Minutes*

Senate Committee on Finance and Planning
Tuesday, May 6, 2003
2:15 - 4:00
238A Morrill Hall

Present: Charles Speaks (chair), Prince Amattoe, Jean Bauer, Charles Campbell, David Chapman, Tom Gilson, Gary Jahn, Thomas Klein, Joseph Konstan, Brittny McCarthy Barnes, Kathleen O'Brien, Richard Pfutzenreuter, Sue Van Voorhis, Warren Warwick, Susan Carlson Weinberg

Absent: Stanley Bonnema, Tim Church, Robert Cudeck, Abu Jalal, Michael Korth, Tim Nantell, Daniel O'Connor, Thomas Stinson, Terry Roe, Michael Volna

Guests: Vice President Kathryn Brown, Professor Art Erdman (Advisory Committee on Athletics), Professor Laura Coffin Koch (Faculty Academic Oversight Committee on Intercollegiate Athletics); Senior Vice President Frank Cerra, Professor Fred Morrison (Benefits Advisory Committee)

[In these minutes: (1) institutional support for Twin Cities intercollegiate athletics; (2) health care benefits changes]

1. Institutional Support for Twin Cities Intercollegiate Athletics

Professor Speaks convened the meeting at 2:20 and noted that he had provided copies of three items: a draft statement from the Committee concerning institutional support for the Twin Cities intercollegiate athletic program, an email from Professor Borgida (chair of the Advisory Committee on Athletics) concerning the language of the resolution, and a message from President Bruininks concerning the draft statement.

The Committee held a lengthy, off-the-record, discussion about institutional support for Twin Cities intercollegiate athletics.

2. Health Care Benefits

Professor Speaks turned next to Senior Vice President Cerra and Professor Morrison for a discussion of health care benefits.

Senior Vice President Cerra distributed copies of a multi-page handout of PowerPoint slides containing data and information that had been presented to the Committee at one of its previous meetings. He briefly reviewed the data with the Committee.

The major challenges to the UPlan are the rising cost of health care, tailoring health benefits, with the Benefits Advisory Committee, to better meet the needs of University employees, promoting wellness

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and improvements in the health status of University employees, and providing quality, cost-effective health benefits during a major budget challenge.

The guiding principles for the UPlan are these:
-- Provide quality, cost-effective benefits
-- Offer a basic "basket" of benefits and consider changes in coverage and eligibility after consultation with the Benefits Advisory Committee
-- Continue to offer several choices of health plans
-- Consider a variety of mechanisms to reduce the rate of rise of premium costs
-- Give strong consideration to affordability and to the continuity of care
-- Promote wellness and improvements in health status for the University community

Basic covered benefits are employee medical and dental coverage and employee life and AD&D insurance. Optional benefits include family medical and dental coverage, optional life and AD&D insurance, disability insurance, long-term care coverage, and reimbursement accounts for health and dependent care.

Dr. Cerra reviewed the four options for medical coverage as well as improvements in wellness and health status. The latter included providing flu shots for 3.661 employees, assessment of wellness program opportunities for employees, and recruitment of a Wellness Program Manager. The effects of a disease-management program on premium costs will not be evident for several years, and for longer for a health promotion program.

Dr. Cerra next reviewed cost projections for the UPlan 2002-2005. With no changes in the program, the cost to the University is projected to increase from $97.2 million in the current year (89% of the total cost) to $111.6 million next year (87.5% of the total cost) and to $129 million the following year (also 87.5% of the total). Employee costs would increase from $11.9 million to $16 million to $18.5 million. There is a "double squeeze" occurring, Dr. Cerra said: employer costs are rising, from $97.2 million to $129 million while University revenues are shrinking. The response will be thoughtful management and cost reductions, including cost-sharing with employees.

The framework for the cost reductions will consist of several elements. Current covered medical services will be maintained. The University will implement a wellness/prevention program which should show a benefit in the next biennium. The current four medical programs will be maintained. There will be alterations in the health plan designed to control costs. The health plan design will be moved to Big Ten and public-sector benchmarks. (All changes will be subject to bargaining for bargaining-unit employees.) Was one goal a reduction in the consumption of services, Professor Konstan asked? One could say that the intent was to decrease utilization by X dollars next year and X+ dollars the following, Dr. Cerra said, and to accomplish that reduction by increasing co-pays, etc. But that would be difficult to achieve and it would be better to put in incentives and identify where the University will shift costs to employees in order to keep the same basket of services. They have looked at a lot of alternatives; the cost-avoidance and cost-reduction proposals came from that consideration. Even with increased employee contributions, the University would be paying most of the cost of health care.

Is this an across-the-board cut, Professor Konstan asked? It is, he concluded; employees will be worse off and must pay more out-of-pocket expenses. One can debate whether consuming less health care will improve health. But it is not a cut; the University is avoiding spending some money in order that it has money to send to colleges for academic purposes.

If the University is to maintain services there are two approaches that can be taken, Dr. Cerra said. One is to shift cost to employees, the other is to provide incentives to reduce utilization. There are very poor data on any relationship between utilization and health.

Another goal is to get people on to other health care plans, Professor Konstan observed. Dr. Cerra agreed. The proposal includes moving to a tiered system (for single coverage, single plus one, family, etc.) that will require a lot of discussion.

Dr. Cerra next discussed comparative data for Big Ten public universities, the State of Minnesota, Hennepin County, Twin Cities public institutions, and a national survey of colleges and universities. The average cost for single coverage in the Big Ten is $20 per month; at the University, the State, and Hennepin County it is zero; in the Twin Cities public institutions it is about $41, and in the national survey it is about $29. In terms of percentage of employee premium paid by the employer (single coverage), at the University it is 100%, in the Big Ten it is about 95%, in the Twin Cities it is about 91-92%, and in the national survey it is about 88%.

Employee cost for dependent coverage varies widely. The dollars per month are about as follows:

University	45
Big Ten	90
State	50
Henn Cty	270
TC pub	140
survey	190

The percentage of the family coverage premium paid by the employer varies accordingly as well, from about 95% at the University to 90% in the Big Ten to about 78% in the Twin Cities to about 70% in the national survey.

Dr. Cerra also reviewed similar benchmark standards for the costs of prescription and office visit co-pays and out-of-pocket maxima for prescriptions and health care expenditures in general.

The administration has developed a framework for cost reductions by altering the plan design. Some are administrative: changing the stop-loss insurance, standardizing prescription amounts, increase the waiting period for new employees, improve benefits coordination, and remove University of Minnesota Physicians (UMP) from the base plan. Operational changes are to increase co-pays for office visits and prescriptions and to make them geographically uniform, raise the maximum out-of-pocket limits, eliminate lab co-pays, change prescription coordination of benefits, offer the option to opt out of coverage, all employees pay a portion of the premium, and dependent/family share increases.

The UMP care system is more expensive than others in the system. About 49% of the UMP patients use UMP Family Practice and 49% use Boynton. The Committee discussed the UMP system briefly; Dr. Cerra commented that it does support the Medical School mission and that the Health Services Research people in the School of Public Health will analyze the data and experience for the UPlan.

Dr. Cerra then reviewed the initial proposals to change the health care system at the University, entitled "Moving Toward Benchmarks."

-- The University would pay 90% of single coverage low-cost-provider costs (compared to 100% now, 94% in the Big Ten, and 92.5% in the Minnesota public institutions).

-- The University would pay 85% of family coverage (compared to 94% now, 90% in the Big Ten, and 79% in Minnesota public institutions).

These two items together are projected to save about $12 million next year.

-- Prescription co-pays would increase from $10 to $15 (compared to $8.70 in the Big Ten, $10.30 in the Minnesota public institutions).

-- The out-of-pocket maximum for prescriptions would increase from $500/1000 (single/family) to $1000/2000 (compared to 1000/1600 in the Big Ten, 300/600 in Minnesota public institutions).

These two items together are projected to save about $670,000 per year.

-- The office co-pay would increase from $5 to $10 (compared to $10 in the Big Ten, $8.70 in Minnesota public institutions).

This item is projected to save about $3.1 million per year.

Professor Konstan commented that the plan overshoots the goal; it represents a strange definition of "toward" (i.e., "moving toward benchmarks"). The numbers do get into a gray range, Dr. Cerra agreed; it is not a good idea for the University to be on the lower end of the standard. If the private sector were included, the University's benefits would look much more generous. The numbers would also be different if one used the top 30 research universities as a benchmark.

Dr. Cerra reviewed briefly the cost savings from administrative changes in the medical plan as well as the benchmarks for dental coverage. (The University would pay 89% of single base plan dental coverage, compared to 100% now and 60% in the Big Ten; the University would pay 50% of family coverage, compared to 69% now and 54% in the Big Ten.)

The overall effects of the proposed changes decreases the rate of increase in University health care expenses. Instead of the costs increasing from $97.2 to $129 million (if there were no change), they would increase from $97.2 to $108 million in 2005 (and actually decrease to $95.1 million in 2004). The cost to employees, instead of going from $11.9 to $18.5 million (if there were no change), would increase from $11.9 million to $31.7 million. The brunt of the change in costs would be paid by the employee in 2004 but by the University in 2005. It is also estimated that the total cost of the plan would decrease slightly over the next two years, by $4.5 million next year and by $8.5 million in 2005. Presumably some parts of the system would not be used, Dr. Cerra said, because of behavioral changes. It is in part behavioral changes and in part because employees will be paying more, Professor Morrison added.

The next graph the Committee looked at showed the projected costs for medical plans with and without the proposed changes. The cost to the University in 2004 will decrease by $16.4 million compared to the projected costs with no changes in the system (and cost the University $2.2 million less than the year before). So one element of the cut in funding from the state is that the University will shift costs to employees in the amount of $16.4 million, Professor Speaks concluded. There will also be $2.2 million in savings, Dr. Cerra said. The total savings in health care for the University will be about $17 million, Professor Speaks said, is that both cost-avoidance and savings? It is, Dr. Cerra said.

Has all of this solved anything or is this a one-year solution that will come back again next year, at which time the University will have to say it must again increase employee costs, Professor Konstan asked? Will the University be in the same position in 2006? Dr. Cerra said it might be and that the University has bought itself two years. The inflation in health care costs is not likely to change. A wellness program could lead to a reduction in disease, but that is a low-probability event because the change takes 8-10 years to have an effect. He said he saw no forces in the health care marketplace to control costs.

The University can reduce its costs but if one is a user, one will pay more. They are also trying to contain costs, but the issue will be back in the next biennium. There will be serious questions in the next two years that need to be addressed. Should the University change benefits? Should there be a defined contribution plan? Should the University offer its own pharmacy program? Should it mine its own data on disease prevention? Long-term there may be a different approach to health care. The University must struggle with these questions and he would like to engage the minds of those involved in health care at the University to see what can be done.

Is anything being done to increase email physician consultation, Professor Konstan asked? There is, Dr. Cerra said. There is at present no mechanism to compensate the physician for the time, but email consultation is coming.

Professor Speaks asked if (1) there had been any calculation of the actual dollar impact of these proposals on employees, and (2) in a year when there will be salary freezes, will there be an effort to protect low-income employees? The dollar impact varies substantially by medical plan, Professor Morrison said. In the base plan, the premium increase for individual coverage will be about $350 per year. For family coverage, the increase will be about $800 per year. The Benefits Advisory Committee (BAC) takes the position that no one should see a premium increase that is more than 2% of salary and that the University should offset any larger increases, at least until the next time there is a salary increase. He said he did not know how the University would cover the 2% cap on increases in costs for employees.

The BAC also recommends that the University not move to a 90/85 plan (the University will pay 90% of single coverage and 85% of family coverage), as proposed, but rather to a 90/90 plan, so the increase is only about $350 to $400 for families.

The BAC also recommended holding the out-of-pocket cap for pharmacy at $500/$750 the year after next. This is insurance, in its view, and pharmacy costs should not be loaded on sick people but should be averaged across the University. $750 is 50 standard prescriptions, which is a lot (more than four per month, which means one likely has a problem and insurance should assist with the cost). With respect to dental insurance, the BAC recommended the University pay for 60% of the family coverage, not 50%, but this is so inexpensive that it is not a large number.

What is the impact of these changes from the original proposal, Professor Bauer asked? Several million dollars to the budget, Professor Morrison said. Dr. Cerra said the BAC did "an incredible job" of analyzing the data and its recommendations are very close to what the administration proposed. The administration will return to the BAC on May 15 to present a response. The administration agreed with the proposal to go to 90% for family coverage, not 85%, with the possibility of going to 85% in 2005 once it sees the data for 2004.

Ms. Weinberg asked what the total increased cost to an individual would be, not just for premium increases but also including co-pays. Professor Morrison said that is difficult to say. The cost is smaller for an individual and larger for a family. The BAC calculated that expenditures beyond the premium cost increase would go up by about $55 per person on average (based on seeing a doctor four times per year and receiving seven prescriptions). Once they have the final numbers, Dr. Cerra said, they will do an analysis by premium and increases in co-pays. They operate on the principle that each carrier is self-sustaining, Professor Morrison added, so if one is less efficient, the premium will go up; as a result, there are different adjustments with each provider.

Professor Jahn asked if there is a surplus in the fringe benefit pool. There is; if so, could not the surplus be exhausted to reduce the cost increases, he asked? Ordinarily the surplus is distributed to the schools and colleges, Dr. Cerra said, to in order to drop the fringe benefit rate. The University, however, has chosen to use the money because each dollar means fewer lay-offs or program cuts.

For the long term, the only solution is a structural change nationally or behavioral changes, Professor Konstan said. Is any modeling being done to achieve behavior change? Dr. Cerra responded that if employees are given money to spend on fringe benefits, it could be taxable. In addition, they can obtain answers to the questions but always in retrospect (e.g., the effect of raising co-pays). It will be three or four years before they have a robust enough database to provide answers. The actuary working with the BAC reported that higher co-pays for employees doe not change behavior, Professor Morrison reported, because people get their prescriptions in any event. With office visits, however, behavior does change. They did see an effect from raising co-pays in the past, Dr. Cerra added, but may not see it in the future.

Professor Speaks thanked Dr. Cerra and Professor Morrison for their report, and adjourned the meeting at 4:05.

-- Gary Engstrand

University of Minnesota