# MINNESOTA Managed Care Review 1991

July 1991

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# MINNESOTA Managed Care Review 1991

## **INTRODUCTION**

The United States is in the midst of a long-running policy debate about how health care is organized, delivered, and financed. No state reflects the vitality of the market and the vigor of the debates better than Minnesota. In the past few years, the Minnesota Legislature has debated whether the state should guarantee that residents of the state have health care insurance. The percent of the population here that has no health insurance is among the lowest in the nation, partly because of state initiatives that have extended coverage to low-income persons. Market penetration in Minnesota by health maintenance organizations (HMOs) and other "managed" health plans is among the highest.

1990 was a remarkable year in Minnesota's dynamic health care marketplace. Health plan companies reported record surpluses and expanded the financing and access options they offer. The use of self-insurance grew, as did preferred provider arrangements.

The Citizens League, a nonprofit, nonpartisan public affairs research and education organization in the

metropolitan Twin Cities area, has long been involved in research and initiatives on issues of health care costs, quality, and access. In 1990, the Citizens League published a report analyzing key trends in finances, enrollment, and hospital utilization for Minnesota's health maintenance organizations.

The title of this year's edition -- Minnesota Managed Care Review -- reflects an expansion of the scope of our research and of this report. We recognize that HMOs, Blue Cross and Blue Shield of Minnesota, and preferred provider arrangements (PPOs) have a good deal in common and are closely related points on a continuum of arrangements by which health care is financed and managed. The sidebar on this page discusses how the term managed care is used.

For this edition, we have included available information about the enrollment, finances, and hospital utilization of Blue Cross and Blue Shield of Minnesota and the PPOs in the state. In future editions, we hope to develop additional information about those plans.

## WHAT IS MANAGED CARE?

Managed care is a widely used, though not very well-defined, buzzword. The Health Insurance Association of America, a Washington-based insurance industry group, describes managed care systems as plans or organizations that integrate the financing and delivery of appropriate health care services to covered individuals using the following basic elements:

- arrangements with selected providers to furnish a comprehensive set of health care services to members;
- explicit standards for the selection of health care providers;
- formal programs for ongoing quality assurance and utilization review; and
- significant financial incentives for members to use providers and procedures associated with the plan.

Much of the information in this report is drawn from annual reports that the HMOs file with the Minnesota Department of Health and that Blue Cross and Blue Shield of Minnesota files with the Minnesota Department of Commerce. We thank the staff members of those agencies for their help.

We also appreciate the assistance provided by the managers and staff of the HMOs, PPOs, and Blue Cross and Blue Shield of Minnesota. Members of the Minnesota Council of HMOs had an opportunity to review a draft of this report prior to publication. However, the Citizens League remains responsible for the accuracy of the information contained in this report and for the opinions expressed. Questions about this report should be directed to Allan Baumgarten at the Citizens League.

## BACKGROUND

Health insurance involves plans and companies who vary widely in their approach. At one end, it includes indemnity insurers who pay providers a usual and customary fee for each service. That segment of the market has declined significantly in recent years. This report focuses on health plan companies that actively seek to manage the care of their enrollees: health maintenance organizations, Blue Cross and Blue Shield of Minnesota, and preferred provider arrangements.<sup>1</sup>

#### HMOS

The first prepaid health plan in Minnesota was established in Two Harbors, in 1944. Eleven HMOs currently operate in Minnesota, enrolling nearly 1.2 million people.<sup>2</sup> Figure 1 provides summary information about those HMOs.

## **BLUE CROSS AND BLUE SHIELD**

Blue Cross and Blue Shield of Minnesota (BCBSM) is organized under state law as a nonprofit health service plan. Under state law, it must accept any provider willing to sign a contract and, in fact, most physicians and hospitals in the state do contract with the company. The company is the largest source of health coverage for Minnesotans, enrolling both individuals and employee groups.

## TYPES OF MANAGED CARE PLANS

*Health Maintenance Organizations:* Prepaid plans that provide comprehensive care to enrollees. An HMO employs or contracts with health care providers.

*Preferred Provider Arrangements:* Used by insurance companies and self-insured employers as a vehicle to contract with a limited panel of providers who agree to a (discounted) fee schedule in anticipation of receiving an increased volume of patients. In *self-insured* plans, the employer assumes the risk for the costs of medical care, rather than paying an insurer a premium to assume the risk.

*Blue Cross and Blue Shield:* A variety of fee-forservice plans offered under contracts with health care providers.

Blue Cross and Blue Shield of Minnesota can be viewed as a preferred provider arrangement, since it contracts directly with providers. However, it is established under its own section of Minnesota law (*Minnesota Statutes* Chapter 62C) and faces a variety of regulatory and organizational issues that do not apply to the other PPOs or to HMOs.

As shown in Figure 1, two HMOs -- Group Health and Blue Plus -- operated "sister" HMOs in 1990. These plans are not federally qualified, and they are considered separate entities for purposes of annual reporting and the financial standards described in this report. We have consolidated enrollment and financial data from Blue Plus and Minnesota Health Plans, Inc., and Group Health and GroupCare. On the other hand, we are still discussing Physicians Health Plan and Share as separate HMOs.

FIGURE 1						
		MINNE	<b>SOTA H</b>	MOs AT A	GLANCE	
нмо	Headquarters	Parent, Owner, or Manager	Year Opened	1990 Enrollment	Federally Qualified?	History/Status
Blue Plus	Eagan	Blue Cross and Blue Shield of Minnesota	1974	76,370	Yes	Changed name from HMO Minnesota in 1988. Absorbed Coordinated Health Care HMO in 1988. Affiliate Minnesota Health Plans, Inc., nonfederally qualified HMO, merged into Blue Plus and corporate existence terminated, effective December 31, 1990
First Plan	Two Harbors	Blue Cross and Blue Shield of Minnesota	1 <b>944</b>	9,053	No	Became operating subidiary of Blue Cross/Blue Shield in 1986
Group Health	Minneapolis	Group Health, Inc.	1957	285,387	Yes	Includes GroupCare, nonfederally qualified HMO
Central Minnesota Group Health Plan	St. Cloud	Group Health, Inc.	1979	16,751	No	Became operating subsidiary of Group Health in 1988
Mayo	Rochester	Mayo Foundation	1986	5,144	No	
MedCenters	Edina	Aetna Health Plan (formerly PARTNERS National Health Plan)	1973	261,161	No	Formed by merger of MedCenter Health Plan and Nicollet-Eitel Health Plan in 1983
Metropolitan Health Plan	Minneapolis	Hennepin County	1983	18,804	No	Created for Medicaid Demonstration Project and Voluntary AFDC Managed Care Program
NWNL Health Network	St. Paul	Northwestern National Life Insurance Co.	1984	20,204	No	Founded as Senior Health Plan. Acquired and renamed by NWNL in 1987
Physicians Health Plan	Minnetonka	United Health Care	1975	329,932	No	PHP and Share combined to form Medica, effective January 1, 1991
Share Health Plan	Bloomington	United Health Care	1973	138,324	No	
UCare	Minneapolis	University of MN Dept of Family Practice	1989	5,587	No	Created for Medicaid Demonstration Project

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# FIGURE 1

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ι ω BCBSM has operated its own HMO -- Blue Plus -- since 1974. This allowed the company to offer plans with a smaller network of providers. In 1984, it introduced its Aware plans, which offer comprehensive benefits similar to those provided by HMOs. It has put increasing emphasis on using the terms of its provider contracts as tools for managing care and costs, and views almost its entire operations as a managed care entity. BCBSM also operates a for-profit third party administrator for self-insured plans, an HMO in western Wisconsin, and an insurance company.

#### **PREFERRED PROVIDER ARRANGEMENTS**

Three local PPOs work with both insured and self-insured plans. Preferred One is sponsored by the HealthOne, Fairview, and North Memorial Hospitals, Select Care is sponsored by the LifeSpan hospital systems, and Family Health Plan is investor-owned. Each "rents" its provider network to insurers and other plan administrators, and may also supply utilization review and claims processing services. Some insurers that strongly prefer to operate their own provider networks in similar markets have chosen to work with local PPOs. Travelers Insurance works with Select Care and Metropolitan Life works with Family Health Plan.

At least two PPOs in town are now working with insurance carriers to develop "gatekeeper" plans where a primary care physician exercises some control over referrals to specialists: Select Care and Travelers Insurance Company are working together, as are Family Health Plan and Metropolitan Life. Regulators at the Minnesota Department of Commerce, who have objected to such plans in the past, have indicated their willingness to approve such plans, if appropriate disclosures are made and consumer protections included.

Many of the HMOs in the state have developed PPOs to offer additional options to self-insured employers. Physicians Health Choice is an affiliate of PHP. Other HMOs, including Group Health, MedCenters (through its Aetna management company), and NWNL Health Network (through its management company), are also offering their own PPO plans for self-insured clients. NWNL is also developing a PPO plan that requires designation of a primary care physician.

The Prudential Insurance Company of America recently announced that it was establishing its own PPO network that it would market to self-insured employers. (Later in this report we discuss CareSpan, Prudential's current major entry in the Minnesota managed care market.) For some employers, Prudential plans to rent portions of Group Health's network of clinics.

## FINANCIAL RESULTS

#### SURPLUSES AND LOSSES

1990 was a very good year for Minnesota's HMOs and for Blue Cross and Blue Shield of Minnesota. As shown in Table 1, all but one of the HMOs in the state posted surpluses. The cumulative surplus for all HMOs was \$57.8 million, or about 3.6 percent of their revenues of \$1.6 billion. This was more than twice the total surplus of \$27.5 million that the HMOs posted in 1989.

Blue Cross and Blue Shield reported a surplus of \$18.2 million in 1990, compared to a loss of \$21.7 million in 1987. Figure 2 shows the surpluses and losses for the four largest HMOs and for Blue Cross and Blue Shield of Minnesota from 1987 to 1990. It should be noted that 1987 was a terrible year for health plans in Minnesota and nationally. That year, Minnesota HMOs and BCBSM lost a combined total of \$44.4 million.

## MINNESOTA MANAGED CARE REVIEW 1991

TABLE 1					
	HMO SUR	PLUSES AND	<b>LOSSES:</b>	1987 - 1990	
НМО	1987	1988	1989	1990	4-yr total
Blue Plus	(\$4,533,209)	(\$3,168,688)	(\$1,558,058)	\$3,729,755	(\$5,530,200)
First Plan	41,549	226,969	(84,566)	(157,837)	26,115
Group Health	110,000	1,639,000	4,113,000	7,031,000	12,893,000
Cent MN Grp H	lth (1,145,927)	(586,221)	79,967	962,166	(690,015)
Mayo	(89,416)	(477,481)	(190,377)	403,270	(354,004)
MedCenters	(1,690,438)	1,652,113	8,673,853		30,533,229
Metropolitan	129,424	(277,838)	(249,068)	14,133	(383,349)
NWNL*	(282,962)	(1,328,439)	33,233	51,079	(1,527,089)
PHP	(\$9,823,000)	1,471,000	8,172,000	16,845,244	16,665,244
Share	(5,384,000)	106,000	8,464,000	6,658,000	9,844,000
UCare	n/a	n/a	59,280	) 317,896	377,176
Total Surplus					<i>,</i>
or (Loss)		(\$743,585)			
	\$1,166,792,481			\$1,585,693,389	
Margin	-1.9%	-0.1%	1.8%	3.6%	1.1%
* In these tables	s, we use the short	thand NWNL to r	efer to the NWN	L Health Network	НМО.



MedCenters reported the highest 1990 surplus of all HMOs: \$21.9 million. Part of its surplus was attributed to one-time investment results. As shown in Table 2, MedCenters also enjoyed a good year with its Medicare programs. About \$6.2 million of its 1990 surplus resulted from favorable results in its Medicare plans.<sup>3</sup> Share also made money on its Medicare Risk contracts. PHP, which had replaced its Medicare Risk plan with a Medicare Cost plan, reported losing \$5.9 million on its Medicare Cost Plan. All plans, except for Group Health, reported surpluses on their plans for Medical Assistance and General Assistance recipients.

		T.	ABLE 2			
FINANCIAL RESULTS ON MEDICARE AND MEDICAID PLANS: REPORTED SURPLUSES AND (LOSSES), 1990						
НМО	Medicare Risk	Medicare Cost	Medicare Supplement	Med Assist/ Gen Assist	TOTALS	
Blue Plus	(\$600,601)	(\$171,939)	(\$486,925)	Jen Assist	(\$1,259,465)	
First Plan	(\$000,001)	(\$96,104)	(\$+00,723)		(\$96,104)	
Group Health	\$600,000	(\$20,104)	(\$1,373,000)	(\$362,000)	(\$1,135,000)	
Mayo			\$17,417	(4502,000)	\$17,417	
MedCenters	\$4,727,702		\$1,460,556	ψ <del>α</del>	\$6,188,258	
Metropolitan				\$1,578,215	\$1,578,215	
NWNL*					n/a	
PHP		(\$5,910,960)		\$155,173	(\$5,755,787)	
Share	\$5,965,000	•••			\$5,965,000	
UCare				\$317,896	\$317,896	
TOTALS	\$10,692,101	(\$6,082,899)	(\$478,056)	\$1,689,284	\$5,820,430	

\* NWNL does not bear risk and does not report separate financial results for administering the General Assistance Medical Care program in Ramsey County.

## **COMPLIANCE WITH STATE NET WORTH REQUIREMENTS**

In 1988, the Minnesota Legislature imposed more stringent financial requirements for HMOs in the state. HMOs were required to build up their reserves over the next five years so that, by the end of 1993, each HMO would have to accumulate reserves equal to at least one month of operating expenses. HMOs must maintain a positive working capital and must also have restricted deposits of at least \$500,000.

The Legislature was responding to concerns that arose when two small HMOs -- More in Virginia and Health Partners, operating in the Marshall and Brainerd areas -- were declared insolvent in 1987.<sup>4</sup> Some of the large HMOs had sustained large losses in 1987 and had very thin reserves.

<sup>&</sup>lt;sup>3</sup> In Medicare Risk contracts, the HMO accepts the financial risk of both inpatient and outpatient care. In Medicare Cost contracts, the HMO is only at risk for outpatient care, and that is the basis for the capitated rate paid to the HMO. Medicare Supplement plans provide coverage for certain deductibles and co-payments. PHP has argued unsuccessfully to federal authorities that, by managing the outpatient care of its Medicare Cost enrollees, it is having a positive impact on inpatient utilization which should be reflected in adjustments to its capitated rates.

<sup>&</sup>lt;sup>4</sup> The HMO industry supported the intensified solvency standard. Legislators also considered and rejected proposals to include HMOs in the state's Life and Health Insurance Guaranty Fund or to establish a separate HMO guaranty fund.

#### **MINNESOTA MANAGED CARE REVIEW 1991**

As of December 31, 1990, HMOs were required to have net worth equal to the greater of \$1 million or 40 percent of one month of expenses. (In statutory language: "two-fifths of 8-1/3 percent of the sum of all expenses.") Table 3 shows how HMOs in the state comply with the net worth requirement. Five of the HMOs, including the four largest, have sufficient net worth to comply on their own. Large additions to their net worth during 1990 assured compliance. Three HMOs now have at least one month of net worth, which is the requirement for December 1993.

Six HMOs still do not have sufficient net worth on their own to meet the December 31, 1990 requirement, but state law allows parent organizations to guarantee their net worth. For example, Hennepin County guarantees the net worth requirements of its Metropolitan Health Plan. Other guaranteeing arrangements: Blue Cross and Blue Shield of Minnesota provides guarantees for both Blue Plus and First Plan. Group Health, Inc. guarantees the net worth of Central Minnesota Group Health. The Mayo Foundation provides guarantees for its HMO, and Northwestern National Life Insurance Company is the guarantor for NWNL Health Network.

#### TABLE 3

#### 1990 HMO COMPLIANCE WITH STATUTORY NET WORTH REQUIREMENTS

НМО	Net Worth*	Change from 1989	Required 1990	Need to add in 1990**	Need to add by 1993***
Blue Plus	3,568,335	2,568,335	4,788,957	1,220,622	6,904,058
First Plan	810,594	-127,141	1,000,000	189,406	189,406
Group Health	47,993,000	7,856,000	12,435,103	0	0
Central MN					
Group Health	-296,923	869,463	1,000,000	1,296,923	1,447,207
Mayo	-365,474	378,612	1,000,000	1,365,474	1,365,474
MedCenters	30,336,902	22,747,764	9,613,518	0	0
Metropolitan	479,431	13,147	1,000,000	520,569	520,569
NWNL	459,212	-13,148	1,000,000	540,788	733,790
PHP	29,405,929	16,028,929	12,712,958	0	2,376,466
Share	9,309,000	5,798,000	7,920,117	0	10,491,291
UCare	1,019,266	1,019,266	1,000,000	0	0
Total	\$122,719,272	\$60,698,472			

\* Statutory net worth differs in some respects from net worth calculated using Generally Accepted Accounting Principles.

\*\* Shows the difference between the actual net worth and required net worth. Each HMO that shows a shortfall has a guaranty arrangement that satisfies state law.

\*\*\* Based on expenses for 1989. Most HMOs are likely to show increased expenses in future years, resulting in a corresponding increase in the net worth requirement.

Under state law, Blue Cross and Blue Shield of Minnesota, which guarantees the net worth of two HMOs, is subject to a more stringent net worth requirement than HMOs. It must maintain net worth equal to at least two months of expenses but not more than four months. In 1990, it increased its net worth by \$26.1 million, and has reserves equal to 2.6 months.

Table 4 shows other key financial indicators for Minnesota HMOs. With the exception of Central Minnesota Group Health, all reported positive working capital. Several made very significant additions to their working capital. Most showed improvements in their current ratio (the ratio of current assets to current liabilities) when compared to 1989.

<b>TABLE</b>	4
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#### **OTHER KEY FINANCIAL INDICATORS**

	Wo	rking Capi	tal	<u>Curre</u>	nt Ratio*		
НМО	1990	Weeks	Change	1989	1990		
Blue Plus	\$4,149,045	1.92	\$7,737,201	0.88	1.16		
First Plan	557,318	2.70	107,728	1.27	1.36		
Group Health	15,546,000	1.80	-893,000	1.31	1.22		
Cent MN Grp Hlth	(540,273)	-1.72	1,024,331	0.40	0.85		
Mayo	\$46,855	5.06	1,390,941	0.33	1.38		
MedCenters	31,417,825	5.54	23,650,396	1.18	1.62		
Metropolitan	868,902	2.51	931,392	0.97	1.16		
NWNL	882,260	1.86	403,102	1.11	1.15		
PHP	25,356,686	3.97	18,743,686	1.09	1.23		
Share	9,981,000	2.00	8,579,000	1.03	1.19		
UCare	1,019,266	12.46	N/A	N/A	1.66		
Total	\$81,321,674	,					
* Current ratio = current assets/current liabilities. If the ratio is greater than 1.0, current assets exceed current liabilities.							

## **REVENUE TRENDS**

#### PREMIUMS

We looked at changes in premium revenues in two ways. First, we compared the premium tables reported to the Department of Health. As shown in Table 5, all HMOs reported doubledigit rate increases during 1990. However, the usefulness of these rate tables is unclear, since HMOs use a wide variety of factors to adjust the rate tables in order to set the actual premium offered to a given group.<sup>5</sup>

Table 6 compares the premium revenues that each HMO realized on its commercial plans (excluding Medicare and Medical Assistance) in 1989 and 1990. The comparison is on a per member per month basis, and shows something about how HMOs are setting their prices. In 1990, the statewide average revenue was about \$87 per member per month. The average increase in 1990 was 16.9 percent.

TABLE 5							
PREMIUM INCREASES IN 1990							
HMO	Base Premium	Increase					
Blue Plus	1/1/91	1990-91					
Cent MN	\$287.00	15.4%					
Grp Hlth	\$260.49	21.8%					
Group Health	\$240.82	12.7%					
MedCenters	\$241.30	15.0%					
NWNL	\$247.36	24.0%					
PHP	\$274.50	13.9%					
Share	\$218.60	12.1%					

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Rates based on two-person household as of January 1, 1990 and January 1, 1991. Comparisons not possible for First Plan, Mayo, Metropolitan, and UCare.

Note that an HMO may be reporting here its rate for a two-person household or its rate for an employee plus all dependents. Group Health changed its reporting in 1990, apparently from the latter to the former.

<sup>&</sup>lt;sup>5</sup> For example, an HMO may make adjustments based on group demographics, past health care utilization, broker commissions, and family size.

For example: Metropolitan Health Plan and Mayo Health Plan show the highest revenue per member per month, with PHP highest among the larger plans. Later in this report, we show that both are also high users of hospital care.

While premiums continue to increase for HMOs and indemnity insurers alike, anecdotal evidence suggests that certain groups are seeing some actual price competition in the proposals they are getting from HMOs in 1991. The more substantial reserves that the HMOs have established give them some cushion for negotiating prices.

The same anecdotes also suggest that, in cases where companies currently offer a choice of several HMOs or other plans, HMOs are more often presenting proposals by which one HMO would replace all other health plans offered to employees.

## **COORDINATION OF BENEFITS**

#### TABLE 6

#### PREMIUM REVENUE PER MEMBER PER MONTH FOR COMMERCIAL PLANS

нмо	1989	1990	Change
Blue Plus	\$67.73	\$74.05	9.3%
First Plan	67.48	81.21	20.3%
Group Health	71.62	<b>81.97</b>	14.5%
Cent MN			
Grp Hlth	72.78	84.51	16.1%
Mayo	90.97	100.76	10.8%
-			
MedCenters	74.48	88.13	18.3%
Metropolitan	72.26	111.55	54.4%
NWNL	63.02	75.78	20.3%
PHP	83.02	98.47	18.6%
Share	75.19	86.32	14.8%
AVERAGE	\$74.81	\$87.45	16.9%

Some HMOs will coordinate benefits; that is, they attempt to collect part of the costs paid to medical providers by identifying other insurance coverages that might apply to the family and trying to recover from those other insurers. Those other sources can include other health insurance, workers' compensation, and the medical portion of auto insurance. As shown in Table 7, MedCenters continues to be the largest user of coordination of benefits.<sup>6</sup> For 1990, it reported \$20 million in revenues from coordination of benefit recoveries.

In some cases, medical groups under contract with HMOs will independently seek to coordinate benefits. If they are receiving a capitated fee from the HMO, coordination of benefits is an opportunity to improve the providers' bottom line.

This year, for the first time, Share is reporting some revenues from coordination of benefits. The extent of HMO managers' responsibility for attempting to coordinate benefits was one of the issues in the dispute between the Aspen Medical Group and Share.<sup>7</sup>

<sup>&</sup>lt;sup>7</sup> During 1990 and 1991, Share and the Aspen Medical Group, its largest provider group, have been in arbitration of disputes over certain sections of their provider agreement.

TABLE 7							
COORDIN	ES REPORTI Ation of 1 987 And 199	BENEFITS:					
HMO	1987	1990					
Blue Plus							
First Plan	\$29,238	\$18,212					
	Group Health						
CentrMN Grp Hlth	239,847	782,915					
Mayo	237,047	262,450					
1villiy0		202,450					
MedCenters	1,624,192	20,062,898					
Metropolitan							
NWNL							
Share		820,000					
PHP							
UCare							
TOTAL	\$1,893,277	\$21,946,475					

<sup>&</sup>lt;sup>6</sup> Note that other plans may not have reported their activity in this area as a separate line item. Blue Plus says that it actively coordinates benefits but does not report the results separately.

## **ENROLLMENT**

## **HMOS**

In 1990, total HMO enrollment in the state increased by 4.8 percent, to 1,166,537. With 26.1 percent of the state's population in HMOs, Minnesota is one of four states where HMO enrollment exceeds one-fourth of the population. The others, according to InterStudy, the Excelsior-based health care research center, are California (30.8 percent), Massachusetts (26.5 percent), and Oregon (25.1 percent).<sup>8</sup>

Figure 3 shows that enrollment in Minnesota HMOs reached its peak in 1987, at just over 1.2 million. It dropped by almost 10 percent in 1988, as participation in Medicare plans declined and as some HMOs withdrew from their operations outside the Twin Cities area. HMO enrollment also declined as some HMOs did not renew employer groups whose claims were high.

Overall, HMO enrollment increased by about five percent in 1990. Table 8 shows that PHP added 38,000 members while Group Health added about 22,500. Two smaller HMOs --Metropolitan and NWNL Health Network -showed significant percentage increases in their enrollment. Blue Plus lost more than one-fourth of its enrollment. Later in this report we discuss an overall shift in Blue Cross and Blue Shield's mix of business from insured plans to selfinsured products.

While enrollment increased in all three program categories, the largest source of growth in 1990 was among the state's Medical Assistance and General Assistance Medical Care recipients.<sup>9</sup> The number of public assistance recipients in HMO more than doubled last year.

Public assistance recipients are likely to be a major source of HMO enrollment growth in the

FIGURE 3 ENROLLMENT IN MINNESOTA HMOS: 1980 - 1990 1,200,000 1,200,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000 1,000,000,000 1,000,000,000 1,000,000,000 1,000,000,000,000,0001,000,000,000,0

future. Later this year, Ramsey County and the Minnesota Department of Human Services plan to seek proposals to enroll recipients of Aid to Families with Dependent Children (AFDC) in HMOs. That could add about 20,000 to 25,000 new enrollees. The state and other counties are also exploring expanded use of HMOs for public assistance recipients in other parts of the state.

<sup>&</sup>lt;sup>8</sup> InterStudy, *Managed Care: A Decade in Review*, 1990. About 14 percent of the population of the United States is enrolled in HMOs.

<sup>&</sup>lt;sup>9</sup> Medical Assistance is the Minnesota name for the Medicaid program, created under Title XIX of the Social Security Act. General Assistance Medical Care is a state-funded program providing medical care for lowincome persons.

	TABLE 8						
HMO ENROLLMENT BY PROGRAM							
нмо (	Commercial	M Medicare (	led Assist/ Gen Assist	1990 Total	1989 Total	Change	
Blue Plus	59,071	17,299	0	76,370	103,192	-26.0%	
First Plan	7,985	917	151	9,053	8,766	3.3%	
Group Health Cent MN	260,865	21,362	3,160	285,387	262,936	8.5%	
Grp Hlth	16,538	213	0	16,751	14,370	16.6%	
Mayo	4,537	607	0	5,144	4,924	4.5%	
MedCenters	241,894	19,267	0	261,161	260,356	0.3%	
Metropolitan	5,175	0	13,629	18,804	10,087	86.4%	
NWNL	14,596	0	5,428	20,024	12,013	66.7%	
PHP	263,971	39,877	26,084	329,932	291,462	13.2%	
Share	96,690	41,634	0	138,324	145,014	-4.6%	
UCare	0	0	5,587	5,587	0		
1990 Total	971,322	141,176	54,039	1,166,537	1,113,120	4.8%	
1989 Total	959,542	129,529	24,049				
Growth by pr	ogram 1.2%	8.9%	124.7%				
Program Sl	nares:						
1990	83.3%	12.1%	4.6%				
1989	86.2%	11.6%	2.2%				

Figure 4 shows the penetration of HMO enrollment in regions of the state. More than 85 percent of HMO enrollment is concentrated in the metropolitan Twin Cities area, where 43.4 percent of the population is in an HMO. That proportion peaked in 1987 at 46.3 percent. There are also large pockets of enrollment in the St. Cloud area and in northeastern Minnesota. A larger share of the Medicare enrollees -- about one-fourth -- live outside the Twin Cities area.

Enrollment in HMOs provides another indicator of how population growth in the Twin Cities metropolitan area has taken place outside the core of the region. Some enrollment growth has been seen in recent years in western Wisconsin and in the next ring of counties around the seven counties of metropolitan Twin Cities region. In 1987, about 10,000 HMO enrollees lived outside the state, mostly in western Wisconsin. That number has now increased to nearly 19,000. In general, these are households that get their coverage through a Minnesota employer. In addition, Blue Cross and Blue Shield of Minnesota operates HMO Midwest, a Wisconsin-licensed HMO, with about 9,000 enrollees in Hudson, Wisconsin. (HMO Midwest's enrollment is not included in the reported enrollment of either Blue Plus or Blue Cross and Blue Shield of Minnesota.)

#### **OPEN-ENDED HMO PLANS**

Open-ended plans (also variously known as point-of-service plans and choice plans) have become an important product for HMOs in recent years. Under these plans, enrollees received comprehensive coverage from their HMO's panel of providers and also receive indemnity coverage, with higher enrollee cost-sharing, when they use non-HMO providers. This allows HMOs to promote their plans as offering a broader choice of providers. Of the 11 active HMOs in Minnesota, eight offer open-ended plans. We discuss open-ended HMO enrollment as a subset of total HMO enrollment.



CITIZENS LEAGUE

#### **MINNESOTA MANAGED CARE REVIEW 1991**

InterStudy has tracked enrollment in open-ended plans in recent years. According to InterStudy, about 382,000 Minnesotans, or 34.9 percent of all HMO enrollees, were enrolled in open-ended HMO plans on July 1, 1990. As shown in Figure 5, the number continues to grow: a year earlier, 30.3 percent of HMO enrollees in the state were in open-ended plans. While open-ended plans are growing rapidly in popularity nationally, Minnesota is far ahead of all other states. Minnesota HMOs account for 36.7 percent of national enrollment in open-ended plans.



For several years, Prudential and Group Health have teamed to offer their CareSpan product, an openended HMO plan for which Prudential provides the indemnity coverage. There are about 40,000 enrollees in CareSpan. Prudential announced this spring that it would develop its own PPO network (PruNetwork) in the Twin Cities area that it would market to self-insured employers. Prudential's ability to market CareSpan was sometimes limited in 1990 because Group Health lacked clinic capacity to serve a few large groups or because national clients wanted a Twin Cities plan that was the same as their Prudential plans in other markets. Furthermore, Group Health is also interested in marketing its own PPO product. While both Group Health and Prudential say that they will continue to renew CareSpan contracts and to market the product, it seems likely that Prudential will focus its marketing activities on its new PPO plan.

In the past, state law required that HMOs offering open-ended plans team up with an insurance company to write the indemnity part of the coverage. That law was changed in 1989, permitting HMOs to offer these "supplemental benefits" on their own.<sup>10</sup> While most of these plans are still offered with insurance company partners, four HMOs have begun to use the new authority: Group Health, MedCenters, PHP, and Share.

<sup>10</sup> Minn. Stat. §62D.05, subd. 6. Under the old way, HMOs have to go to two regulatory agencies (the Departments of Health and Commerce) to get approval of these offerings. The law requires that an HMO offering supplemental benefits maintain additional reserves in proportion to its expenses for supplemental benefits.

According to reports filed with the Commissioner of Health, Group Health and PHP offered supplemental benefits in 1990. Group Health showed a surplus of \$720,200 on revenues of \$4.2 million, while PHP reported losing \$1.2 million on revenues of \$9.0 million. MedCenters and Share also reported offering supplemental benefits, but with little or no expenses for 1990.

Recent General Counsel memoranda from the U.S. Internal Revenue Service suggest that the IRS might question the tax exempt status of Minnesota HMOs offering supplemental benefits. Nonprofit HMOs (and in Minnesota all HMOs are required to be nonprofit) are exempt from federal tax if no substantial part of their activities consists of providing commercial-type insurance. However, the IRS might conclude that the indemnity benefits in open-ended plans are not of a kind customarily provided by HMOs.

## **ENROLLMENT IN OTHER PLANS**

Blue Cross and Blue Shield of Minnesota is the single largest insurer in Minnesota. As shown in Table 9, enrollment in its insured and self-insured plans (but not its Blue Plus HMO) is just under 1 million.

Table 9 also shows the enrollment in insured and self-insured plans reported by seven other managed care plans in the state.<sup>11</sup> Preferred provider arrangements have become a significant force in the Minnesota marketplace, enrolling about 470,000 Minnesotans at the end of 1990. Local HMOs have joined in, offering their own PPO products to self-insured employers. For example, Physicians Health Choice, the PPO affiliated with PHP, has more than 47,000 enrollees in self-insured plans. The HMOs do not bear any risk for these plans, and the enrollment or "eligibles" reported are not part of their HMO enrollment. Promoting PPO options is an important part of HMOs' strategy to maintain and expand their market share in the face of competition from PPOs and administrators of self-insured plans.

#### SELF INSURANCE

While enrollment in HMOs and other insured plans has leveled off in the past few years, there has been a significant increase in enrollment in self-insured plans. Table 9 shows that enrollment in managed care self-insured plans grew to more than 650,000 in 1990. However, measuring that growth is difficult. Not all growth in PPO self-insured enrollment reflects employers converting to self-insurance. In some cases, enrollment in PPOs has grown because groups that were already self-insured chose to use a managed care plan.

Self-insuring a plan offers opportunities for saving money and for better managing cash flow. Selfinsured plans are not subject to state laws mandating benefits and do not contribute to state risk insurance pools. (Minnesota's pool is discussed later in this report.)

Local health plan managers interviewed for this project all agreed that the "minimum" size of selfinsuring groups has dropped dramatically in recent years. Only a few years ago, the conventional wisdom held that a minimum of 500 employees was needed for a self-insured group. That floor has dropped steadily, and now it is not unusual to find groups of fewer than 100 or even 50 employees

<sup>&</sup>lt;sup>11</sup> Note that these data are as reported by BCBSM and by the PPOs, and that counting PPO enrollment is still more an art than a science. None of these plans faces any statutory requirement to report their enrollment or medical care utilization in any of the detail that is required of HMOs. Furthermore, enrollment practices among these plans vary quite widely. For example, many PPOs do not formally enroll all persons eligible for care. In reporting enrollment, they estimate the number of persons eligible for care. In some cases, that is based on taking the count of employees covered, applying assumptions about how many of them have dependents with coverage, and then applying a multiplier to come up with a number of dependents. The trend in PPOs is toward formally enrolling all employees and dependents. Some, such as Family Health Plan, say that they are already there.

TABLE 9						
ENROLLMENT IN OTHER MANAGED CARE PLANS						
Plan Blue Cross/Blue Shield	<b>Year</b> 1989 1990	<b>Insured</b> 792,495 681,713	<b>Self-insured</b> 177,968 299,274	<b>Total</b> 970,463 980,987		
Preferred One	1989 1990	81,450 82,000	99,550 123,000	181,000 205,000		
Select Care	1989 1990	12,300 11,000	110,700 99,000	123,000 110,000		
Family Health Plan	1989 1990	24,876 24,063	74,627 72,188	99,502 96,251		
Physicians Health Choice	1989 1990		44,955 47,035	44,955 47,035		
Aetna PPO	1989 1990		7,500 9,600	7,500 9,600		
Group Health PPO	1989 1990		7,092 1,546	7,092 1,546		
TOTAL	1989 1990	911,121 798,776	522,392 651,643	1,433,512 1,450,419		
* Comparable data we	re not availabl	le for Private Heal	th Care Systems.			

choosing to self-insure. The smaller groups typically purchase some stop-loss or excess risk coverage for which the attachment point (the size of claims where the excess risk coverage kicks in) is quite low.

Figure 6 shows how self-insured enrollment at Blue Cross and Blue Shield of Minnesota and at five area preferred provider arrangements (PPOs) has grown significantly in the past two years. The growth in self-insurance in Minnesota and elsewhere is due to several reasons. For example, HMOs and other insurers may find it desirable to convert money-losing insured groups into self-insured ones. Changes in Blue Cross and Blue Shield of Minnesota's mix of business since 1988 may provide the clearest example. As shown in the table, BCBSM is the largest administrator of self-insured plans, managing plans for about 300,000 individuals. That is 28.3 percent of its total membership, including its Blue Plus HMO, compared to 11.4 percent in 1988.

From 1988 to 1990, enrollment in BCBSM's regulated plans dropped by 164,000. According to BCBSM, most of them converted to self-insured plans. BCBSM's marketing strategy is not to steer employers to self-insurance, but to help the client choose the benefit design that best meets the client's needs. A few years ago, it combined the sales forces of the health plan and the HMO.

For many insurance companies, administration of self-insured plans is now a large part of their mix of business. As noted earlier, three local PPOs -- Preferred One, Select Care, and Family Health Plan -- do business with insurance carriers in the state who want to offer managed care plans to their clients. Private Health Care Systems (PHCS) is a national PPO, owned by insurance companies, that also works with insurance carriers offering insured and self-insured plans in Minnesota.



There is no central source of data on enrollment in health plans offered by the indemnity insurance companies in the state or on the enrollment in self-insured plans that are administered by insurance companies. Table 10 shows the leading health insurers in the state, based on premium volume. Seventeen insurers reported more than \$10 million in premiums in 1989. For all indemnity insurers, total 1989 premiums were about \$650.7 million, slightly more than half of what HMOs collected that year.

## **EXPENSES**

## **HMO HOSPITAL UTILIZATION**

## **Commercial Plans**

Last year, Minnesota's 11 HMOs paid more than \$1.3 billion to physicians, hospitals, and other providers for medical care. Although some HMOs reported large increases or decreases in medical spending, the overall increase was only

## TABLE 10

#### HEALTH INSURERS WITH 1989 PREMIUMS ABOVE \$10 MILLION

	Insurer	1989	Premiums		
1.	Principal Mutual Life	5	692,271,161		
2.	Prudential		35,875,426		
3.	State Farm Mutual		31,015,203		
4.	Federated Mutual		28,669,162		
5.	Aetna		26,279,163		
6.	MidAmerica Mutual		24,842,106		
7.	Mutual Benefit Life		23,711,013		
8.	Employers Health Ins.	Co.	23,586,490		
9.	Mutual Services Life		22,738,363		
10.	John Alden		17,274,271		
11.	Travelers		15,351,708		
12.	Bankers Life & Casualt	v	14,208,537		
13.			11,660,141		
14.			11,142,658		
15.	Mass Mutual		11,061,339		
16.	Guardian Life		10,264,283		
17.	Central States		10,101,658		
Source: Minnesota Comprehensive Health Association, 1991 Interim Assessment.					

3.1 percent over 1989, in a year when HMO enrollment grew by 4.8 percent.<sup>12</sup>

<sup>&</sup>lt;sup>12</sup> The change in medical expenses is skewed by a change in PHP's book of business. PHP reported a decrease of \$48.4 million in health care expenses in 1990. That generally results from its change from Medicare Risk to Medicare Cost plans. Under the Medicare Cost plans, PHP was no longer buying most hospital care for its Medicare enrollees. When PHP's expenses were not included, health care spending for all other HMOs increased by 10.2 percent in 1990.

#### **MINNESOTA MANAGED CARE REVIEW 1991**

Reporting of hospital utilization data for 1990 is based on new ground rules intended to improve comparability between HMOs, so we have not attempted to compare the 1990 data with previous years' results. During 1990, representatives of HMOs and state agencies developed new requirements for reporting hospital utilization data. (Reporting requirements for ambulatory care have yet to undergo a similar review.) In previous years, HMOs had reported their utilization data on April 1 of the following year. Because the reporting deadline was delayed beginning this year until July 1, the data submitted by HMOs included fewer projections of claims for services provided in 1990, but not yet submitted for payment.

Most of our analysis is focused on enrollees in "commercial" HMO plans who are under 65 years of age. Commercial plans are those offered to employee groups and individuals and do not include HMO coverage provided through the Medicare or Medicaid programs. We also analyzed the activity of HMOs enrolling public assistance recipients.

Historically HMOs and other managed health care plans have tried to contain the growth of medical costs by reducing admissions to hospitals and by trying to shorten the stays of those members that are admitted. One measure used to compare hospitals is the number of inpatient hospital days used for every 1,000 enrollees. A low rate reflects well on an HMO's ability to manage medical care and costs.

Under the new reporting procedures, non-acute care and well newborn care are reported separately. In addition, we have separated out mental health and chemical dependency treatment (MH and CD), two areas where approaches to treatment and management can be much different, and where the daily cost is usually lower than for acute care hospital stays.

We calculated the inpatient days per 1,000 enrollees in commercial plans, under the age of 65. (We used end-of-year enrollee counts and did not adjust for member months.) As shown in Table 11, the average for all HMOs in 1990 was 227 acute care days per 1,000 enrollees. Group Health's rate of utilization was 174 inpatient hospital days for acute care for every 1,000 enrollees under 65. Note that the annual statements don't provide sufficient information to adjust the utilization measures for characteristics of the enrollees.

TABLE 11						
HOSPITAL UTILIZATION FOR HMO COMMERCIAL PLANS, 1990 (ENROLLEES UNDER 65)						
				erage Length of Stay		
	Acute Care	MH/CD	Total	(Acute Care Only)		
Blue Plus	262.66	52.53	315.20	3.82		
First Plan	313.56	50.29	363.85	4.08		
Group Health	174.36	25.86	200.22	3.46		
Cent MN Grp Hlth	213.23	45.13	258.36	3.77		
Mayo	350.44	115.33	465.78	3.88		
MedCenters	227.52	49.64	277.16	3.48		
Metropolitan	384.86	85.89	470.75	3.63		
NWNL	222.09	24.84	246.93	3.78		
PHP	255.18	27.00	282.18	4.07		
Share	249.21	31.24	280.45	4.05		
State Average	226.90	35.52	262.41	3.74		

Among the smaller HMOs, Central Minnesota Group Health and NWNL Health Network reported the lowest rate of hospital utilization. In general, hospital use by HMO enrollees is lower than by the

general population. Data from the Department of Health show that Minnesotans under the age of 65 used inpatient hospital care at a total rate of 464 days per 1,000 people.<sup>13</sup>

Different approaches to medical care management don't necessarily yield different results. PHP and Share, which joined this year to form an HMO called Medica, reported very similar rates of inpatient hospital days. PHP allows enrollees to choose from a wide range of physicians and to self-refer to specialists. Share uses a system of primary care physicians or groups, that regulate referrals to specialists.

Group Health's use of inpatient care for chemical dependency and mental health was also low: 26 days per 1,000 enrollees, compared to the state average of 36 days. PHP's rate of 27 days was also quite low. PHP subcontracts its mental health and chemical dependency treatment programs to specialized managed care organizations. Figure 7 arrays the HMOs by their acute care hospital days per 1,000 enrollees.



#### **Public Assistance Plans**

Table 12 shows hospital utilization rates for HMOs offering plans for public assistance recipients. The statewide average for acute care only is about 370 days. Among the six HMOs serving public assistance recipients, UCare, sponsored by the University of Minnesota Department of Family Practice, and Metropolitan Health Plan, operated by Hennepin County, reported the lowest rates: 247 and 264 days per 1,000 enrollees, respectively. (Again, non-acute care, well newborns, chemical dependency and mental health treatment are not included.)

<sup>&</sup>lt;sup>13</sup> Note that the hospital days reported by the Department of Health includes all hospital stays, including some that are excluded from our analysis; that is, well newborns and non-acute care stays. We estimate that inclusion of well newborn and non-acute care days would add 10 to 15 percent to the inpatient days of the HMO enrollees. The statewide hospital data may also include some people coming to Minnesota hospitals from other states. Note also that this comparison is somewhat fuzzy at the 65 years break point. The State Demographer divides the state's population, according to the 1990 census into over 65 and 65 and under. The Department of Health reports hospital days for 65 and over, and so do the HMOs' annual statements.

## TABLE 12

## HOSPITAL UTILIZATION FOR HMO MEDICAL ASSISTANCE/GENERAL ASSISTANCE PLANS, 1990 (ENROLLEES UNDER 65)

	Inpatient Days	s per 1.000 En	rollees	of Stay (Acute
	Acute Care	MH/CD	Total	Care Only)
Group HealthDemo*	449.63	46.69	496.33	4.81
Group HealthAFDC Vol**	311.00	109.25	420.26	2.96
Metropolitan	263.97	27.63	291.60	3.73
NWNL***	1,212.96	341.97	1,554.93	6.26
PHP	270.89	64.28	335.17	3.69
UCare	247.33	70.35	317.68	3.44

Enrollees in the Medicaid demonstration project for Hennepin and Dakota Counties

\*\* Voluntary enrollment by AFDC recipients

\*\*\* NWNL Health Network administers the Ramsey County General Assistance Medical Care program. On average, GA recipients have more medical problems than AFDC/MA recipients.

By comparison, the average days per 1,000 enrollees for commercial HMO enrollees was 227. Department of Human Services managers note that the AFDC enrollees include a relatively high number of women in their child-bearing years, and General Assistance recipients are single males, many of whom have medical problems.

The state pays HMOs a capitation rate which is from five to eight percent less than what it would expect to pay for fee-for-service care for the enrollees. Its experience has been that hospital utilization by Medical Assistance recipients enrolled in HMOs is higher than in the HMOs commercial plans, but lower than for the rest of the Medical Assistance recipients. The General Assistance enrollees in Ramsey County, whose coverage is administered by NWNL Health Network, show the highest rates of acute care hospital use: 1,213 days per 1,000 enrollees.

Both Metropolitan and UCare were created to serve Medical Assistance recipients. Metropolitan now also serves General Assistance recipients and provides commercial coverage for employees of Hennepin County and some cities.

#### Medicare Risk Plans

Table 13 shows hospital utilization for the four HMOs still offering Medicare Risk plans. HMOs generally did not report hospital utilization for their other Medicare plans.

## TABLE 13

## HOSPITAL UTILIZATION FOR ENROLLEES IN MEDICARE RISK PLANS

	Inpatient Days po	er 1.000 Enro		erage Length tay (Includes
НМО	Acute Care	MH/CD	Total	MH/CD)
Blue Plus	2,045.00	156.00	2,201.00	7.10
Group Health	1,143.70	85.70	1,229.40	5.80
Group Health Seniors Plus*	1,327.30	148.30	1,475.60	5.70
MedČenters	1,576.00	40.00	1.616.00	7.10
Share	1,346.00	58.00	1,404.00	5.45
<ul> <li>* Seniors Plus is Grou</li> </ul>	p Health's Social HM	O plan.	-	

## HOSPITAL USE BY OTHER PLANS

Blue Cross and Blue Shield of Minnesota reports that its rate of acute care inpatient days for 1,000 enrollees under age 65 was 282.9 in 1990.<sup>14</sup> This has declined from 297.9 in 1988. Similarly, its rate of inpatient days per 1,000 enrollees for chemical dependency and mental health treatment was reported to have declined from 92.3 in 1988 to 68.2 in 1990.

Among the PPOs, Family Health Plan reports average inpatient hospital days per 1,000 of 177.9 for acute care only. It reports additional chemical dependency and mental health treatment days of 96.9, and well newborn days of 25.9. Family Health Plan notes that it has several group contracts which do not use Family Health Plan's utilization review procedures for chemical dependency hospital admissions, resulting in higher utilization.

Preferred One reports inpatient hospital days in 1990 of about 320 per 1,000 enrollees, down from 350 in 1987 and 1988. That would include acute care as well as chemical dependency and mental health treatment.

Select Care reports 230 inpatient days per 1,000 enrollees in 1990, down from 276 days in 1989. It also reports a decrease in average length of stay from 3.87 days in 1989 to 3.4 days in 1990. These figures do not include mental health and chemical dependency treatment.

## AMBULATORY CARE

#### **Commercial Plans**

Ambulatory care -- office visits -- is also an important component of health care utilization. As shown in Figure 8, two small HMOs -- NWNL Health Network and Mayo -- recorded the lowest rates of ambulatory care encounters, with averages of three and four encounters, respectively. PHP, which has made relatively wide use of co-payments for office visits, reported the lowest rate of ambulatory care encounters among the large HMOs. The average PHP enrollee under 65 had about 4.5 ambulatory encounters in 1990.

By comparison, the state average was 5.3 encounters. Group Health enrollees, who are low users of hospital care, averaged 6.1 ambulatory encounters. Some of the difference reported here may reflect variations in reporting data, though Group Health has a reputation of wanting it to be easy for members to get appointments.

## **Public Assistance Plans**

Figure 9 compares HMOs on average ambulatory encounters per member for enrollees in Medical Assistance and General Assistance Medical Care plans. Metropolitan Health Plan reports the lowest average in 1990: 2.8 encounters per member. Enrollees in Group Health's two programs had the highest rate of ambulatory encounters.

<sup>&</sup>lt;sup>14</sup> The caveats noted above on the reporting of PPO enrollment data also apply here. The data are as were reported to the Citizens League by the PPO. Furthermore, if the PPO does not have defined enrollment, then it can't really know the denominator for calculating inpatient days per 1,000 enrollees. Similarly, unless the PPO pays the claims (or otherwise knows about them) for all care, whether from PPO providers or others, it can't know the full extent of hospital use.

#### MINNESOTA MANAGED CARE REVIEW 1991





#### **PROVIDER NETWORKS**

An essential component of any managed care plan is its provider network. Table 14 compares Minnesota HMOs and PPOs on the size of their physician networks. In general, the plans continue to add physicians. As enrollment grows outside the Twin Cities area and in western Wisconsin, plans add physicians serving those areas.

#### ADMINISTRATIVE COSTS

Administrative costs are a key item for HMOs. Statewide, administrative costs for HMOs increased by 17.8 percent in 1990.

Figure 10 shows that, on average, HMOs spend about \$14.04 per member per month on administration. The range is wide, with small HMOs reporting both the highest and lowest administrative costs per member per month.

Figure 11 views the comparison in a different way: the percentage of 1990 expenses attributed to administration. On average, HMOs in the state devoted 12.5 percent of their budgets to administration. Among the largest HMOs, MedCenters reported the lowest cost: \$12.96 per member per month.

The results shown in Figures 10 and 11 are similar: the plans with the highest administrative costs per member per month also have the highest administrative percentage. PHP shows the highest percentage there, while Group Health's administrative percentage is the lowest among the large HMOs.<sup>15</sup>

Blue Cross and Blue Shield of Minnesota reports an administrative overhead of 13.7 percent of its expenses in 1990. No data are available on the administrative costs of any other PPOs.

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## **PHYSICIAN NETWORKS**

НМО	1989	1990
Blue Plus	3,944	4,471
First Plan	127	132
Group Health*	460	524
Cent MN Grp Hlth	8	11
Mayo**	211	211
MedCenters	1,445	1,653
Metropolitan	672	741
NWNL	1,151	1,462
PHP	3,923	3,959
Share	502	512
UCare	783	1,199
PPO		
Blue Cross/Blue Shield	8,517	9,077
Family Health Plan	1,400	1,600
Preferred One	2,800	3,200
Select Care	1,750	2,400
	• • • •	· · · ·

\* Group Health includes staff physicians and physicians from affiliated clinics

\*\* Mayo network does not include Mayo Clinic which has 815 consultants and 864 residents



<sup>&</sup>lt;sup>15</sup> Note that a plan that successfully contains its costs might find that its fixed administrative costs are a relatively higher percentage of revenues or total expenses

#### MANAGEMENT ARRANGEMENTS AND FEES

Under Minnesota law, HMOs must be nonprofit organizations. However, many of the HMOs have relatively small administrative staffs and contract with for-profit management companies for most administrative and marketing services. For example, PHP and Share, which have joined together to form Medica, were both managed by subsidiaries of United HealthCare.

Figure 12 summarizes the management arrangements that HMOs have with their management companies and other related organizations. Management fees are typically related to gross premiums collected, although some HMOs have devised fee arrangements in recent years that link the management company's fee to the HMOs performance. On a per member per month basis, UCare pays the highest administrative fee: \$17.66 per member per month.

## MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION

One reason for Minnesota's relatively low rate of uninsurance is the number of people covered by programs like the Minnesota Comprehensive



Health Association. MCHA was created in 1975 to provide health insurance to persons who had been turned down in the private market, usually because of pre-existing health conditions.

Eligibility for MCHA has been widened in recent years, often to accommodate persons who, for various reasons, cannot continue coverage that they had under group policies. By law, premiums are limited to 125 percent of the price of comparable plans in the private market.

According to a 1988 study by the U.S. General Accounting Office, MCHA enrolls more persons than similar plans in 15 other states combined. As of June 30, 1991, more than 27,500 persons were enrolled in MCHA, compared to 11,300 in 1985.

MCHA's losses are recovered through an assessment against HMOs, BCBSM, and indemnity insurance companies, in proportion to their premium revenues. Presumably, these assessments are passed on to enrollees or reduce a plan's bottom line. Because of the federal ERISA preemption, self-insuring employers are not assessed for any share of MCHA's deficit.<sup>16</sup>

<sup>&</sup>lt;sup>16</sup> The federal Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulation of *employee benefit plans*, although it specifically reserves to the states the power to regulate *insurance*. The distinction is not always clear, especially since many self-insuring firms purchase stop-loss insurance to protect against liability for large claims. However, most courts currently hold that states cannot regulate the content of self-insured plans or assess those firms for the cost of state pools like MCHA on the same basis as insured plans.

## FIGURE 12

#### **HMO MANAGEMENT ARRANGEMENTS AND FEES**

НМО	Management	Fee Arrangement	1989 Fees	1990 Fees	Fee Per Member Month	
Blue Plus	Blue Cross and Blue Shield of Minnesota	HMO charged for receiving substantially all general and administrative services	\$12,234,656	\$11,917,855	\$12.49	
MedCenters	Aetna Health Plans (formerly PARTNERS National Health Plan)	Fee based, in general, on a percentage of the HMO's gross revenues	\$28,824,001	\$33,004,459	\$10.51	
Мауо	Mayo Management Services, Inc. (MMSI), a for-profit corporation wholly owned by Mayo Foundation	HMO pays an annually negotiated percentage of its gross revenues. For the year ended 12/31/90, the negotiated percentage was 12% for Group Services. The negotiated percentage was 15% for Medicare Supplemental Services until June 30, 1990, and then the rate was changed to 12% with a 10% commission	\$746,404	\$729,518	\$12.13	
NWNL	NWNL Health Management Corp., a wholly owned subsidiary of NWNL Benefits Corp	Based on premium revenues	\$1,238,378	\$2,401,000	\$11.58	
PHP*	United Healthcare Management Corporation	PHP pays UMC a fee calculated as a percentage of PHP's consolidated revenue	\$45,601,000	\$50,162,000	\$13.55	
Share*	Share Development Corp., a wholly- owned subsidiary of United Healthcare Management Corporation	(Not public data)	\$18,345,000	\$20,277,000	\$11.97	
UCare	University Affiliated Family Physicians, P.A.	\$17 per member per month		\$575,029	\$17.66	

\* On February 8, 1991, Share and PHP entered into an affiliation agreement to form MEDICA. Subject to regulatory approval, a new management contract with United Health Care Management will replace the separate contracts. The initial term of the management contract between United Health Care Management and MEDICA is from January 1, 1991 to December 31, 1997.

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CITIZENS LEAGUE

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#### **MINNESOTA MANAGED CARE REVIEW 1991**

MCHA's losses in recent years have been high, because claims paid are twice as much as premium income. As shown in Figure 13, MCHA losses have grown steadily in recent years, even faster than enrollment. Thus, avoiding MCHA assessments is another reason to self-insure.



Although its audited financial statements for 1990 have not been released as of this writing, MCHA's managers estimate its loss for 1990 at about \$27 million. In addition, changes in federal tax law have been interpreted to mean that MCHA must pay federal income taxes. Thus, it will need to assess members to pay a federal income tax liability going back to 1987.

MCHA assessments for HMOs now exceed one percent of HMOs' annual revenues. In April 1991, MCHA assessed \$20 million as an interim assessment for 1991. Figure 14 shows how HMOs and BCBSM paid almost 75 percent of that amount. Medica, the HMO formed by PHP and Share, paid \$5.2 million.

The continued growth of self-insurance in Minnesota will narrow the funding base for MCHA. When combined with MCHA's growing losses, the burden on those that remain in regulated plans will increase. As their burden increases, they will face additional pressure to consider self-insurance.

## SUMMARY

Minnesota's managed care industry enjoyed strong financial results in 1990. In 1991, it is redefining itself and further blurring distinctions that once seemed clear. HMOs are entering self-insurance because, with the potentially significant exception of public assistance recipients, there are no obvious sources of new HMO enrollment. Furthermore, HMOs find themselves in competition with PPOs, which have become an established and sizable force in the market.



The basis of any insurance system is pooling risk across a group of premium payers large enough to share losses. The 1991 Minnesota Legislature passed a bill, later vetoed by Governor Carlson, which sought to solve the problems of the uninsured by assembling a large pool of previously uninsured or "underinsured" persons and establishing a state-subsidized plan to insure them. The Legislature would have also imposed additional regulation on insurance companies, affecting those employers that have kept their groups inside the pool of commercial insurance. The result of the new regulations, according to some observers, would have been the departure of employer groups from the commercial insurance pool.

For better or for worse, the trend in Minnesota and elsewhere is the narrowing of commercial pools for health insurance. Self-insurance is growing generally. That growth is being helped along by HMOs and Blue Cross and Blue Shield that seek to maintain and expand their market share by promoting self-insurance options. As self-insurance grows, the financing base for MCHA narrows, accelerating the cycle. Avoiding payment of a share of MCHA's large losses has become another persuasive reason for firms to self-insure. How big MCHA will become and how responsibility for funding MCHA should be shared are key questions for state policymakers.

## Citizens League Research on Health Care in Minnesota:

# Three Opportunities

We hope that you found this report useful. The Citizens League, a nonprofit public affairs research and education organization in the Twin Cities, has long been involved in research and initiatives in Minnesota's dynamic health care marketplace.

With the publication of *Minnesota Managed Care Review 1991* this year, the League took another important step in assembling and analyzing important information about health care in the state. Last year's edition received wide national and local coverage because it was the first of its kind: a dispassionate, intelligent analysis of trends in a key health care marketplace.

We are now offering three opportunities to make the Citizens League's expertise work for you.

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By sharing copies of this report with your clients and associates, they'll see that you understand the importance of having the best analysis and information. We offer an attractive discount for purchases of multiple copies.

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## **Opportunity 2: Use Our Data Files**

Our staff built computer files with four years of data from the HMOs' annual reports to the Department of Health, Blue Cross and Blue Shield of Minnesota's annual statement to the Department of Commerce, and other sources. With your own copy of the data, you can use your computers to analyze trends affecting the managed care plans, providers, and employers that you work with.

#### Sample data file excerpt

FILE: Income State		d revenue items (	1987-90), 6-year	surplus/(loss) a	nalysis,
administrative cost an REVENUES 1990				~~~~~	
НМО	Member months	Premium	Medicare	Medicaid	Total revenue
Blue Plus	954,545	\$63,664,861	\$50,789,453	0	\$116,364,614
First Plan	111,716	8,658,989	617,310	99,052	10,594,601
Group Health	3,339,131	249,840,000	67,476,000	3,082,000	457,122,000
Cent MN Grp Hlth	193,423	16,345,604	237,011	0	17,279,956
Мауо	60,140	5,971,111	0	0	6,018,455
MedCenters	3,138,922	255,654,177	57,623,456	0	316,861,358
Metropolitan	145,698	14,865,819	0	0	18,014,558
NWNL	207,273	24,149,224	. 0	0	24,673,427
PHP	3,702,143	312,751,579	0	21,683,417	348,629,688
Share	1,693,819	119,844,000	137,960,000	0	265,563,000
UCare	32,554	4,446,087	0	0	4,571,732
TOTAL	13,579,364	\$1,076,191,451	\$314,703,230	\$24,864,469	\$1,585,693,389

The data files include data for several years on everything from HMOs' balance sheets and income statements to their enrollment, hospital stays, and state risk pool (MCHA) assessments. Besides the base data, the files include the calculations and analysis used to prepare the report. This year, we've added files with additional information about preferred provider arrangements, insurance companies, and Blue Cross and Blue Shield of Minnesota.

The data files are available in two formats: Microsoft Excel for Macintosh computers (3-1/2 inch disk) and Lotus 1-2-3 for use on IBM/DOS personal computers (5-1/4 inch disks)

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*The School Book* also includes information about what to consider when choosing a school, an explanation of Minnesota's school choice law, an application for the open enrollment program, and a Metropolitan Council map of public schools and districts in the region.

You can get a copy of *The School Book* by calling the Citizens League at 612/338-0791 or by using the enclosed order form. League members can buy the book for \$10.00; the nonmember price is \$12.95.

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## New research from the Citizens League

## Minnesota Homestead Property Tax Review 1991 Minnesota Managed Care Review 1991

Two new research reports from the Citizens League provide useful objective information about two topics that almost everyone thinks about: property taxes and health care. *Minnesota Homestead Property Tax Review 1991* builds on the annual property tax survey done by the League for the past 25 years. It includes data and trend analysis on residential property taxes in the Twin Cities area and in cities around the state.

Minnesota Managed Care Review 1991 provides valuable information about Minnesota's health coverage marketplace, including health maintenance organizations, preferred provider arrangements, and Blue Cross/Blue Shield. The report also analyzes key trends in enrollment, self-insurance, and management arrangements and costs. Minnesota Managed Care Review 1991 is a valuable reference for people who need to keep up with Minnesota's dynamic health care marketplace.

League members can buy either report for \$10.00; the nonmember price is \$15.00. Discounts are available for multiple copy orders. To order your copies, please use the enclosed form or call the League at 612/338-0791.

The computer data sets developed by the League staff in preparing its analyses are also available. The property tax data set includes files of multi-year data on property tax rates, valuations, and calculations of taxes on homes of different values. The managed health care files include data on health plan enrollment, finances, utilization, etc. The sets can be used on your PCs and Macintosh computers. Call the League office for details.

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