



Steve Dahl & Patrick Pechacek, Directors, Deloitte Consulting

Civic Caucus, 8301 Creekside Circle #920, Bloomington, MN 55437

October 1, 2010

Present: Verne Johnson (Chair); Janis Clay, Marianne Curry, Paul Gilje, Jim Hetland, Sallie Kemper, Dan Loritz, Tim McDonald, Wayne Popham, Clarence Shallbetter, Bob White

Summary of Dahl and Pechacek's comments: In 2002 the Minnesota state government began using Minnesota Advantage, a cost-tiered strategy put together by Deloitte Consulting to manage the health care providers in the state employee health benefits network. Providers are rated based upon their average cost for services, and then assigned to one of four cost tiers. Different levels of co-payments and other benefit features encourage insured employees to choose providers that cost less-though the other higher-cost providers continue to be available to them.

While they have not measured for quality outcomes directly, Dahl and Pechacek have observed a relationship between lower cost and higher quality-a trend found by others in the field.

This new plan reduced state health premiums by 10 percent in the first year, and has held the rate of cost inflation to 5-6 percent below health-plan trend projections. The tiered structure of Minnesota Advantage could be applied to other public and private health insurance plans, in an effort to hold down the overall growth of health care costs.

A. Context of the meeting -Through its focus on ideas for redesign of public services the Civic Caucus has sought ways to make Minnesota a leading state-both in the quality of its functions, and through innovative cost-savings. The area of medical and hospital services promises to be a major opportunity for improvement. During his visit with the Caucus in July (see: <http://tinyurl.com/26fezsu>), Bill Blazar of the Minnesota Chamber of Commerce introduced the Caucus to this innovative program devised by Deloitte for state employee health plans in 2002.

B. Welcome and introductions - Patrick Pechacek is a director at Deloitte Consulting, and has been with the company since 1986 specializing in human resources and partnerships. He is a graduate of the University of Minnesota.

Steve Dahl is the Midwest region leader for Deloitte Consulting LLP's Public Sector practice. He has extensive experience in process, organizational and system assessments, as well as business and technical strategy. A certified public accountant, he graduated summa cum laude from the University of Texas at San Antonio.

C. Comments and discussion -During Dahl and Pechacek's visit with the Civic Caucus, the following points were raised:

Deloitte has a strong working relationship with state government.

Describing Deloitte, the pair told the group that, "What we do is define and implement transformational ideas to bring about more efficient and effective services. We work extensively with the legislature and executive branch, forming coalitions to move good government ideas forward."

Minnesota Advantage was developed as a health plan for state employees.

Deloitte developed the program called Minnesota Advantage that has been effective at lowering the cost of health care for state employees. The program organizes provider groups into categories based on the cost for certain services, and provides incentives for employees to choose the lower-priced plans. Dahl and Pechacek worked with the state's Office of Management and Budget to develop and implement this tiered framework.

Prior to 2002, Minnesota had been working with a "managed-competition" plan: The state would determine which competing plan had the lowest cost, apply their established benefits plan to it, and then employees would pay the difference between that lowest-cost plan and other plans. This process saved money for the state, but did nothing to lower the cost of the plans.

And the managed-competition model had a serious flaw: Healthier members would switch to the lower-cost plans, driving costs of other plans higher and prompting more members to switch plans. Seeing premiums continue to increase, and anticipating practical difficulties in cost sharing with employees, the state decided that a change needed to be made.

Deloitte examined all health care provider groups in the state and applied risk adjustments (to account for severity of illness) to determine the average cost for a particular service, by provider. They listed the 52 providers from lowest to highest cost. The difference between the lowest-cost and highest-cost provider-for the same base service-came out to be almost 160 percent. This difference was for the same service, for the same type of patient. (Note: this data was for provider groups, not individual clinics.)

This is a remarkable variance. In tables shown to participants in the discussion, Dahl and Pechacek described how a provider in level one (the lowest-cost tier) may provide a service for \$394, another in tier two may charge \$445; another in tier three, \$485; or the most costly provider in tier four, \$694, all for the same service to patients with identical severity levels.

Minnesota Advantage in practice works to change consumer and provider behavior.

This program covers 116,000 members through state employee health insurance plans.

Providers are tiered according to costs as outlined above, and then deductibles and co-pays are devised for each tier as incentives for employees to choose the lower-cost providers. "We knew from the managed-competition days," Pechacek said, "that when you go from a zero co-pay to even as little as a \$10 co-pay, the healthy patients will move to a lower-cost plan." Public employees pay a

smaller share of the cost of health plans than in the private sector, but even so they are very price sensitive. This begins to shift behavior in the marketplace, because providers actively seek to figure out how to increase (or prevent the decline of) patient traffic into their clinics. This may result in efforts to get higher productivity at lower cost.

In rural areas, there may sometimes be no tier-one or tier-two clinics available. In those cases the plan artificially drops a tier-three clinic into the second tier to assure access in those underserved areas.

While the plan drives costs down, it appears that quality also improves.

This program does not account for quality of care, Dahl and Pechacek said, though they do observe evidence of a relationship between the lower cost of providers and superior quality of outcomes. This would be consistent with work done by Ellwood and McClure in the 1980's that found that the highest-quality providers of medical services consistently cost 20 percent below the mean. Deloitte has drawn from their work.

Ellwood and McClure developed a matrix comparing providers on scales of quality and cost. At the time there was risk-adjusted data available on morbidity and complications. A participant asked if either of the speakers knew of people doing that kind of data collection now. Pechacek said that Minnesota Community Measurement is doing some of that, but without quite the same statewide scope.

"We're the only ones that are rating these provider groups independently on cost," Pechacek said. Providers are all working to improve quality, but that is not being driven directly by this model.

The result has been lower cost to the state.

When the state first introduced the model most people had been visiting what were determined to be tier-two and -three providers. After introducing pricing incentives, change happened quickly: "Once all the dust settled we had most employees in tier-one plans," Dahl said. "If people know how much they have to pay, they respond." In the first months of the program's life, clinics in tiers three and four lost as much as half their state employee patient traffic.

The numbers are significant. Minnesota Advantage reduced premiums by 10 percent in the first year- 5 percent related to cost sharing, and 5 percent through efficiency. While that substantial initial decline in premiums will not be repeated in subsequent years, growth in the cost of claims has been controlled: From 2004-08 claim costs have averaged 5-6 percent lower than projected trend estimates for the plan (\$120 million lower in actual terms).

The speakers recounted that since the program has been in effect some providers have called to express concern that they found themselves in tier-three or -four and might begin losing patients. This can be an effective incentive for them to change behavior. The providers receive a preliminary letter that says at present they are in a certain tier-sometimes they are able to change their pricing structure quickly enough to move into a new tier before the plan year begins.

A participant questioned the macroeconomics of the program, and its effect on changing the patterns of cost and quality in an entire market. "It's one thing for the public employees portion of these

providers to decline in cost," he said, "but they may be only a small portion of the provider's portfolio and thus the provider will shift the cost to other patients or not pay much attention if their bottom line is only slightly affected."

The cost-tier strategy could be applicable elsewhere in business and local government.

A participant asked whether the plan might be applied elsewhere, with similar results. Could businesses use this approach for their employee health plans?

Yes, Dahl and Pechacek believe this approach can be applied in other arenas and would be happy to have conversations with business leaders. But there is a challenge with "critical mass." Remarkably, the large companies like General Mills have only about 10,000 employees in the metro area. With this number of workers spread out across the state visiting a large number of different clinics, there has not been a strong impetus for pursuing this plan. "What this really points out," a participant observed, "is the failure of business leaders to unite together to form a larger cooperative purchasing group."

The speakers suggested that one option would be to have all public employees in the entire state-local government employees and teachers included-take this approach. Local governments tend to prefer their own plans, Pechacek said, but some are looking more seriously at joining the state plan as budgets become more strained. The state teachers' union has expressed a clear preference for a tiered plan.

Another option would be to look at areas where services are provided without much competition, and to apply a "managed competition" model in that case. "When you can put some form of managed competition in place there is a measurable effect on results."

The more the state can move to aligning incentives to the desired outcome, the more change there will be. This has got to be voluntary, the speakers emphasized. Without real incentives for people to shift to lower-cost providers, such a change is very hard to bring about.

What is the scope of implementable change? "It could apply to every public employee." The primary question has been what would constitute a meaningful demonstration of this program? But interest in the program does continue to grow. At the local level some public employee groups have been asking for the state to assume more control over health care, while others want to maintain local control. It may be possible to build this into Local Government Aid. Teacher union locals are expressing interest in the state's taking over their plan so they can take health care out of the contract bargaining process.

The Department of Human Services has explored applying this tiered network concept to the Medicaid population, recognizing that it had not been done anywhere else. So far it has not taken action. "These are really two very different programs," Dahl said of the state and Medicaid reimbursement models. "We're taking baby steps."

D. Closing

As the conversation drew to a close there was discussion about the great potential for impact on other state and private plans, and for adding a factor of quality assessment. In government, the speakers said, the leadership on this issue has been-and will likely need to be from-the executive branch.

Thank you, to Mr. Dahl and Mr. Pechacek, for a good visit.