



*Minnesota State Employee Group
Insurance Program*

Biennial Report

2005-06



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I. Introduction

Minnesota Management and Budget

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

The departments of Employee Relations (DOER) and Finance were combined in June 2008 to create MMB. Previous to the merger, DOER housed SEGIP. This report covers calendar years 2005 and 2006 a period in time during which DOER was responsible for SEGIP.

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 insurance benefits. This report covers calendar years 2005 and 2006.

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 \$7,500 (reported as required by M.S. 3.197).

State Employee Group Insurance Program (SEGIP)

SEGIP is the single largest employer group purchaser of insurance in Minnesota, covering more than 48,000 employees as well as their dependents, a total of nearly 118,500 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 more than \$432 million in 2006. The majority of these costs, approximately 94 percent, were associated with health coverage, with the balance expended for dental, life, and disability coverage as well as the supporting administration fee. Insurance benefits are a significant feature of total employee compensation, accounting for nearly 14.4 percent of state government's approximately \$3 billion payroll. These expenditures are also an important part of the state budget and make SEGIP an important, visible presence in the state's health care market.

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

New developments summary

Throughout 2005 and 2006, SEGIP actively worked with the unions representing state employees to develop new methods of controlling health care costs and quality. It also worked with other Minnesota employers to use their combined buying power to move the health care industry in a more cost effective and quality oriented direction. New techniques were introduced that sought to hold down health care costs and improve the quality of care and access for its members. This goal was accomplished by emphasizing three key areas: targeting member's specific health conditions; providing a set of diverse means for members to better understand their conditions, insurance benefits and other health care related questions, and instituting new methods of accessing and delivering health care.

Several new initiatives sought to provide members with programs that help maintain and improve health. Health risk assessments provide employees with information about their future health risks so that they know what action they need to take now to ensure good health in the future. Bridges to Excellence, a multi-employer pay-for-performance program, controls costs by rewarding providers who achieve pre-determined levels of quality in areas that target costly health conditions experienced by state employees. The disease management program was further developed so that members with chronic illnesses are better able to manage their conditions and learn about treatment options and outcomes.

New tools were added that provide members information enabling them to better understand their benefits and choose quality health care. *Advantage Health Advisors! (AHA!)* is a new program that affords state employees and their family members the opportunity to consult with licensed nurses to help make informed health care decisions. State Employee Express (SEE), a one-stop website, provides employees with personalized information about their benefits. Centers of Excellence identify health care providers and facilities with the best patient care and outcomes so that members have information to help make wise decisions about their individual health care. MN Community Measurement provides members access to information about the quality of the clinics in the Advantage network. Finally, eValue8, a nationally recognized health care purchasing and quality improvement tool, provides information to help make choices based on quality and not just price.

New avenues for employees to access cost effective and accessible health care were introduced. Convenience clinics were added to the provider network to improve access. Convenience clinics are in locations where employees typically frequent and have extended hours allowing evening and weekend access. SEGIP contracted with a vendor to open a convenience clinic on the Capitol Campus where state workers can access health care and quickly return to work. Finally, it added a Canadian drug program that offered certain prescriptions at a cost significantly less than otherwise available through other outlets.

SEGIP continues to develop and implement new methods and programs that seek to reduce costs while improving quality and member access. It recognizes that multiple and overlapping programs are necessary for members to engage in a program that meets their needs. For example, some employees learn better from direct contact while others learn better from electronic contact. It will continue to use its size and purchasing power to encourage providers to improve quality while reducing costs.

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 48,000 employees, 60,000 dependents, 10,000 retirees and over 500 COBRA participants.

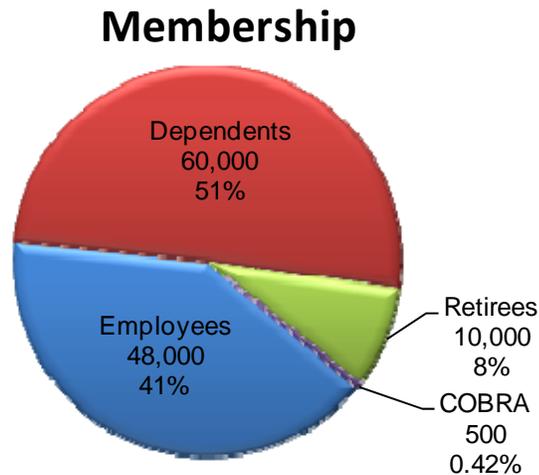


Figure 1 – Membership

Minnesota law requires that state employee health benefits be negotiated between the executive branch and the bargaining units. Approximately 83 percent of all state employees belong to a union. Although the state's 22 bargaining units negotiate different contracts with the state, insurance benefits are the same for all bargaining units and are extended to the 17 percent of employees who are not represented by unions.

Insurance benefits with employer contribution

During 2005 and 2006 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 certain health, dental, daycare, and transportation expenses. SEGIP provides assistance to members for insurance-related issues through a variety of services and programs, including *AHA!*, disease management, health risk assessments, and other services provided by the contracted health plans, other vendors, and in-house resources. Finally, SEGIP offers state agencies and employees and their family members the Employee Assistance Program which works with people to restore and strengthen the health and productivity of employees and the workplace.

Premiums

Total premiums collected on an annual basis are over a half billion dollars per year. Total premiums and administrative costs in 2005 were \$542,648,445 and \$551,563,579 in 2006. Medical premiums were \$470.9 million in 2005 while the premiums and fees combined amounted to \$71.7 million or 13 percent of total premiums and fees contributed. In 2006, the medical premiums were \$475.6 million and all other premiums and fees totaled \$75.9 million or 14 percent of total premiums and fees contributed.

Total Program Costs by Product - 2005 and 2006

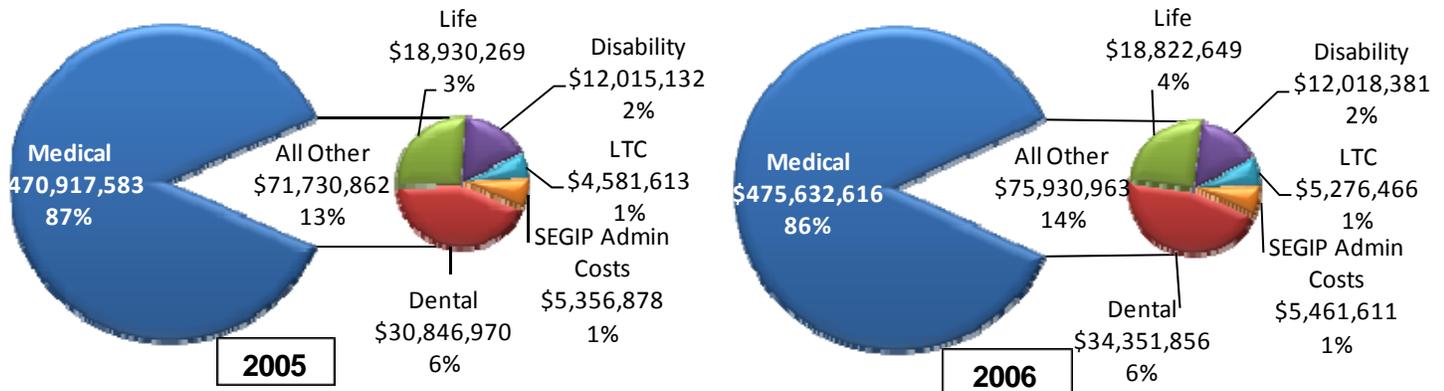


Figure 2 – Total premiums by program in 2005 and 2006

State agencies paid 78.5 percent of total premiums in 2005 and 78.1 percent in 2006. Employees and retirees paid 18.6 percent in 2005 and 19 percent in 2006. The participating quasi-state agencies and their employees paid approximately 2.9 percent of total premiums in both 2005 and 2006.

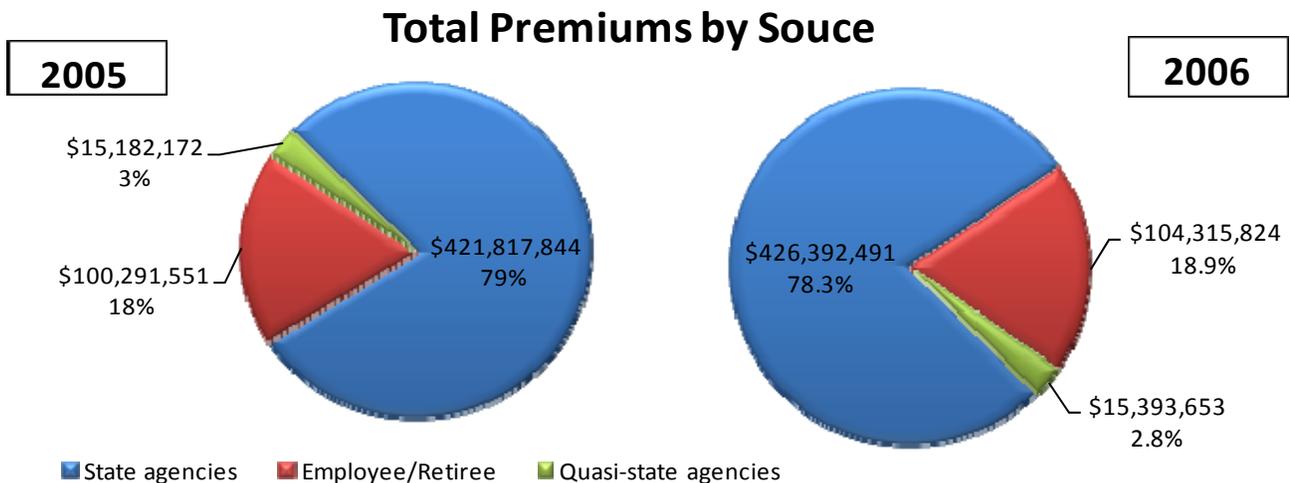


Figure 3 – Total premiums by source

II. Program description

Medical insurance – the Minnesota Advantage Health Plan

The most costly and most visible insurance benefit provided by SEGIP is medical coverage. When the state first began offering “medical insurance” in 1945, the cost of health care was relatively low and coverage was optional and paid entirely by enrollees. Since then, health coverage has evolved into an integral part of employee compensation. On a national basis, it comprises approximately 6.9 percent of employees’ total compensation.¹ The state’s cost of health insurance provided to employees and their insurance eligible dependents during 2005 and 2006 was over \$797 million. Employees paid more than \$121 million over this time period for their share of the premium costs in addition to out-of-pocket costs.

When the Minnesota Advantage Health Plan (Advantage) was introduced in 2002 it was a tiering pioneer. Since then, tiering has become an industry norm. Under Advantage, 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.

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

The cost of health insurance continues to grow. SEGIP’s health coverage cost increased 75 percent from 2000 through 2006. Nationally, the cost of health coverage increased by 87 percent over the same period.² Comparatively, inflation rose 18 percent and cumulative wage increased by 20 percent during the same period.³ SEGIP health insurance costs from 2000 through 2006 rose faster than inflation or wages but did not rise as much as did health care costs nationally.

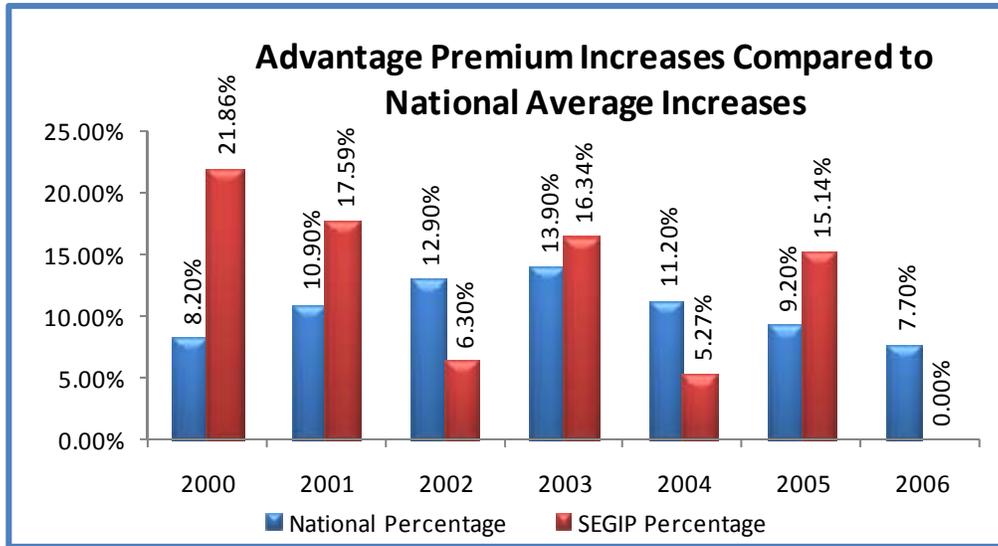


Figure 4 – Advantage premium increases compared to national average increases.⁴

Note: SEGIP 2000 and 2001 premiums are a blend of the 6 different plans offered at that time. With Advantage’s introduction in 2002, SEGIP moved to one (single and family) premium across all carriers from 2002 through 2006.

Advantage Health Plan income

The Advantage Health Plan generates its income primarily through premiums paid. SEGIP is authorized to retain its interest income and it was approximately one percent of premiums collected in 2005 and one and a half percent in 2006. In 2005, \$470.9 million was collected in premiums while \$4.6 million was earned in interest income. During 2006, \$475.6 million in premiums was collected and \$7.5 million was earned in interest income.

Advantage Income 2005 - 2006		
	2005	2006
Premiums	\$470,917,583	\$475,632,616
Interest	\$4,591,227	\$7,489,989
Total Income	\$475,508,810	\$483,122,605

Figure 5 – Advantage Income 2005 - 2006

Health premiums

State agencies pay the majority of health premiums. In both 2005 and 2006 state agencies contributed 84 percent of the premiums, employees and retirees contributed 13 percent and quasi-state agencies paid the remaining three percent.

In 2005, a total of \$470.9 million was contributed in health premiums. Of that, state agencies paid \$396.4 million, employees and retirees contributed \$60.6 million and quasi-state agencies and their employees contributed the remaining \$13.9 million.

In 2006, a total of \$475.6 million was contributed in health premiums. Of that, state agencies paid \$401.1 million, employees and retirees contributed \$60.4 million and quasi-state agencies and their employees contributed the remaining \$14 million.

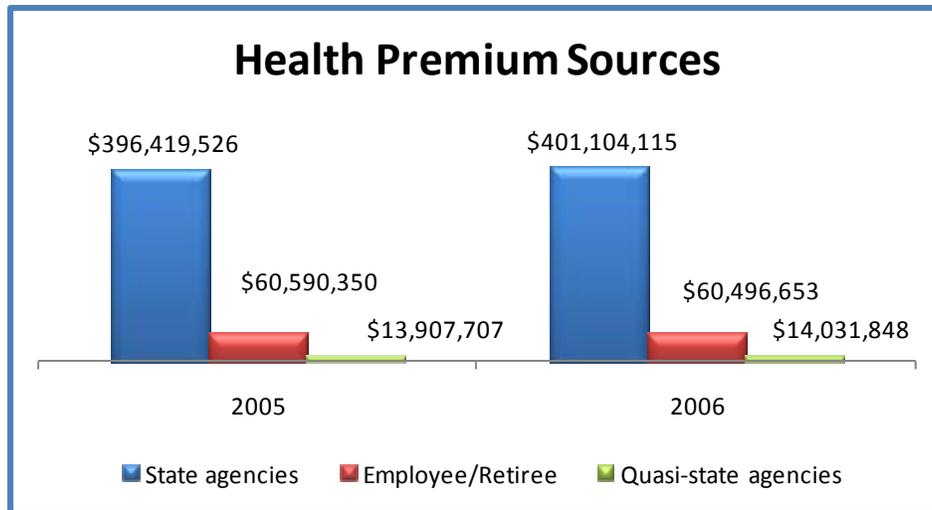


Figure 6 – Health premium sources

The Advantage premiums were the same in both 2005 and 2006. The monthly premium for single coverage was \$368.68. The family coverage premium was \$1,084.16 of which the state paid \$976.84 per month, the employee paid \$107.32 per month.

Monthly Health Premium 2005 – 2006						
Monthly	Single Coverage			Family Coverage		
All Plans	Total	State	Employee	Total	State	Employee
	\$368.68	\$368.68	\$0	\$1,084.16	\$976.84	\$107.32

Figure 7– Advantage monthly single and family premiums

Health premium for single coverage

Advantage’s annual cost for single coverage in 2006 was \$4,424 compared to the national average of \$4,242.⁵ Employees with single coverage in self-funded plans, on average, paid for 17 percent of their insurance premiums.⁶ Under Advantage, the state pays the full cost of health insurance for members with single coverage.

Advantage members with single coverage do not pay a premium. Nationally, 40.6 percent of private-sector employers offered at least one health insurance plan that required no contribution from the employee for single coverage in 2005.⁷ In Minnesota that number is slightly lower at 36.1 percent.⁸ In 2006, 41.2 percent of private employers offered at least one plan that required no employee contribution for single coverage and in Minnesota 37.1 percent of employers required no contribution.⁹ Advantage’s feature of not requiring an employee contribution for single coverage is somewhat similar to the requirement for private sector employer health plans.

Health premiums for family coverage

Advantage’s annual family premium, in both 2005 and 2006, was \$13,010, which was higher than the national average family coverage premium of \$11,480.¹⁰ However, in 2006, the employee portion of the family premium was lower than the national average. Advantage members paid 8.6 percent of the total family premium while on a national basis, employees with family coverage in self-funded plans, on average, paid 23 percent of the premium.¹¹ Nationally, covered employees on average paid 27 percent of the premium for family coverage in 2006.¹²

Under Advantage, employees pay a portion of the family coverage premium. Nationally and in Minnesota, 77.2 percent of private sector employers who offered health insurance offered at least one health insurance plan that required an employee contribution for family coverage in 2005.¹³ In 2006, 78.7 percent of private sector employers that offered health insurance required an employer contribution for family coverage.¹⁴ In Minnesota, 22.8 percent of employers required no employee contribution for family coverage in 2005.¹⁵ In 2006, only 19.8 percent of Minnesota employers required no contribution for family coverage.¹⁶ The employee premium contribution for family coverage is in keeping with the requirement for most private sector employer health plans.

Out-of-pocket costs

In addition to a premium contribution for family coverage all members have limited out-of-pocket cost responsibilities.¹⁷ 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.

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 2005 and 2006 are:

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

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. A cost level 1 office visit copayment for single and family coverage is \$20 while the cost level 4 copayment is \$35. By taking the health risk assessment members receive a \$5 discount on all office visit copayments for themselves and their covered dependents.

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

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

In 2005, Advantage members paid 9.15 percent of the plan's costs through cost sharing and in 2006 that number decreased to 8.85 percent. Eighty percent of all insured workers, including Advantage members, are limited to how much cost sharing they can experience in a plan year.¹⁸ In 2005 and 2006, Advantage members were limited to the out-of-pocket maximum of \$1,000 for single coverage and \$2,000 for family coverage. In addition, there is a separate maximum for prescription drug coverage of \$650 for single coverage and \$1,300 for family coverage.

Nationally, 69 percent of employees with single coverage are in preferred provider organizations that require a general deductible be met before plan benefits are provided.¹⁹ Under Advantage, members with single coverage pay a deductible between \$30 and \$500 depending on the chosen cost level, and those with family coverage pay between \$60 and \$1000.

Advantage Plan expenses

Advantage expenditures are primarily claims. That cost increased from \$362.8 million in 2004 to \$397.4 million in 2005 an increase of approximately 9.5 percent. Claims increased by \$39 million from 2005 to 2006 or by approximately 9.5 percent. Claims were nearly 94 percent of program costs in 2006 and approximately 92.3 percent in 2005. In addition to claim costs, the Advantage Health Plan had these additional expenses:

- Administrative and Reinsurance: The carrier's administration costs and reinsurance combined was approximately 7 percent of total health program premiums in both 2005 and 2006.²⁰ SEGIP's health carrier administrative costs are lower than Minnesota's average health plan administrative cost of 8.3 percent in 2005 and 8.2 percent in 2006.²¹
- Prior years – settlement paid: Carrier settlements relating to a prior calendar year.
- Premium holiday: Represented on this spreadsheet as a cost, it was one biweekly premium payment that was waived as a means of returning funds to the participants and agencies. This was not technically a cost; it was lost, or waived, premiums.
- Funds transferred to the General Fund: Transfer of funds, as required by statute, was made in June, 2004.²²
- Federal liability on funds transfers: Dollars set aside to reimburse the federal government for its share of transfers to the General Fund. The actual payment to the federal government was \$5.05 million and was made in 2007. It represents a total of 14.05 percent of the transfers to the general fund. (This amount includes reimbursement on the transfer of \$11 million to the general fund that was made in 2003.)

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. Specifically, the purpose of the contingency reserves is to pay claims in excess of premiums. The contingency reserves also stabilize the premium rates by eliminating the need for large premium increases in reaction to large unexpected one-time costs. At the end of 2005 the reserves were 21.6 percent of the annual expenses and 19.6 percent at the end of 2006.

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Advantage Health Plan – Financial Statement

	CY 2004	CY 2005	CY 2006
Income			
Premiums	409,721,979	470,917,583	475,632,616
Interest Income	1,980,735	4,591,227	7,489,989
	411,702,714	475,508,810	483,122,605
Expenditures			
Claims Paid & Incurred	362,768,653	397,397,129	435,354,910
Admin & Reinsurance (Paid to Carriers)	27,874,333	29,402,553	30,923,152
Consulting, EAP, and Other Costs	876,182	955,888	858,284
Prior years - Settlements Paid	(767,291)	0	(3,069,534)
Premium Holiday			19,902,735
Funds Transferred to General Fund		23,000,000	
Federal Liability on Fund Transfers	1,500,000	3,100,000	
	392,251,877	453,855,570	483,969,547
Gain or Loss	19,450,837	21,653,240	(846,942)
Contingency Reserves - End of Plan Year	70,637,965	92,291,205	91,444,263

Figure 8 – Advantage Health Plan Financial Statement. Note: This income statement has not been independently audited. A "Statement of Net Assets," on a Plan Year Basis has not been prepared.

Dental insurance

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

In 2005 and 2006, the SEGIP offered three different dental plans: Blue Plus Dental, State Dental Plan and HealthPartners Dental. All three of the SEGIP dental plans provide substantially the same comprehensive coverage and each offers a network of dental providers. Both employees and the state pay dental premiums.

SEGIP 2005 - 2006 Biennial Report

2005 Dental Premium Rates – Monthly Rate						
Health Plan	Single Coverage			Family Coverage		
	Total	State	Employee	Total	State	Employee
Blue Plus Dental	23.46	20.66	2.80	68.30	43.14	25.16
State Dental plan	22.96	20.66	2.30	67.92	43.14	24.78
HealthPartners Dental	22.94	20.66	2.28	67.88	43.14	24.74

2006 Dental Premiums Rates – Monthly Rate						
Health Plan	Single Coverage			Family Coverage		
	Total	State	Employee	Total	State	Employee
Blue Plus Dental	25.82	20.82	5.00	75.14	45.32	29.82
State Dental plan	25.02	20.02	5.00	74.00	44.52	29.48
HealthPartners Dental	25.68	20.68	5.00	75.98	45.18	30.80

Figure 9 –Monthly dental rates 2005 and 2006

Both the state and employees pay dental premiums. Total dental premiums in 2005 were \$30,846,970. Of those dollars, state agencies paid \$18,113,235, employees paid \$11,888,726 and quasi-state agencies and their employees paid \$845,009. In 2006, total dental premiums were \$34,351,856. Of those dollars state agencies paid \$18,861,735, employees paid \$14,540,857 and quasi-state agencies and their employees paid the remaining \$949,264. The increase in employee and retiree insurance premiums from 2005 to 2006 is attributable to a change in plan design negotiated between the state and the unions representing state employees.

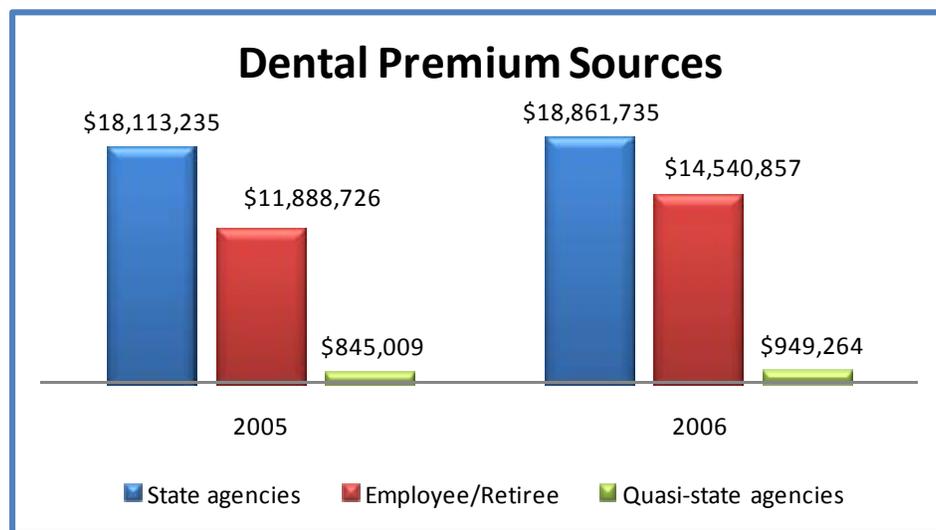


Figure 10 – Dental Premium Sources

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 collective bargaining agreement or plan that covers the employee's job and is based on the employee's annual salary.

A total of \$7,356,245 was paid for life insurance premiums in 2005. Of that the state paid \$6,933,836, employees and retirees paid \$192,368 and the quasi-state agencies and their employees paid \$320,041

A total of \$6,432,739 was paid for life insurance premiums in 2006. Of that the state paid \$6,067,276, employees and retirees paid \$162,114 and quasi-state agencies and their employees paid \$203,349.

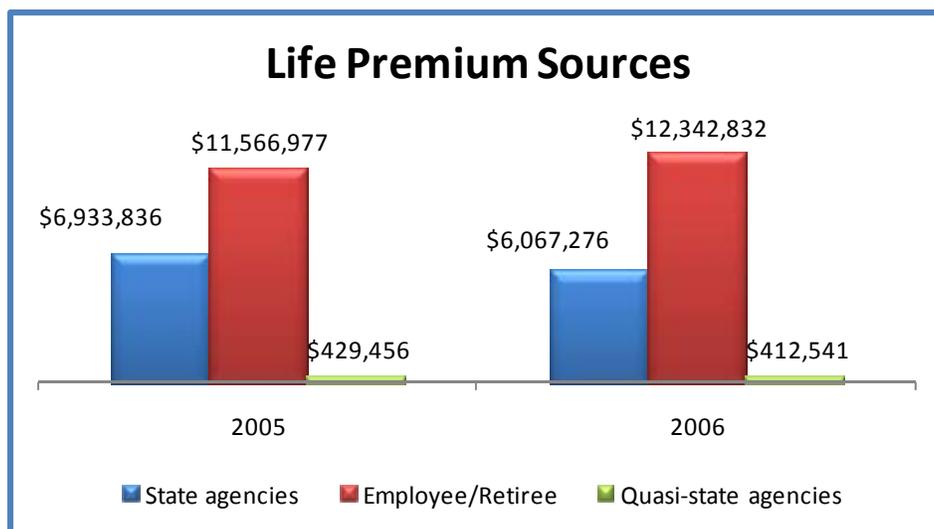


Figure 11 – Life Premium Sources

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 \$456,648 was paid in 2005, of which \$351,247 was paid by the state and \$105,401 was paid by employees. In 2006, \$467,124 was paid, of which the state paid \$359,365 and employees paid 107,759.

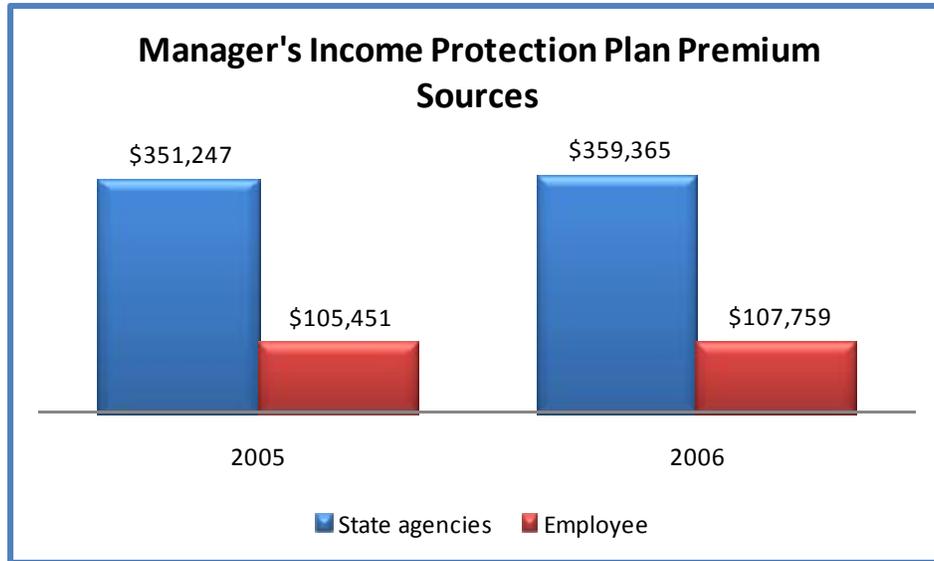


Figure 12 – Manager’s Income Protection Plan Premium Sources

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. These life insurance products listed immediately below generate about \$18.6 million each year while employee and spousal accidental death and dismemberment generates approximately \$250,000 in annual premiums.

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 2005, a total of \$11,574,024 was contributed in premiums. Of that, employees and retirees paid \$11,374,609 and quasi-state agencies and their employees paid \$199,415. In 2006, a total of

\$12,180,718 was contributed in premiums. Of that, employees and retirees paid \$12,389,910 and quasi-state agencies and their employees paid \$209,192.

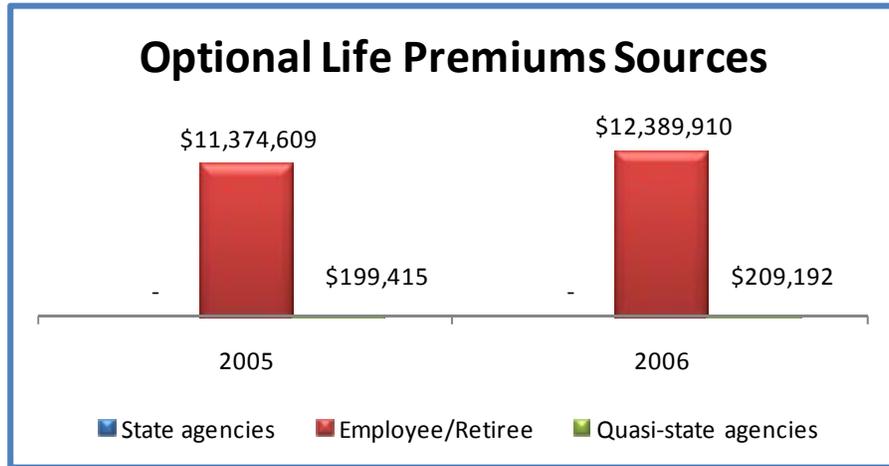


Figure 13 – Optional Life Premium Sources

Disability coverages

The program offers both short and long-term disability insurance to active state employees. Short-term disability insurance provides employees with income when injury, sickness or pregnancy results in continuous total disability. Benefits begin on the first day of disability due to accident, or the eighth day of a disability due to sickness or pregnancy. Benefits do not continue for more than 180 days for any one period 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 \$11,558,434 was paid in disability premiums during 2005. Of that, state employees paid \$11,558,434 and quasi-state agencies and their employees paid \$287,059. In 2006, a total of \$11,5512,257 was paid in premiums of which state employees paid \$11,263,252 and quasi-state agencies and their employees paid \$288,005.

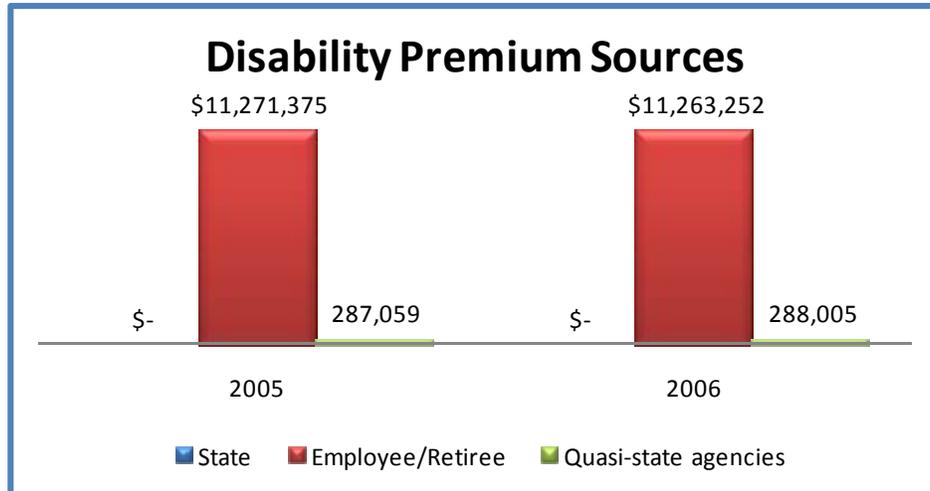


Figure 14 – Disability premium sources

Long-term care insurance

Long-term care (LTC) insurance 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.

The program offered through SEIGP is available to both active and retired state employees as well as their spouses and parents. This is the only program offered through SEGIP that has been covers extended family members. The program provides members with a relatively new type of coverage that has not yet fully embraced. Consequently, the number of participants is relatively low. However, as the population ages and a greater percentage of the population are unable to care for themselves, this coverage is expected to become more common.

Long-term care insurance is wholly paid for by participants. In 2005, 4,766 employees and 2,568 dependents opted for this coverage, paying a combined total of \$4.6 million in premiums. In an effort to generate increased interest in long-term care, insurance SEGIP hosted a special open enrollment in 2006. That effort resulted in 6,739 employees and 3,056 dependents enrolling during 2006 for a total of \$5.3 million in premiums.

Pre-tax accounts

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

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

These dollars result in substantial tax savings, as they are not subject to payroll taxes for either the employee or the employer. In 2005, 15,030 members participated in the pre-tax programs

and contributed \$20.1 million. In 2006, 15,861 members contributed \$21.6 million. In both years, members saved approximately 30 percent and the state saved more than 7.5 percent in employment related taxes.

Program administration

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

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

Benefits Administration is responsible for enrollment and billing services for the nearly 118,000 participants. The unit's primary task is processing transactions for the program, including the enrollment of newly eligible employees and changes to existing coverage. During 2005, the unit processed over 55,200 transactions and another 57,000 during 2006. To accomplish this task the unit provides support for the information system insurance application and supporting software tools.

This unit also hosts the annual Open Enrollment during which members are allowed to make certain changes to their benefit set. During the 2005 Open Enrollment, there were 20,800 transactions and 2,598 phone calls. In 2006, Open Enrollment the unit processed another 23,024 transactions and answered 4,945 phone calls.

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 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 agencies are charged \$4.02 per employee per month and members directly paying premiums are assessed a two percent administration fee. SEGIP administrative fees are approximately one percent of total premiums per year while the administrative fees of the carriers (not including long-term care) are approximately six percent. The combined total of SEGIP and carrier administration costs is approximately seven percent of total premiums per year compared to a national average of between 10 and 15 percent per year.²³ (In Minnesota, health carriers average just over eight percent per year in administrative costs.) SEGIP's administrative fee has not increased since January 1999.

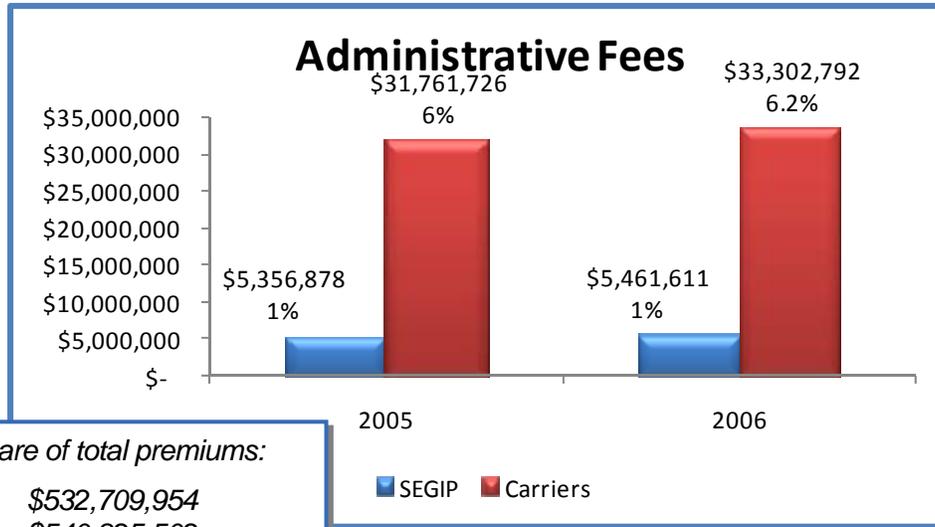


Figure 15 – SEGIP administration fees in 2005 and 2006

III. A brief history of SEGIP

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

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

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

1967 University of Minnesota employees joined SEGIP.

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

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

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

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

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

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

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

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

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

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

2003 SEGIP began disease management programs.

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

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

IV. Important program developments

During 2005 and 2006, SEGIP continued to be a leader among employer health care programs. Led by the Governor's Health Cabinet and working with the unions representing state employees, SEGIP championed a variety of new programs that sought to control costs while ensuring quality and access for its members. These programs included payment reform efforts that rewarded providers for delivering quality care rather than for the number of services delivered regardless of outcomes. It added programs that provided more flexible access to health care. Other new programs provide members with information about their benefits and health care quality and options.

SEGIP delivered these new features while working to ensure the program was effectively managed. It delivered the first premium holiday, which saved payers \$19.9 million dollars in premiums. In addition, it kept the program's administrative costs below both the state and national averages without increasing those fees since 1999.

Premium holiday

SEGIP offered its first ever premium holiday for health insurance and waived approximately \$19.9 million for those paying health insurance premiums in December 2006. This saved payers approximately 4.4 percent of the total premiums paid in 2006. The premium holiday was attributed to Advantage having performed better than expected.

Advantage's benefit set is the result of negotiations between the state and its employee unions with premiums representing the cost of providing that benefit set. New plan features introduced in 2004 included additional out-of-pocket costs for plan members. The result of these bargained features generated more savings than commonly experienced by other employers implementing similar features.

Tobacco litigation refund

A tobacco litigation refund was made to retirees who were participants in the Blue Cross Blue Shield Coordinated Plan as of June 15, 2001. These dollars were the result of a class action suit between BCBS and five employer groups over the use of proceeds from a lawsuit against the tobacco industry. SEGIP received \$400,000, the maximum allowed for a single plan, and distributed those dollars equally among the 6,500 eligible members. The interest generated by these dollars paid SEGIP's administrative costs with the remainder also distributed to eligible members.

Convenience clinics

SEGIP added convenience clinics to its list of providers in 2006. This option provides members with quality and reasonably priced service at a convenient location and time. They are usually located in a shopping center or retail store. Convenience clinics are staffed by a nurse practitioner or physician assistant who are qualified to evaluate, diagnose, and prescribe medications for simple illnesses and are able to provide certain types of vaccinations and screenings.

Under the Advantage Plan, these services are available to members at a reduced co-payment of \$10 per visit with the first dollar deductible waived. Advantage saves an average of \$50 per visit compared to the cost of care delivered at a doctor's office, emergency room or urgent care center. In 2006, members made 4,487 visits to convenience clinics, saving the program an estimated \$224,350. As these clinics become more available and members become more comfortable utilizing their services, the direct savings is expected to grow.

In addition to the direct savings, the use of convenience clinics also provides indirect savings. Employees are typically able to visit a convenience clinic at a location and hour better suited to their family needs and work schedule. Because employees are able to visit these clinics during non-work hours and without an appointment, the time needed for a visit is usually shorter than for traditional medical venues and employees miss less work. The increased availability of this health care delivery method saves the state an average of \$48 per visit in time away from work.

Convenience clinics are gaining presence in the health care industry. American insurance companies and Medicare have extended their coverage to include these clinics. It is likely that the clinics will continue to grow in popularity because of the convenience and cost savings they provide.

MinuteClinic in the Centennial Office Building

The opening of the MinuteClinic in the Centennial Office Building, March 2006, was an effort to provide quality medical care for minor illnesses to state employees and their families as well as to the general public. Located on the State Capitol campus, the MinuteClinic is staffed by a certified physician assistant who is qualified to evaluate, diagnose, and prescribe medications (when clinically appropriate) for simple illnesses, and to provide certain types of vaccinations and screenings. Services are available to state employees at \$10 per visit, with no charge for preventive care.

SEGIP worked with MinuteClinic, the only vendor available at that time, to test the idea of locating a convenience clinic in a workplace. In the 10 months that the clinic was open in 2006, the savings in reduced cost per visit plus reduced employee time away from work was enough to cover the state paid clinic start up costs of approximately \$50,000. The contract for the MinuteClinic ran through June 2007 and included the option to extend three additional years.

Advantage Health Advisors (AHA!)

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

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

Chronic Disease Management

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

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

The carriers invite SEGIP members to participate in a disease management program based on the presence of one or more of six chronic disease states: asthma, diabetes, coronary heart disease, chronic obstructive pulmonary disease, chronic kidney disease and depression.

Members in this program receive regular calls from a carrier representative, usually a registered nurse. The nurse seeks to ensure the member is successfully managing the condition and provides additional services as necessary. Generally, 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, implemented in 2005, is a benefit negotiated between the executive branch and the unions representing state employees. Each of the three health carriers provided state employees an assessment which asks a series of questions about health, lifestyle and health history. Questions are based on research of modifiable health factors that can lead to future serious medical issues. The assessments only identify health conditions that are addressable through behavior change.

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.

It is important to know the existence of a health risk because having one means there is a strong chance of developing the risk-related diseases. For example, an individual with obesity or high cholesterol is at greater risk to develop heart disease and/or vascular disease or diabetes. A smoker has a higher chance to have respiratory diseases or/and lung cancer while a heavy drinker is at risk of developing a fatty liver. The assessment identifies modifiable behaviors and provides the individual the opportunity to change behavior and either prevent or delay illness.

In both 2005 and 2006, approximately 70 percent of employees took the assessment. The table below, combines the data for both years and illustrates the risk factors employees face. The three leading modifiable conditions are weight, pre-hypertension and high cholesterol. This data is used to ensure that SEGIP programs are targeted to the conditions that most affect employees.

Prevalence of modifiable risk factors

<u>Risk factors</u>	<u>Prevalence, percent</u>
Pre-diabetes	5.7
Pre-hypertension	35.3
High cholesterol	25.3
Overweight	38.1
Obesity	27.0
No exercise or little exercise	11.2
Cigarette smoking	8.7
Secondhand smoke	14.3
Alcohol (heavy drink)	7.8
Depression	16.2
Stress	22.7

To date SEGIP has had to rely on the health carriers to provide estimates of the value impact the health assessment tool has had on overall program costs. SEGIP's next step is to better integrate this tool with its efforts to measure engagement in programs to improve health through behavior change thereby reducing claim costs.

MN Community Measurements

MN Community Measurements (MNCM) is a non-profit organization formed by all of Minnesota's health plans and the Minnesota Medical Association. Its purpose is to improve the quality of health care for Minnesota consumers by monitoring and reporting on the provider groups' performance.

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. 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 MNCM than any other employer or website in Minnesota or the nation.

State Employee Express (SEE)

State Employee Express was implemented in 2005 to provide employees with one easy-to-use, online site detailing employee benefits and human resource policies. It is another tool designed to help employees get the most out of their benefits by listing each benefit elected or waived. It provides information about each benefit along with insurance plan contact information. SEE draws employee data daily from the state's payroll and Human Resource system.

Canadian mail order pharmacy

A Canadian pharmacy option, Minnesota Advantage Meds, was introduced in 2005 to allow state employees and their dependents the option to purchase prescription medications at a cost effective price. Members saved up to \$180 a year per prescription in waived copayments by ordering maintenance drugs through a Canadian pharmacy.

Members selected from a limited number of brand name "maintenance drugs" that are sold only in three-month quantities. The list included only medicines that were approved for use in the United States and were in their original packages. (The site directed members to purchase short-term medicines and new prescriptions from a local pharmacy or domestic mail order pharmacy.)

Employees ordering through this option mailed or faxed the prescription to the Canadian pharmacy. A Canadian doctor reviewed the information and approved the prescription. Approved prescriptions were shipped to the member and the state was billed. A department of Human (DHS) Services pharmacist approved the Canadian dispensing facilities. The intent of this program was to complement a similar program sponsored by DHS for citizens of Minnesota.

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.

BTE 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). In 2004, less than 6 percent of patients in Minnesota were receiving diabetic treatment that met the ICSI standard.

Diabetes is one of the most prevalent and fastest growing chronic illnesses in Minnesota and the nation. SEGIP estimates that each diabetic member receiving optimal care saves \$700 per year: \$350 in direct medical costs and \$350 in indirect costs including reduced absenteeism and increased productivity.

When SEGIP began participation in April 2006, the BTE goal was for 10 percent of patients within a medical group to receive optimal diabetic care. MN Community Measurement (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. The outcomes and experiences of 2006 will lead to changes and improvements in future years.

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 effectively and efficiently manage the care of patients with select costly disease states or procedures that require highly specialized, technical care. COEs have been established in the areas of bariatric surgery and transplants. Networks for the treatment of lower back pain and cardiac conditions are on the immediate horizon.

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

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

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

eValue8

eValue8 is a nationally recognized health care purchasing and quality improvement tool developed by a coalition of health care purchasers to provide information necessary to make choices based on quality and not just price. SEGIP participates in this program through its membership in the Buyers Health Care Action Group (BHCAG).

From January through April 2006 all three of the Advantage carriers participated in the eValue8 process conducted by BHCAG. These carriers, as well as others, responded to a standard request for information that included questions about clinical quality and administrative efficiency. The responses were verified and a report was produced.

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

Governor's Health Cabinet

Governor Tim Pawlenty created the Governor's Health Cabinet to develop solutions to rising health care costs and deliver more value for health care spending. The Health Cabinet is comprised of five state agency heads, MMB, Health, Human Services, Commerce, and Labor and Industry. The members work together to find solutions to health care issues and to implement many of the health care reform ideas identified by a citizens' panel on health care reform also created by the Governor. Through this collaborative approach, SEGIP has another avenue to develop methods to hold down and even reduce health care costs. It was through the cabinet that many of the new programs (BTE, COE, eValue8) were developed.

V. Complaints

Number of complaints remains low

Members may file a complaint, or appeal, if they believe an insurance coverage decision or transaction was made in error. Appeals range from a member's claim that she/he did not receive an enrollment packet and were unable to enroll to a transaction was erroneously processed. In both 2005 and 2006, approximately one quarter of one percent of members filed an appeal. Of the appeals filed in 2005, 46 percent were approved while 54% were denied. In 2006, 42 percent of all appeals were approved and 58 percent were denied.

Open Enrollment Appeals

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

Non-Open Enrollment Appeals

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

Figure 16 – Appeals

VI. End Notes

1 U.S. Department of Labor, Bureau of Labor Statistics, 2005 and 2006 data for private industry. <http://data.bls.gov/cgi-bin/surveymost> . Accessed on August 16, 2007. In 2005, the average was 6.8 percent and in 2006 it was 6.9 percent.

2 Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, 2006 Annual Survey, page 18. [hereinafter Kaiser]

3 *Id.* at 6.

4 *Id.* at 1. National numbers, SEGIP numbers were develop by SEGIP staff.

5 Kaiser, *supra* at 18.

6 Kaiser, *supra* at 70.

7 MEPS U.S Department of Health & Human Services, Medical Expenditures Panel Survey 2005. http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2005/tia2b.htm Accessed on August 16, 2007

8 *Id.*

9 MEPS U.S Department of Health & Human Services, Medical Expenditures Panel Survey 2006. http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2006/tia2b.htm Accessed on August 16, 2007.

10 Kaiser, *supra* at 18.

11 Kaiser, *supra* at 70.

12 Kaiser, *supra* at 60.

13 MEPS U.S Department of Health & Human Services, Medical Expenditures Panel Survey 2005. http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2005/tia2c.htm Accessed on August 16, 2007 [hereinafter MEPS Family 2005]

14 MEPS U.S Department of Health & Human Services, Medical Expenditures Panel Survey 2006. http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2006/tia2c.htm Accessed on August 16, 2007 [hereinafter MEPS Family 2006]

15 MEPS Family 2005, *supra*.

16 MEPS Family 2006, *supra*.

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

18 Kaiser, *supra* at 4.

19 Kaiser, *supra* 3.

20 The administrative cost was compared to total health care costs without the 2005 \$23 million transfer to the general fund and without consideration of the 2006 premium holiday.

21 Administrative Costs at Minnesota Health Plans in 2006, Minnesota Department of Health. January 2008. <http://www.health.state.mn.us/health/economics>

22 Laws of 2003, 1st Special Session, Chapter 1, Article 14, Section 14, Subdivision 4.

23 Julia Philips, actuary, Minnesota Department of Commerce, e-mail to SEGIP, St Paul, Minnesota October 9, 2008.