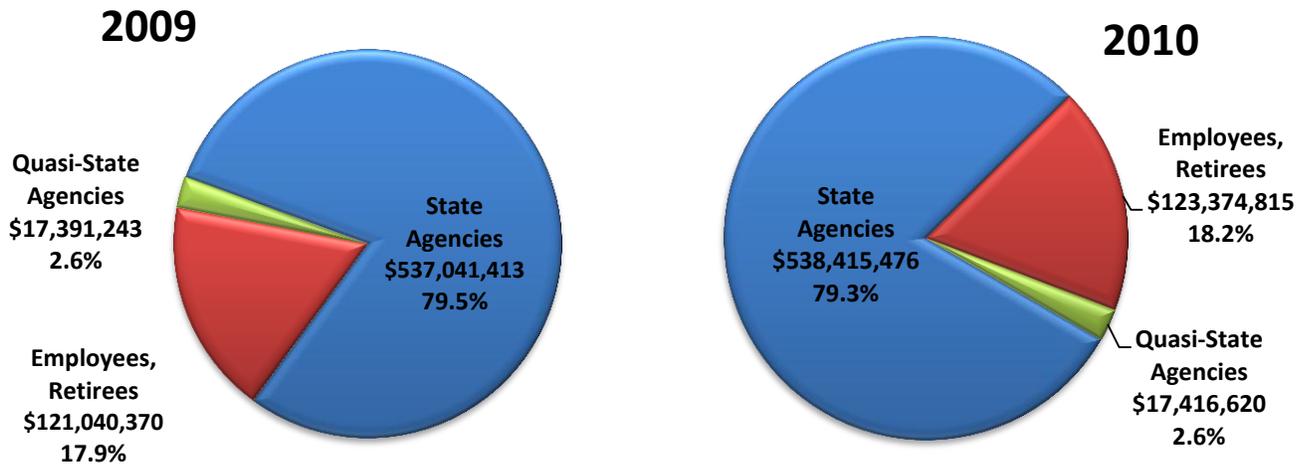


Figure 3 – Total premiums by source

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 2010, 69 percent of firms offered health benefits² and 99 percent of firms with 1,000 or more workers also offered health benefits.³

The total cost of health insurance for state employees and their insurance eligible dependents during 2009 and 2010 was nearly \$1.2 billion. Of this, state agencies paid \$1 billion, employees and retirees paid \$143 million, and quasi-state agencies and their employees paid \$31.5 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 administrators, Blue Cross Blue Shield of Minnesota, HealthPartners and PreferredOne. These vendors pay claims, make available access to a network of health care providers, and disease management services. All three vendors provide access to the same Advantage Health Plan.

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 more prevalent in the industry.

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 Plan’s premium increases are generally lower than the national average. Between 2002 and 2008 the Advantage health premium increased on average by 8.09 percent compared to the national average of 9.4 percent. In 2009 the national average premium increase for family coverage was 5 percent and the single coverage average premium did not increase at all. During this same period the Advantage health premium increased 3.5 percent for both family and single coverage. During 2010 the Advantage premium did not increase while the national average family premium increased by 3 percent and single premiums increased by 5 percent.⁴

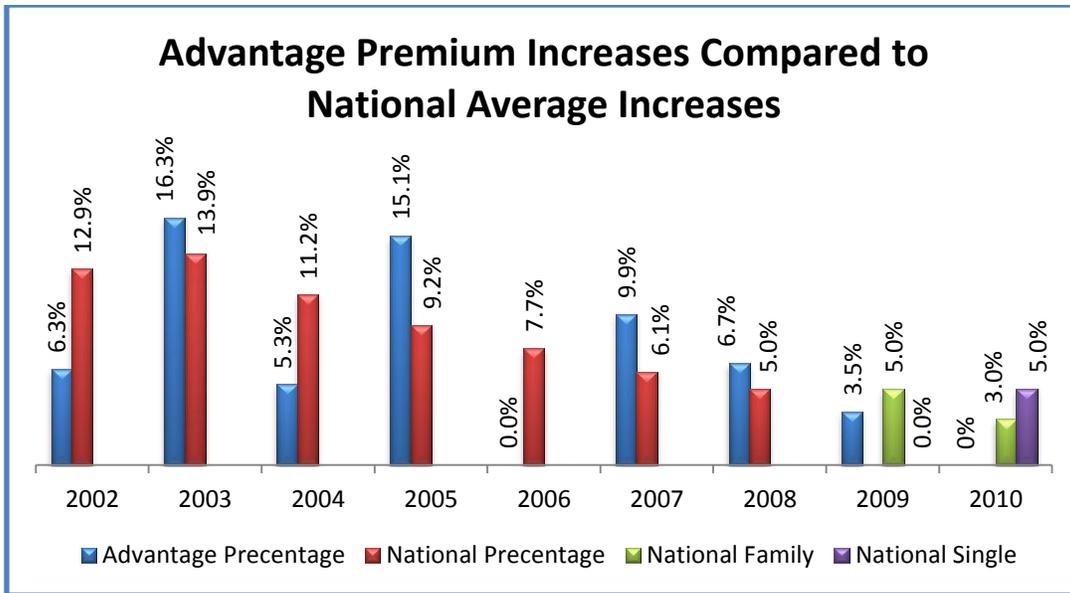


Figure 4 – Advantage premium increases compared to national average increases⁵

Note: In 2008, the method for calculating the national average increase changed.⁶ Beginning in 2009 the national numbers are broken down between single and family coverage. Earlier years features a combined number. While the Advantage Plan has separate family and single rates, both increase at the same rate.

Between 2002 and 2008 the Advantage health premium and the U.S. national average family premium both rose faster than medical inflation or all item inflation. During 2009 and 2010 SEGIP's health premium fell below both inflation measures while the national average premium fell below only in 2010. Between 2002 and 2010 the national average family premium increased by an average of 8.2 percent compared to the SEGIP health premium which increased on average 7 percent. During this same period the U.S. medical care consumer price index (CPI) increased on average 4 percent and the U.S. all item CPI increased on average 2.3 percent.

Overall, the average Advantage family health premium is growing at slightly lower pace compared to the U.S. national average family health premium. The \$13,770 national average annual family premium in 2010 was 72 percent higher than it was in 2002.⁷ Comparably, the Advantage family premium in 2010 was \$15,784, 71 percent higher than its family premium in 2002.

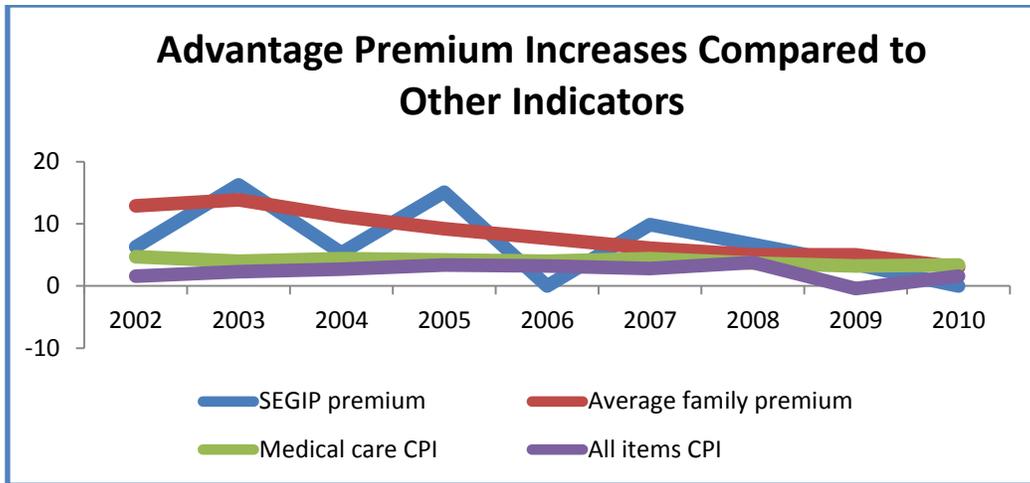


Figure 5 – Advantage premium increases compared to other indicators⁸
 Sources: Kaiser/HRET Survey of Employer-Sponsored Health Benefits and Bureau of Labor Statistics and Consumer Price Indexes (CPI).⁹

The Advantage Health Plan’s average family premium compares to both the U.S. average family premium and the average state government employee health plan family premium

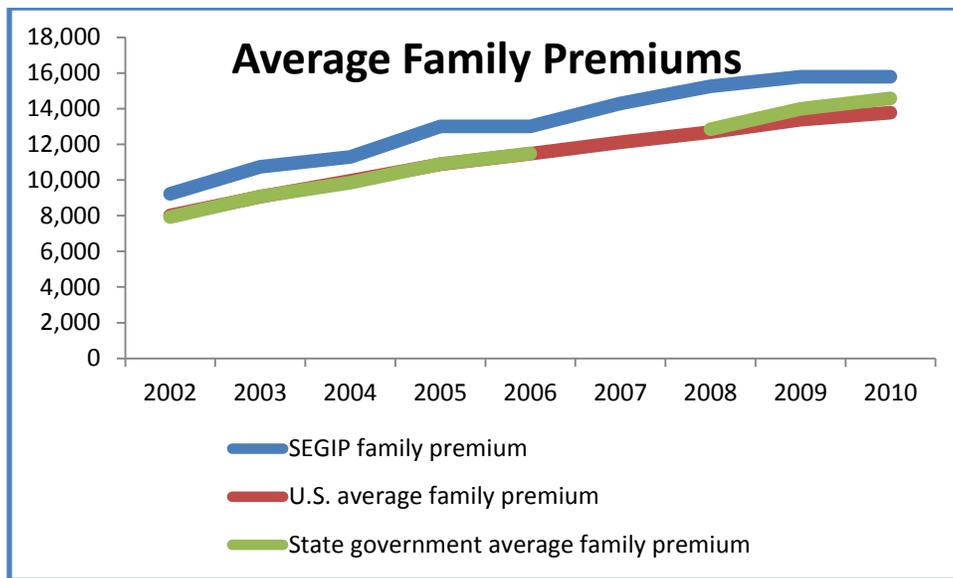


Figure 6 – Advantage annual family premium compared to the U.S. average annual family premium¹⁰ and the average annual family premium for a state government employee plan¹¹ from 2002 to 2010

NOTE: The average state family premium was not reported for 2007

In addition to health care trend (cost and utilization), there is a variety of forces that impact the cost of health care coverage. Older members tend to cost more to cover than do younger members. Over 48 percent of SEGIP’s participating employees are age 50 or older which tends to increase premium costs. Union-bargained health coverage tends to be more comprehensive and cost more than coverage for employers without union representation. Over 80 percent of SEGIP’s employee population is represented by a union. Self-insured plans tend to cost less to operate than do fully-insured plans because the administrative costs are lower. The Advantage Health Plan is a self-

insured product. While many factors force costs higher or lower these features in particular are industry-standards that tend to impact costs, and are features that are easily comparable from plan to plan.

Average Annual Premiums for Covered Workers with Single Coverage, by Firm Characteristics, 2010				
	All Small Firms (3–199 Workers)	All Large Firms (200 or More Workers)	All Firms	SEGIP
Unions				
Firm has at least some union workers	\$5,726	\$5,196*	\$5,263*	\$5,367
Firm does not have any union workers	\$4,948	\$4,926*	\$4,936*	\$5,367
Older Workers				
Less Than 35% of Workers Are Age 50 or Older	\$4,825*	\$4,969*	\$4,918*	\$5,367
35% or More Workers Are Age 50 or Older	\$5,466*	\$5,200*	\$5,291*	\$5,367
Funding Arrangement				
Fully Insured	\$4,972	\$5,286*	\$5,060	\$5,367
Funding arrangement is self-insured	\$5,428	\$5,001*	\$5,041	\$5,367

Figure 7 – Select features impacting the cost of the Advantage Health Plan

Note: All figures other than the SEGIP premium are a product of Kaiser¹²

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.¹³ During 2007, the Advantage Health Plan earned interest equal to approximately 1.6 percent of its total income. The economic downturn began in roughly late 2007 and SEGIP’s interest income has steadily fallen since. In 2008 interest income was 1.4 percent, in 2009 it was 0.86 percent and by 2010 the rate of return fell to less than one-half percent.

Advantage Income by Source								
2007 - 2010								
Year	2007		2008		2009		2010	
	Dollars	Percent	Dollars	Percent	Dollars	Percent	Dollars	Percent
Premiums	530,671,700	98.35%	570,711,698	98.60%	596,965,546	99.14%	599,503,165	99.57%
Interest	8,905,293	1.65%	8,092,692	1.40%	5,178,986	0.86%	2,573,564	0.43%
Total	539,576,993	100%	578,804,390	100%	602,144,532	100%	602,076,729	100%

Figure 8 – Advantage income 2007 - 2010

Health premiums

State agencies pay the majority of health premiums and the percent they contribute has increased slightly since 2004. Agencies contributed 84.2 percent of total premiums in 2004 and by 2009 their contribution increased to 85.4 percent and stayed at that level through 2010. During the same period, the portion contributed by employees and retirees fell from 12.9 percent to 12 percent. Quasi state agencies paid 2.8 percent of total health premium in 2009 and 2.6 percent in 2010. Generally, the percent of contribution is stable with slight variations.

In 2009, a total of \$597 million was contributed in health premiums. Of that, state agencies paid \$510 million, state employees and retirees contributed \$71.1 million and quasi-state agencies and their employees contributed the remaining \$15.8 million.

In 2010, a total of \$599.5 million was contributed in health premiums. Of that, state agencies paid \$511.8 million, state employees and retirees contributed \$71.9 million and quasi-state agencies and their employees contributed the remaining \$15.8 million.

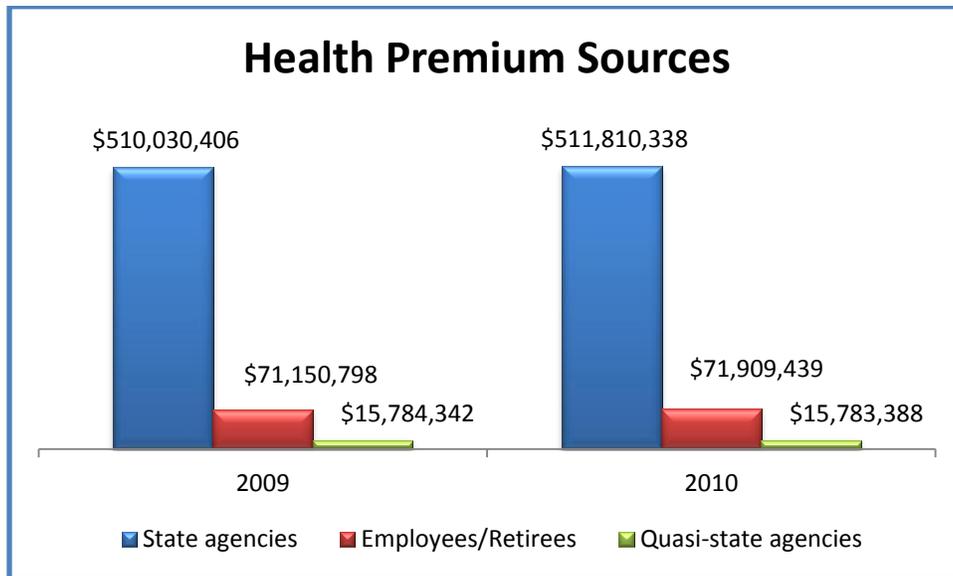


Figure 9 – Health premium sources

The Advantage Health Plan’s premium experienced a 21 percent increase between 2005 and 2010. The premium increased by 9.9 percent in 2007, 6.70 percent in 2008, 3.5 percent in 2009, and there was a zero percent increase in both 2006 and 2010.

The single premium held steady from 2009 to 2010. The single monthly premium in 2008 rose by \$15.12 to \$447.28 per month, or \$5,267 per year, and remained at that level in 2010. The state pays the full single premium and absorbed the full 3.5 percent increase in 2009 and no increase in 2010.

The family premium held steady from 2009 to 2010. The family monthly premium rose by \$44.48 in 2009 to \$1,315.34 per month, or \$15,784 per year, and remained at that level in 2010. The state paid \$1,185.14 per month and the employee paid \$130.20 per month. Both the state and the employee experienced a 3.5 percent premium increase in 2009 and no increase in 2010.

Advantage Monthly Health Premiums 2005 – 2010										
<i>(in rounded dollars)</i>										
Year	2005 - 2006	2007			2008			2009 and 2010		
	Total	Total	State	Employee	Total	State	Employee	Total	State	Employee
Single monthly	369	405	405	0	432	432	0	447	447	0
annual	4,424	4,682	4,862	0	5,186	5,186	0	5,367	5,367	0
Family monthly	1,084	1,192	1,074	118	1,271	1,145	126	1,315	1,185	130
annual	13,010	14,298	12,883	1,415	15,250	13,741	1,510	15,784	14,332	1,562
Percent increase	15% / 05 0% / 06	9.9%			6.7%			3.5% / 09 0% / 10		

Figure 10 – Advantage monthly single and family premiums

Health premium for single coverage

Single coverage in 2009

In 2009, the Advantage single coverage contribution was \$447.28 per month compared to the national average of \$402 per month.¹⁴

Advantage’s annual cost for single coverage in 2009 was \$5,367 compared to the national average of \$4,824.¹⁵ The average single premium per employee enrolled through a state government job was \$5,582.¹⁶

Under Advantage, employees make no contribution for single coverage. Nationally, 38.2 percent of all private sector establishments that offer health coverage offer at least one plan that pays the full single coverage.¹⁷ Only 11.1 percent of firms over 1,000 employee pay the full single premium while 64.2 percent of small firms (with less than 10 employees) pay the full single premium.¹⁸

Nationally on average workers contribute 17 percent of the premium for single coverage.¹⁹ The average monthly contribution for single coverage was \$65.²⁰ Workers in self-funded plans, such as Advantage, pay on average 18 percent for single coverage²¹ and workers in firms that had at least some union workers paid on average 16 percent.²² On average employees of state and local governments pay 11 percent of the premium for single coverage.²³

The average total single premium per employee enrolled through a state government job was \$5,451.²⁴ Comparably, state government employees nationally, contributed an average of \$582 annually (or \$48.50 per month) in 2009.²⁵

Less than half of all employers offered a health plan that required no contribution from employees for single coverage. Nationally, 38.2 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.²⁶ In Minnesota, that number was 31.1 percent in 2009.²⁷ Nationally, 38.2 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.²⁸

Single coverage in 2010

In 2010, the Advantage single coverage contribution rate was \$447.28 per month compared to the national average of \$421 per month.²⁹

Advantage's single rate was higher than the national average but less than the national average for state and local governments. In 2010, the Advantage annual cost for single coverage was \$5,367 compared to the national average cost of premiums for single coverage of \$5,049.³⁰ The average total single premium per employee enrolled through a state government job was \$5,582.³¹

Under Advantage, employees make no contribution for single coverage. Nationally, 35 percent of small firms pay the full premium while only six percent of large firms pay the full premium.³² On average covered workers contributed 19 percent for the single premium.³³

Nationally the average covered worker contributed \$900 per year (or \$75 per month).³⁴ Comparably, state government employees nationally, contributed an average of \$566 annually (or \$47.17 per month) in 2010.³⁵ Workers in self-funded plans, as is Advantage, paid on average 17 percent for single coverage and workers in firms that had at least some union workers paid on average 17 percent for single coverage.³⁶

Less than half of all employers offered a health plan that required no contribution from employees for single coverage. Nationally, 35.9 percent of private sector employers that offered health insurance that offered at least one health insurance plan that required no contribution from the employee for single coverage.³⁷ That is down from 40.7 percent in 2008³⁸ and from 71.4 percent in 2002.³⁹ In Minnesota, that number was 34 percent in 2010.⁴⁰ 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.⁴¹

Health premiums for family coverage

Family coverage in 2009

In 2009, Advantage's family rate was \$1,315.34 per month compared to the national average of \$1,115 per month.⁴² Advantage's annual family premium rate was \$15,784, which was higher than the national average of \$13,375 for family coverage premium.⁴³ The average total family premium per employee enrolled through a state or local government in 2009 was \$14,024, the total for just state governments was slightly lower at \$13,992.⁴⁴

Under Advantage, the annual employee contribution for family coverage in 2009 was \$1,562.40 compared to a \$3,515 contribution by the average worker nationally.⁴⁵ Workers in large firms paid the national average of \$3,182 for family coverage.⁴⁶ Nationally, 19.9 percent, and in Minnesota 15.7 percent, of private sector employers who offered health insurance offered at least one health insurance plan that required no employee contribution for family coverage in 2009.⁴⁷

The employee portion of the family premium contribution under Advantage was 9.9 percent of the premium compared to 27 percent paid on average by workers nationally,⁴⁸ 23 percent was the average for self-funded plans,⁴⁹ and 21 percent was the average paid by workers in firms that had at least some union workers.⁵⁰

Nationally, 19.9 percent, and in Minnesota 15.7 percent, of private sector employers who offered health insurance offered at least one health insurance plan that required no employee contribution for family coverage in 2009.⁵¹ Nationally, 29.5 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.⁵²

Family coverage in 2010

The Advantage family premium contribution in 2010 was comparable to national averages. The Advantage monthly premium for family coverage was \$1,315.34 compared to the national average of \$1,147 per month.⁵³ Advantage's annual family premium, in 2010 was \$15,784 compared to the national average of \$13,770 per year.⁵⁴ The average total family premium per employee enrolled through a state or local government in 2010 was \$14,988, the total for just state governments was slightly lower at \$14,583.⁵⁵

Under Advantage, like most workers nationally, employees paid a portion of the family coverage premium contribution. Nationally, 18.7 percent, and in Minnesota 15.1 percent, of private sector employers who offered health insurance offered at least one health insurance plan that required no employee contribution for family coverage in 2010.⁵⁶ Nationally, 23 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.⁵⁷

Out-of-pocket costs

In addition to a premium contribution for family coverage, all members have limited out-of-pocket cost responsibilities.⁵⁸ 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 2009, Advantage members paid 8.8 percent of the plan's allowable claims through cost sharing and in 2010 that number was 8.1 percent.

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 2010 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 2010, the deductible for single coverage in cost level 1 was \$50 or \$100 for a member with family coverage. Cost level 2 provides a \$140 deductible for single coverage and \$280 for family coverage. Single coverage in cost level 3 is \$350 while the family deductible is \$700. In cost level 4, a member with single coverage will pay a \$600 deductible while the family deductible was \$1200.

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. By taking the health risk assessment, members receive a \$5 discount on all office visit copayments for themselves and their covered dependents. In 2010, the cost level 1 office visit copayment for single and family coverage was \$17 (or \$22 without the health assessment). The cost level 4 copayment was \$37 (or \$42 if the employee did not take the health assessment).

The plan also features copayments for several other services. A visit to a convenience clinic entailed a \$10 copayment for 2006 through 2010 for all tier levels. 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 2010, Advantage included coinsurance for:

- Prosthetics and durable medical equipment: 20 percent for cost levels 1 through 3 and 25 percent for cost level 4 members.

- Lab, pathology, X-rays; and certain other expenses (such as home health care and outpatient hospital services): 5 percent for cost levels 1 and 2, 10 percent at cost level 3, and 25 percent at cost level 4.

Advantage members were limited to the aggregate out-of-pocket maximum of \$1,100 for single coverage and \$2,200 for family coverage in both years 2009 and 2010. Nationally, in 2010 13 percent of covered workers with an out-of-pocket maximum had one between \$1000 and 1,499 for single coverage.⁵⁹ Nationally, in 2010 10 percent of covered workers with family coverage had an aggregate out-of-pocket maximum paid between \$2,000 and 2,999.⁶⁰

Advantage Plan expenses

SEGIP expenditures are a combination of claims and related administrative expenses. In 2009, health claim costs alone comprised 94.3 percent of the program's total program expenditures. Those claims increased from \$521.3 million in 2008 to \$553.8 million in 2009, an increase of \$32.5 million or 6 percent over those paid in 2008. In 2010, health claims increased to \$588.1 million. This represented an increase of \$34.4 million or 6.2 percent increase over health claims paid in 2009.

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

- Administrative and Reinsurance: The plan administrator's administration costs and reinsurance combined was approximately 5.5 percent of total health program premiums in 2009 and 5 percent in 2010. SEGIP's health plan administrator's administrative costs were lower than Minnesota's average health plan administrative cost of 7.9 percent in 2009 and 7.2 percent in 2010.⁶¹
- Employee Health Reimbursement Account: A \$125 health reimbursement account was provided to each contract holder in 2011. The \$9.495 million includes the cost of the accounts as well as the associated administrative fees. The cost was allocated to 2010 because eligibility for the HRA was based on membership on December, 2010. The HRAs were awarded in January 2011.
- Consulting, EAP, and other costs: Includes the cost of the state EAP program, the program's actuaries, attorney and other related costs.
- Prior years – settlement paid: plan administrators 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 reserve 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 2008, the reserves were 31 percent of the annual expenses and 36 percent at the end of 2010. The program's actuaries estimate that a Contingency Reserve equal to 16.7 percent of annual claim expenses will adequately ensure the solvency of the fund. To achieve this goal annual premium increases 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 2015.

Advantage Health Plan - Financial Statement			
<i>Actual - in dollars</i>			
	CY 2008	CY 2009	CY 2010
Income			
Premiums	570,711,698	596,965,546	599,503,165
Interest	<u>8,092,692</u>	<u>5,178,986</u>	<u>2,573,564</u>
Total Income	578,804,390	602,144,532	602,076,729
Expenditures			
Claims Paid and Incurred	487,647,098	523,266,630	558,027,179
Administration Fee & Reinsurance*	33,664,288	30,517,856	30,116,923
Employee Health Account	16,318,750	0	9,495,000
Consulting, EAP, and other costs	432,814	424,841	512,328
Prior years - settlements (received) paid	<u>(4,260,598)</u>	<u>569,263</u>	<u>2,930,079</u>
Total Expenditures	<u>533,802,352</u>	<u>554,778,590</u>	<u>601,081,509</u>
Gain or (Loss)	45,002,038	47,365,942	995,220
Contingency Reserves - End of Plan Year	<u>167,186,626</u>	<u>214,552,568</u>	<u>215,547,788</u>

* paid to plan administrators

Figure 11 – 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.

Consumer Directed Health Plan

The 2008 legislature required a consumer directed health plan (CDHP) be offered to eligible employees eligible whose insurance follows either the Manager’s Plan or the Commissioner’s Plan beginning January 1, 2010.⁶² The Advantage Consumer Directed Health Plan (ACDHP) is an alternative to the “traditionally structured” Minnesota Advantage Health plan. The CDHP must include an option for a health plan that is compatible with the definition of a high-deductible health plan in section 223 of the United States Internal Revenue Code.

The ACDHP offers the same benefit set as the Minnesota Advantage Plan but the costs have a different structure. The plan was accompanied by a Healthcare Savings Account (HSA), a special tax-preferred trust or custodial account established under IRS Code Section 223 that is used to pay for current and future medical expenses. The money deposited into the HSA and earnings thereon are not taxable. The funds can be withdrawn from the account to cover qualified medical expenses on a tax-free basis. Unused balances roll over from year to year.

In 2010, the state made monthly contributions to the HSA of up to \$700 per year for full-time employees with ACDHP single coverage and \$1,400 per year for those with ACDHP family coverage. The HSAs were administered by the financial institution associated with the health plan administering the ACDHP. Nationally, the average annual deductible for workers enrolled in a high deductible health plan with a health savings account was \$2,096.⁶³

The program includes the same tiering structure as Advantage but with different deductibles. Under all tiers the ACDHP pays 100 percent of covered services, the annual deductible is \$1,500 for single coverage and \$3,000 for family coverage. Nationally, the average deductible for workers with family coverage is \$4,006 for workers in a HDHP with an HSA.

Under Advantage the maximum out-of-pocket costs are \$3,000 for single coverage and \$6,000 for family coverage. After the deductible is met, the copayment is 5 percent in Tier 1, 10 percent in Tier 2, 15 percent in Tier 3 and 25% in Tier 4.

Under federal law, an HDHP with a qualified HSA must have a maximum annual deduction and other out-of-pocket liability of no more than \$5,950 for single coverage and \$11,900 for family coverage in 2010.⁶⁴ Under ACDHP the single total is \$4,500 and the total annual family cost is \$9,000.

Advantage, as 94 percent of high deductible health plans with an HSA, does not require members to meet a general annual deductible before preventive care is covered.⁶⁵

In 2010, 34 employees elected single coverage under the CDHP and 29 employees elected its family coverage.

Consumer Directed Health Plan Premiums - 2010									
<i>(in dollars)</i>									
	Employee Coverage			Dependent Coverage			Family Coverage		
Health Plan	Total	State	Employee	Total	State	Employee	Total	State	Employee
Monthly Rates	380.62	380.62	0	801.40	671.20	130.20	1,182.02	1,051.82	130.20
Annual Rates	4,567.44	4,567.44	0	9,616.80	8,054.40	1,562.40	14,184.24	12,621.84	1,562.40

Figure 12 – Advantage Health Plan financial statement

Dental insurance

SEGIP provides employees with optional group dental insurance for insurance eligible employees and their dependents. The program offers two dental plans: HealthPartners Dental and State Dental Plan (Delta). Both 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 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.

2009 Dental Premium Rates – Monthly Rate						
Health Plan	Single Coverage			Family Coverage		
	Total	State	Employee	Total	State	Employee
State Dental plan	26.40	21.40	5.00	78.08	47.24	30.48
HealthPartners Dental	28.08	23.08	5.00	83.08	48.92	34.16

2010 Dental Premiums Rates – Monthly Rate						
Health Plan	Single Coverage			Family Coverage		
	Total	State	Employee	Total	State	Employee
State Dental plan	25.88	20.88	5.00	76.52	46.20	30.32
HealthPartners Dental	27.52	22.52	5.00	81.42	47.84	33.58

Figure 13 – Monthly dental rates 2009 and 2010

Both the state and employees pay dental premiums. Total dental premiums in 2009 were \$37,864,008. Of those dollars, state agencies paid \$20.9 million, employees paid \$16 million and quasi-state agencies and their employees paid \$915,876.

In 2010, total dental premiums were \$37,429,061. Of those dollars, state agencies paid \$20.5 million, employees and retirees paid \$15.9 million and quasi-state agencies and their employees paid the remaining \$908,624.

The administrative cost for the combined dental plans was 7.3 percent of total premiums in 2010. The administrative fee for the State Dental Plan administered by Delta Dental was \$2.2 million and the administrative fee for HealthPartners Dental was \$502,431.

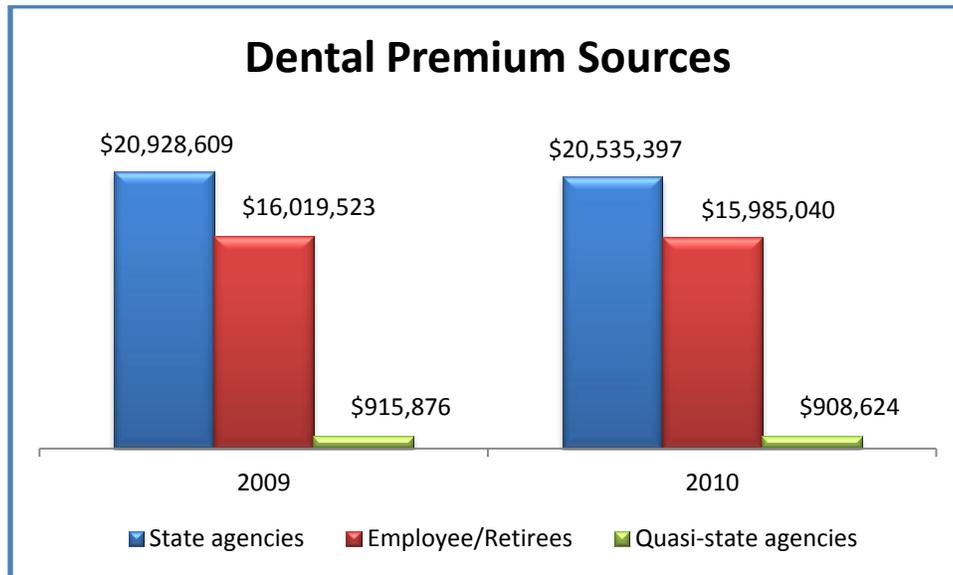


Figure 14 – Dental premium sources

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 \$6,038,723 was paid for life insurance premiums in 2009. Of that the state paid \$5.7 million, employees and retirees paid \$173,148 and the quasi-state agencies and their employees paid \$164,620.

A total of \$6,029,683 was paid for life insurance premiums in 2010. Of that the state paid \$5.7 million, employees and retirees paid \$176,520 and quasi-state agencies and their employees paid \$163,896.

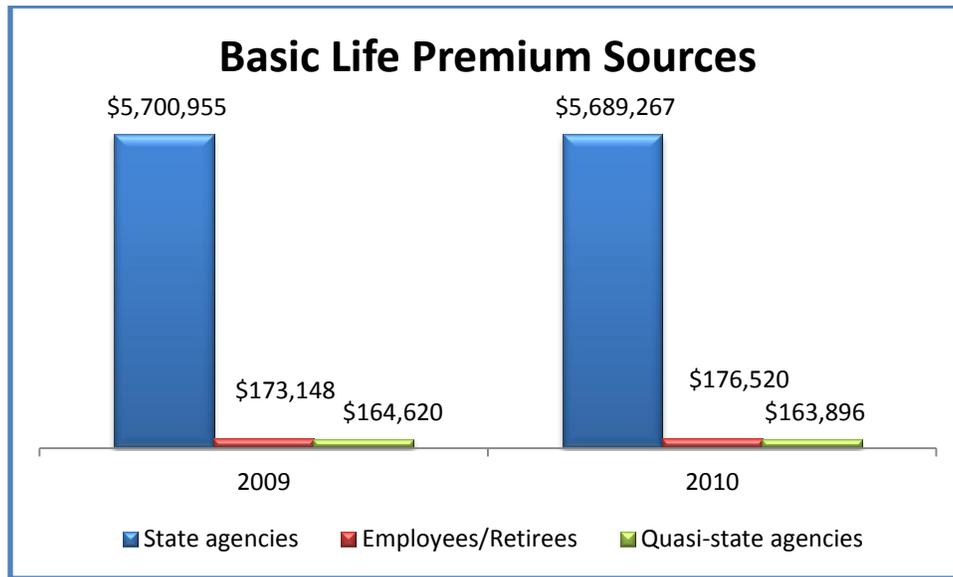


Figure 15 – Basic Life premium sources

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 \$523,092 was paid in 2009, of which \$381,443 was paid by the state and \$141,649 was paid by employees. In 2010, \$523,534 was paid, of which the state paid \$380,474 and employees paid 143,060.

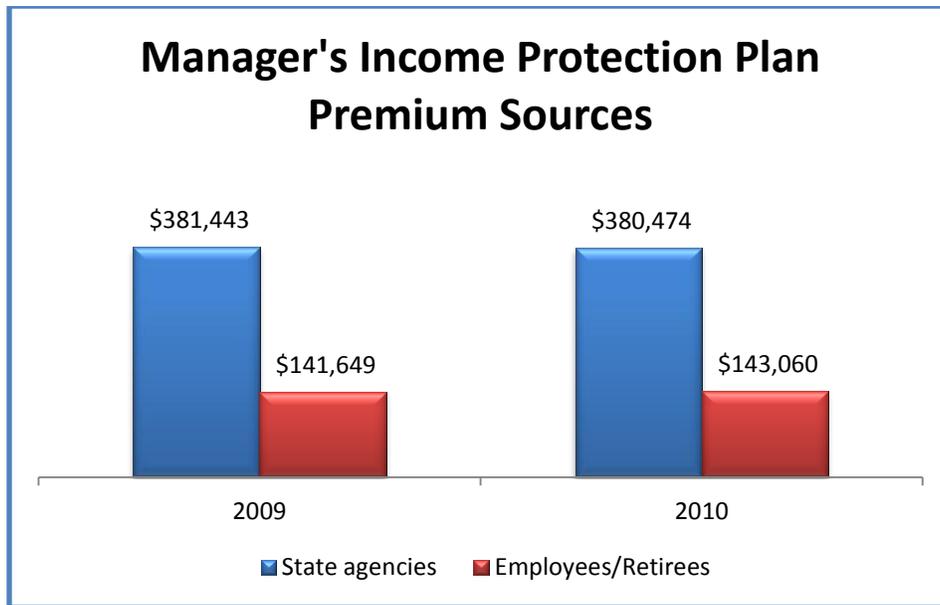


Figure 16 – Manager’s Income Protection Plan premium sources

Fully employee paid coverages

SEGIS 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 insurance. These insurance products combined generate \$13.4 million in 2009 and \$14.8 million in 2010.

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 2009, a total of \$13,388,154 was contributed in premiums for additional life and accidental death and dismemberment coverages. Of that, employees paid \$13.1 million and quasi-state agencies and their employees paid \$227,215. State employees spent \$12,820,913 on additional life insurance products

while the quasi-state agencies contributed \$221,912. State employees and retirees contributed \$340,026 in additional death and dismemberment insurance and quasi-state agencies \$5,303. State agencies do not contribute to these coverages.

In 2010, a total of \$14,831,270 was contributed in premiums for additional life and accidental death and dismemberment coverages. Of that, employees paid \$14.6 and quasi-state agencies and their employees paid \$255,224. State employee contributed \$14.2 on additional life products and quasi-state agencies \$249,969. Additional death and dismemberment coverage generated \$339,725 from state employees and retirees and \$5,255 from quasi-state agencies. State agencies do not contribute to these coverages.

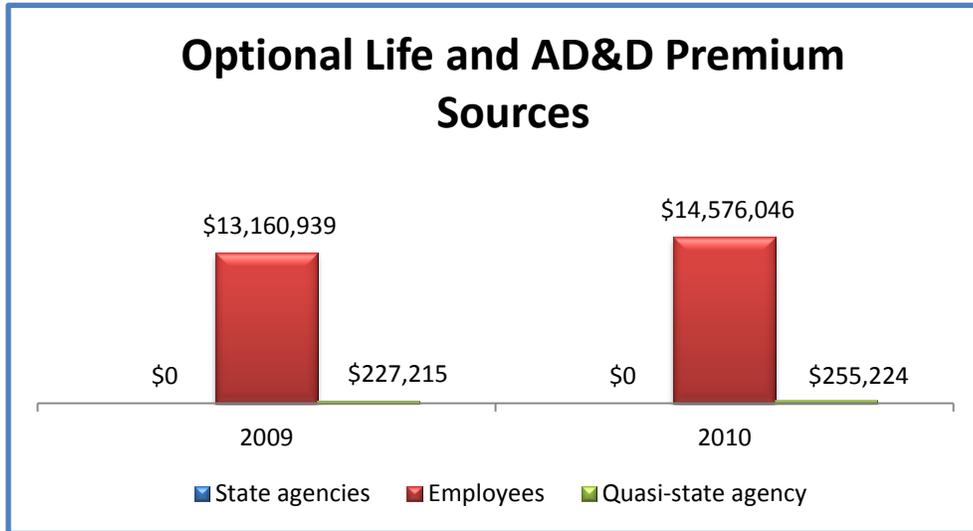


Figure 17 – Optional Life and AD&D Premium Sources

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 \$12,747,003 was paid in disability premiums during 2009. Of that, state employees paid \$12,447,813 and quasi-state agencies and their employees paid \$299,190. State employees contributed \$7,580,805 for short-term disability and \$4,867,008 for long-term disability. For short-term disability quasi-state employees and their employees paid \$171,400 in 2009 and \$127,790 for long-term disability in 2009.

In 2010, a total of \$13,123,470 was paid in premiums of which state employees paid \$12,817,982 and quasi-state agencies and their employees paid \$305,488. State employees contributed \$7,580,745 for short-term disability and \$5,237,237 for long-term disability. For short-term disability quasi-state agencies and their employees paid \$170,896 and \$134,592 for long-term disability in 2010.

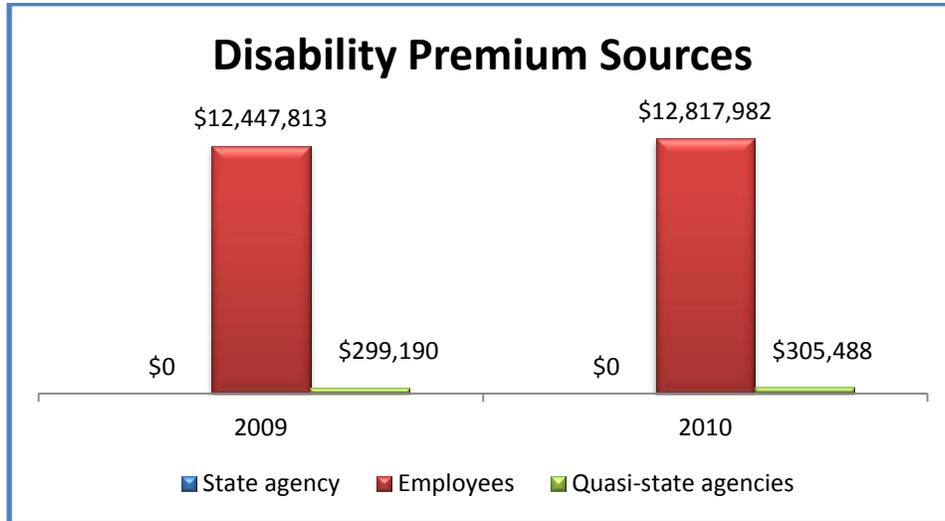


Figure 18 – Disability premium sources

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 14 percent enrollment.

In 2009, the LTCi had 9,306 members, of which 5,548 were employees, 1,731 were spouses, 1,528 were former employees, 434 were retirees and 65 were parents. LTCi is a fully member paid program, and those members contributed \$6,539,661 in LTCi premiums.

In 2010, the LTCi had 10,734 members, of which 6,455 were employees, 1,926 were spouses, 1,652 were former employees, 638 were retirees and 63 were parents. LTCi is a fully member paid program, and those members contributed \$7,766,728 in LTCi premiums.

The LTCi program is a large group that continues to grow. In 2007 it had 9,630 members and it grew to 10,734 members in 2010. Approximately, 1,400 members were added in May 2010 when the program held an Open Enrollment event and invited eligible employees and their family members to enroll without showing proof of good health.⁶⁶ Existing members were offered the opportunity to increase their coverage. The number of retirees with LTCi rose from 251 in 2007 to 638 in 2011, which is a 154 percent increase. Overall program participation grew 11.46 percent from 2007 to 2010.

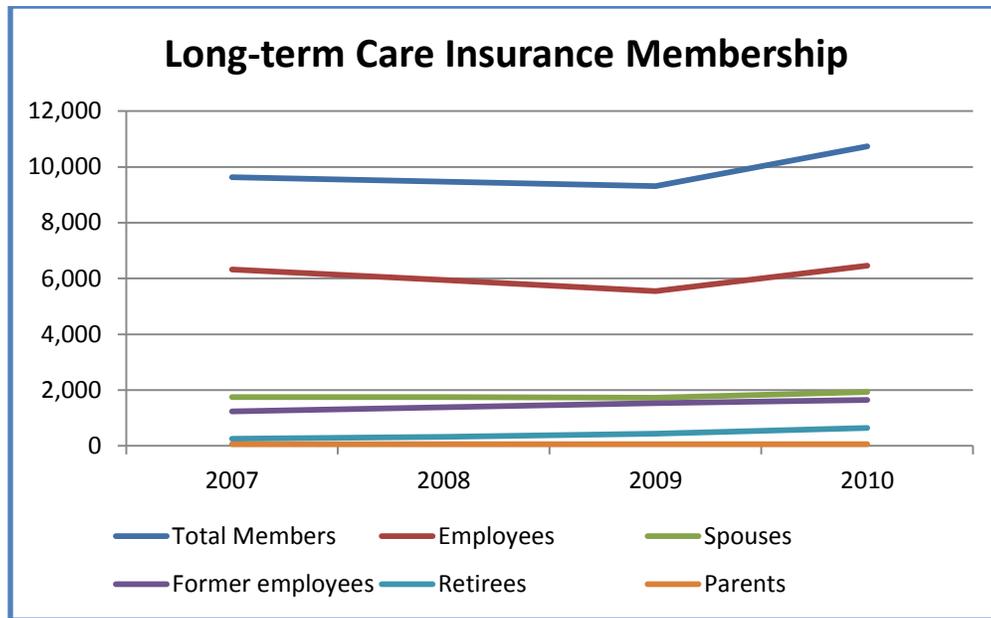


Figure 19 – Long-term care insurance membership

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. The benefit of this program is that participating members avoid paying income taxes on the dollars set aside for this program and the employing agency saves more than 7.5 percent in employment related taxes. At the end of the plan year any dollars a member has not spent on a qualified expense not refunded and remains in the plan.

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 2009, 19,284 members participated in the pre-tax programs and contributed \$26.1 million. In 2010, 20,433 members contributed \$28.4 million. Participation in the program rose by 21.6% from 2006 to 2010.

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 helps identify and resolve personal, family, and workplace problems faced by state employees and organizations.

Through the EAP vendor, employees and their families have 24/7 confidential access to EAP counselors both telephonically and face-to-face. The EAP provides concrete, practical solutions that

result in improved productivity and reduced absenteeism and morale problems. EAP services are free-of-charge and available on demand, which ensures that people can get help when they need it.

The state’s internal EAP “Organizational Health” team provides confidential consultation to state agency managers, supervisors, human resource staff and union leaders. These 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 helps to ensure that employees are healthy, productive, and have job satisfaction.

During 2009 and 2010, 3,583 cases were opened through the state’s EAP vendor, which equaled a use rate of 3.3% of the total employee population.⁶⁷ In July, 2010, MMB increased utilization by introducing a new EAP vendor and expanding its internal EAP consulting team. Total program costs, including the state’s internal EAP, were \$546,068 in 2009 and \$619,539 in 2010.

In 2010, with a new internal consultation team in place, the EAP started to formally track its service delivery. During that year the internal team provided 387 services to state agencies.

EAP services and utilization				
Utilization of EAP vendor by employee / family member:				
	2009		2010	
State Employee	1,282	88%	1,868	88%
Family Member	169	12%	260	12%
Unknown	0	0.06%	4	0%
Total	1,451	100%	2,132	100%
Utilization rate	2.6%		3.9%	
Unit Cost	\$326		\$233	
EAP vendor services provided:				
	2009		2010	
Assessment & counseling	129	9%	266	12%
Assessment, counsel & referral	1,247	86%	1,832	86%
Unknown	75	5%	34	2%
Total	1,451	100%	2,132	100%
Internal EAP services provided:				
	2010			
Consultations with managers, HR, unions			240	62%
Incident response, trainings, etc.			70	18%
Individual coaching, consultation			77	20%
Total			387	100%

Figure 20 – EAP utilization and services provided in 2009 and 2010

Program administration

SEGIP administers all its insurance benefits 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 plan administrator 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 over 123,000 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 2009, the unit processed over 137,838 non-Open Enrollment events and another 133,586 during 2010. 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.

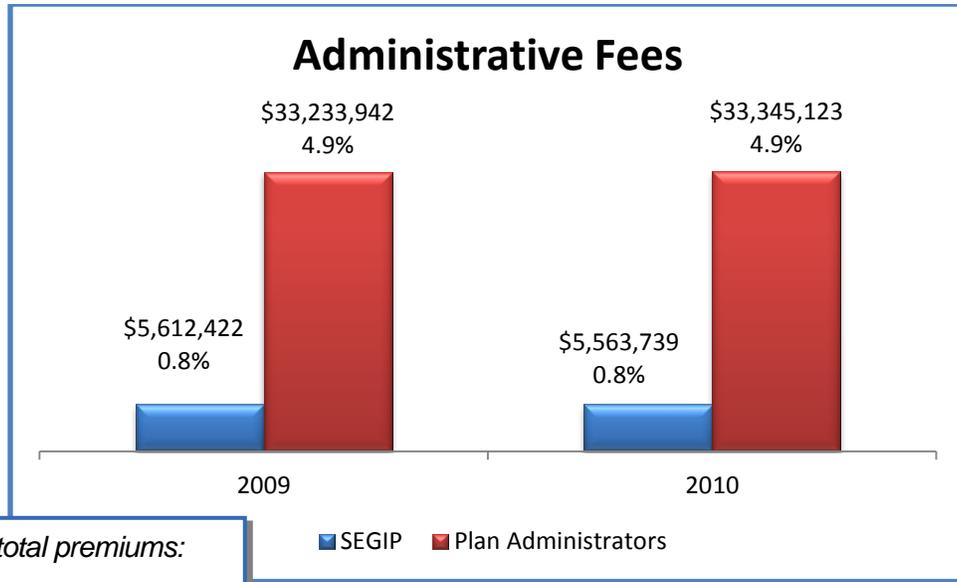
During the 2009 Open Enrollment, 24,434 participants made elections of which 99.5 percent were made electronically while SEGIP staff manually entered the remaining half percent. SEGIP staff also answered 5,859 phone calls, conducted 32 training sessions for state employees and four trainings for state agency human resource staff.

During the 2010 Open Enrollment, 29,384 participants made an election of which 99 percent were electronic. The remaining one percent was manually entered online by SEGIP staff. SEGIP staff answered 5,329 phone calls, conducted 38 trainings for state employees and 4 training sessions for state agency human resource staff.

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 COBRA members are assessed a two percent administration fee. SEGIP administrative fees are less than one percent of total premiums. The combined total of SEGIP's and plan administrator's administration costs was 5.7 percent in both 2009 and 2010. This was down from approximately 6.5 percent in both 2007 and 2008.

SEGIP continues to successfully control its administrative fees, which were below the national average of 8.6 percent for larger employer group coverage in 2010.⁶⁸ They were also below the Minnesota average of 7.9% in 2009 and 7.2% in 2010.⁶⁹ SEGIP's administrative fee has not increased since January 1999.



Percents are of total premiums:
2009 = \$681,085,468
2010 = \$684,770,650

Figure 21 – SEGIP administration fees in 2009 and 2010

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 to start its own employer based health plan.
- 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

Introduction

Throughout 2009 and 2010, SEGIP introduced and maintained 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, other large health care purchasers, and industry groups working to provide high quality health care at an affordable cost. 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 and a \$125 HRA in 2011. 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 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.

COBRA Subsidy

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 such as either a voluntary or

involuntary loss of employment. 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. Typically, most employees do not continue coverage under COBRA because they must pay the full cost of the coverage plus a two percent administration fee.

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 paid 65 percent of the cost leaving the employee to pay the remaining 35 percent. The program paid 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. The Minnesota legislature created a program that paid the employee's share of the premium if certain income guidelines were met.

The program was extended twice and the length of participation was increased. The Department of Defense Appropriations Act for Fiscal Year 2010 (DOD Act) extended the COBRA subsidy premium program for two months, through February 28, 2010 and increased the subsidy from 9 months to 15 months. The Temporary Extension Act (TEA) of 2010 extended COBRA premium subsidy reduction eligibility period for one month until March 31, 2010. It also expanded eligibility to individuals who experienced a reduction of hours any time from September 1, 2008 through March 31, 2010, which was followed by an involuntary termination of employment on or after March 2, 2010.

Former state employees did use the program. During 2008 and through 2009, 186 former employees qualified and received a federal subsidy under this program. Two hundred seventy one former employees participated in 2010 and 62 former employees participated into 2011. The last participants completed the program in August of 2011.

Medical-Dental Debit Card

New to Advantage members in 2009 was a debit card that allowed users to pay for eligible health care related goods and services from the available balance in their state sponsored medical-dental expense account (MDEA) or a health reimbursement account (HRA).

These debit cards are specially designed to allow only the purchase of qualified items. The card was an advantage for members because it allowed real time reimbursement for qualified medical-dental expenses. It does not make the processing of these expenditures completely paperless. Due to technology limitations and federal requirements, users must still be prepared to substantiate, or provide a receipt, to prove the purchase was a qualified medical expense.

Work Well

Work Well is SEGIP's worksite health promotion benefit. It focuses on 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 agency's' wellness initiatives so they might be effective and sustainable.

The program is led 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.

Since 2005, Work Well has guided state agencies in health promotion best practices. The AWC team has grown to include 29 state agencies and MNSCU campuses. In 2009, agencies were invited to complete an annual environmental assessment for the first time. The purpose of the assessment was to gauge their wellness program against best practices and against each other. Thirteen agencies completed the assessment with the average score of 40 percent. In 2010, 18 agencies completed the

assessment and the average score rose to 59 percent. The increased score indicates that more agencies are making greater improvements to the infrastructure—the facilities, policies and culture—that support the health and wellbeing of state employees and visitors.

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 continues to provide valuable services for members. In 2009, it had 3,905 inbound calls and 937 out bound calls. In 2010, there were 3,740 inbound calls and 2114 outbound calls.

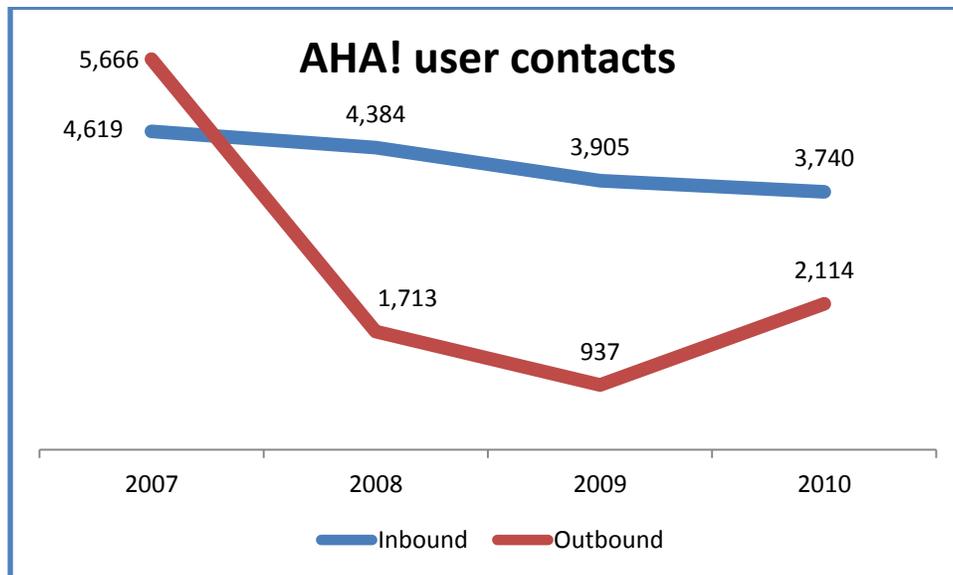


Figure 22 – AHA! User contacts from 2007 through 2010⁷⁰

Worksite Flu Vaccination

SEGIS 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 per employee are lost due to the flu and productivity is compromised when sick employees come to work and their performance is impaired due to the illness.

State employee vaccination clinics are offered each year between September and 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. In 2009, clinics ran from late September through October, and approximately 17,989 flu vaccinations were dispensed at about 192 clinics covering approximately 33% of all state employees.

In 2010, clinics ran from October through early November, and approximately 16,193 flu vaccinations were dispensed at about 192 clinics covering approximately 30% of all state employees.

Preparation for a possible pandemic flu outbreak began in 2009. Very little H1N1 was experienced in the state employee population. Beginning in December 2009 and through early February 2010, 6,985 H1N1 flu vaccinations were dispensed at 143 locations.

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 administrators (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 consumes 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 plan administrators 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 plan administrator's 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 plan administrators provided to own HRA to members enrolled in its system. In 2008, the state moved to a single provider so that members would experience comparable results no matter which health plan administrator 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” which allows members to ask health professionals questions on health topics by phone or secure email.

In both 2009 and 2010, approximately 70 percent of employees took the assessment. The table below shows data from 2010, and illustrates the risk factors employees face. The four leading modifiable conditions are overweight, pre-hypertension, obesity, and secondhand smoke. The data is used to ensure that SEGIP programs are targeted to the conditions that most affect employees.

Prevalence of modifiable risk factors 2010	
Risk factors	Prevalence percent
Pre-diabetes	8.0
Pre-hypertension	37.9
High cholesterol	17.0
Overweight	38.1
Obesity	29.2
Sedentary	2.0
Use tobacco	9.9
Secondhand smoke	18.1
Alcohol (hazardous and harmful drinking)	1.7
Depression (history of)	17.8
Stress (unhealthy)	6.4

Figure 23 – Chronic Disease – prevalence of modifiable risk factors in 2010

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 MNCM 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.

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. Approximately 85 clinics currently offer DIAMOND, including 40 new clinics that began in March 2010. To date, more than 2,400 patients have entered the program. Of those contacted six months after being activated in DIAMOND, 43% are in remission, and an additional 17% have seen at least a 50% reduction in the severity of their depression.

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 (MNCM) 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. MNCM determined the rewards through the analysis of an annual health quality study. After reviewing approximately 700 clinics, MNCM 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 in 2007, MNBTE worked with MNCM to accelerate their implementation of direct data submission (DDS). Through DDS, medical groups submit clinical data for each of their clinic sites to MNCM. MNBTE began to pay rewards for optimal care at the clinic level instead of the medical group level.

The program continues to be refined. In 2009, 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. 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. In 2009, depression management was added. This program addresses screening and improvement and is under evaluation.

During 2009 and 2010 the program continued to pay for excellence:

Bridges to Excellence Performance Pay		
Condition	2009	2010
Diabetes	\$11,000	\$46,000
Cardio vascular	\$7,300	\$11,000
Depression	\$7,600	\$20,000

Figure 24 – Bridges to Excellence Performance Pay in 2009 and 2010

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. Preferred provider networks for the treatment of lower back pain and cardiac conditions are available to assist members in making informed choices.

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.

Beginning in January 2010 inpatient copays were waived for employees and family members who voluntarily use identified COEs for transplant or bariatric surgeries. The cardiology report card and low back best choice provider network information continue to be updated annually and are available to members to assist them in finding a quality provider that meets their needs.

Medication Therapy Management (MTM)

Effective July 1, 2010, SEGIP offered an MTM program in place for its entire population. There is no cost to employees to opt in to this program. This program was designed to help members manage their drug utilization if they’re taking four or more medications to treat or prevent two or more chronic medical conditions. Pharmaceutical care services will be provided for participating employees, as follows:

- Perform a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
- Communicate essential information to the patient’s other providers
- Provide verbal education and training designed to enhance patient understanding and appropriate use of medications.

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. A key incentive is that members receive waivers of copays for their office visit to MTM pharmacists, lab tests ordered by pharmacists, and copays of drugs to treat diabetes, high cholesterol, and hypertension.

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, medication changes, compliance, and adverse drug reactions.

The results of this program continue to be positive. There are five targets for these enrollees to meet including no tobacco use, aspirin use, and appropriate blood pressure, LDL level, and A1c level. In comparing the pilot participants to non-participants, 40.4% of participants reached all five targets over a 30-month period while only 25.5% of non-participants reached all five targets.

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. Participation in eValue8 is voluntary. In 2009, HealthPartners was the only Advantage health administrator that participated in the eValue8 process conducted by BHCAG. In 2010, HealthPartners and PreferredOne participated. These administrators, 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 plan administrators was completed, meetings were held with the plan administrator's leaders and BHCAG to discuss each plan's eValue8 results and identify areas for improvement and collaboration.

Over the years, BHCAG has learned that the longer a health plan participates in eValue8, the better the plan's performance. Health plans become more familiar with eValue8 and the information the survey requests. Health plans that collaborate internally by bringing together subject matter experts become more efficient in developing their responses. Optimally, eValue8 becomes part of the health plan's strategic planning for future investments in health improvement and developing tactics for year-over-year improvement on plan performance.

Purchasers of health care, whether public agencies, large, private employers, or small employers – all of whom may not have access through other means to the type of information provided through eValue8 – benefit from the transparency of the publicly reported results. Public reporting ultimately helps every Minnesotan.

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 that was erroneously processed. Appeals filed during Open Enrollment relate to the actions of MMB. Non Open Enrollment appeals are the result of actions by either SEGIP or one of its vendors.

The number of complaints remains low. In both 2009 and 2010, 0.3 percent of members filed an appeal with SEGIP. Of the appeals filed in 2009, 34.4 percent were approved while 65.6 percent were denied. In 2010, 35.9 percent of appeals were approved and 64.1 percent were denied.

Open Enrollment Appeals

Year	Approved	Denied	Total
2000	215	74	289
2001	154	50	204
2002	207	57	264
2003	84	38	122
2004	na	na	na
2005	93	47	140
2006	53	58	111
2007	43	25	68
2008	72	104	176
2009	37	177	214
2010	31	157	188

Non-Open Enrollment Appeals

Year	Approved	Denied	Total
2000	8	4	12
2001	3	0	3
2002	50	32	82
2003	16	35	51
2004	97	111	208
2005	104	112	216
2006	15	21	36
2007	53	110	163
2008	93	138	231
2009	110	103	213
2010	115	104	219

Figure 25 – Appeals

VI. End Notes

- ¹ The requirement to report the cost of developing a report is in Minnesota Statute 3.197
- ² Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, 2011 Annual Survey at 38. [Hereinafter Kaiser 2010] <http://ehbs.kff.org/2010.html> Accessed on October 23, 2012.
- ³ *Id* at 39.
- ⁴ *Id* at 20.
- ⁵ Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, 2010 Annual Survey, page 14. <http://ehbs.kff.org/2009.html> [Hereinafter Kaiser 2009]; Kaiser 2010, *supra* at 20 and 31; SEGIP percentage increases were developed by SEGIP staff.
- ⁶ For more information about the change in reporting method see Kaiser 2009, *supra* note 4, at 14.
- ⁷ Kaiser 2010, *supra* note 2, at 31.
- ⁸ The Advantage premium increased 3.5 percent in 2009, there was no increase in 2010.
- ⁹ Kaiser 2010, *supra* note 2, at 31. Bureau of Labor Statistics, Consumer Price Index. U.S. City Average. Medical care inflation. Not seasonally adjusted. http://data.bls.gov/timeseries/CUUR0000SAM?output_view=pct_12mths Accessed on 10/26/12.
Bureau of Labor Statistics, Consumer Price Index. U.S. City Average. Inflation. Not seasonally adjusted. All items CPI. http://data.bls.gov/PDQ/servlet/SurveyOutputServlet?data_tool=latest_numbers&series_id=CUUR0000SA0&output_view=pct_12mths accessed on 10/26/2012.
- ¹⁰ Kaiser 2010, *supra* note 2, at 31.
- ¹¹ U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey (MEPS) [Hereinafter MEPS] Public-sector data by gov type/size, census division. Table III.D.1. http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1 accessed on October 11, 2012.
- ¹² Kaiser 2010, *supra* note 2 at 27. *Estimates are statistically different from each other within firm size category (p<.05).
- ¹³ Minnesota Statutes 43A.30 subdivision 4.
- ¹⁴ Kaiser 2009, *supra* note 4, at 14.
- ¹⁵ *Id.* at 14.
- ¹⁶ MEPS, *supra* note 10, at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2010/tiic1.pdf accessed on November 1, 2012.
- ¹⁷ *Id.* at

http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2009/tia2b.pdf
accessed on November 1, 2012.

¹⁸ *Id.* at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2009/tia2b.pdf
accessed on November 1, 2012.

¹⁹ Kaiser 2009, *supra* note 4, at 74.

²⁰ *Id.* at 74.

²¹ *Id.* at 75.

²² *Id.* at 94.

²³ *Id.* at 99. (“Estimate is statistically different within plan type from estimate for all other firms not in the indicated industry ($p < .05$)”).

²⁴ MEPS, *supra* note 10, at
http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2009/tiic1.pdf
accessed on October 24, 2012.

²⁵ *Id.* at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2009/tiic2.pdf
accessed on October 24, 2012.

²⁶ *Id.* at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2009/tia2b.pdf
accessed on October 24, 2012.

²⁷ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2009/tia2b.pdf
accessed on October 24, 2012.

²⁸ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2009/tia2b.pdf
accessed on October 24, 2012.

²⁹ Kaiser 2010, *supra* note 2, at 20.

³⁰ *Id.* at 14.

³¹ MEPS, *supra* note 10, at
http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2010/tiic1.pdf Accessed
on October 24, 2012.

³² Kaiser 2010, *supra* note 2, at 71.

³³ *Id.* at 70.

³⁴ *Id.* at 70.

³⁵ MEPS, *supra* note 10, at
http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2010/tiic2.pdf
at accessed on October 24, 2012.

³⁶ Kaiser 2010, *supra* note 2, at 89.

- ³⁷ MEPS, *supra* note 10, at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2010/tia2b.pdf accessed on October 24, 2012.
- ³⁸ *Id.* at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tia2b.pdf accessed on October 24, 2012.
- ³⁹ *Id.* at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2002/tia2b.pdf accessed on October 24, 2012.
- ⁴⁰ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2010/tia2b.pdf accessed on October 24, 2012.
- ⁴¹ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2010/tia2b.pdf accessed on October 24, 2012.
- ⁴² Kaiser 2009, *supra* note 2, at 14.
- ⁴³ *Id.* at 14.
- ⁴⁴ MEPS, *supra* note 10, at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2009/tiid1.htm Accessed on October 24, 2012
- ⁴⁵ Kaiser 2009, *supra* note 4, at 74.
- ⁴⁶ *Id.* at 83.
- ⁴⁷ MEPS, *supra* note 10, at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2009/tia2c.pdf accessed on October 24, 2012.
- ⁴⁸ Kaiser 2009, *supra* note 4, at 74.
- ⁴⁹ *Id.* at 75.
- ⁵⁰ *Id.* at 76.
- ⁵¹ MEPS, *supra* note 10, at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2009/tia2c.pdf accessed on October 24, 2012.
- ⁵² *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2009/tia2c.pdf accessed on October 24, 2012.
- ⁵³ Kaiser 2010, *supra* note 2, at 22.
- ⁵⁴ *Id.* at 22.
- ⁵⁵ MEPS, *supra* note 10, at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2010/tiid1.htm accessed on October 24, 2012.
- ⁵⁶ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2010/tia2c.pdf accessed on October 24, 2012.

⁵⁷ *Id.* at www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2010/tia2c.pdf accessed on October 24, 2012.

⁵⁸ Out-of-pocket costs are collected at the point of service and the balance of the claim is billed by the plan administrator 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.

⁵⁹ Kaiser 2010, *supra* note 2, a 123.

⁶⁰ *Id.* at 125.

⁶¹ Administrative Costs at Minnesota Health Plans in 2010, Minnesota Department of Health. January, 2012.[Hereinafter Health] <http://www.health.state.mn.us/health/economics> Accessed on November 6, 2012.

⁶² Laws of Minnesota, 2008 Regular Session, Chapter 358, Article 4, Section 1. M. S. 43A.23 subdivision 1 (d).

⁶³ Kaiser 2010, *supra* note 2, at 128.

⁶⁴ IRS Publication 969 Health Savings Accounts and Other Tax-Favored Health Plans. For use in preparing 2010 Returns at page 3. <http://www.irs.gov/pub/irs-prior/p969--2010.pdf>. This publication also states that the annual minimum for single coverage is \$1,200 and the family minimum is \$2,400.

⁶⁵ Kaiser 2010, *supra* note 2, at 129.

⁶⁶ The Long-term care insurance program holds an Open Enrollment event about every three years. LTCi is not usually open during SEGIP's annual Open Enrollment.

⁶⁷ The EAP serves approximately 56,000 employees each year. This population is comprised of the entire employee population, not just those who are insurance eligible. It includes employees in all three branches of state government and the Minnesota State Colleges and Universities (MnSCU) as well as both full and part-time employees.

⁶⁸ Julia Philips, actuary, Minnesota Department of Commerce, e-mail to SEGIP, St Paul, Minnesota October 31, 2012. Based on Nationwide total from Supplemental Health Experience Exhibit, Part 1, National Association of Insurance Commissioners.

⁶⁹ Health, *supra* note 60, at www.health.state.mn.us/divs/hpsc/dap/cdireports/grppurch/admn2010.pdf accessed on October 10, 2012.

⁷⁰ The program operated the last four months of 2006 and during that period received approximately 1,040 inquiries.