BENEFITS ADVISORY COMMITTEE
MINUTES OF MEETING
APRIL 15, 2004

[In these minutes: PatientChoice Plan Review; May 6, 2004 Meeting Announcement and Agenda Items]

[These minutes reflect discussion and debate at a meeting of a committee of the University Senate or Twin Cities Assembly; none of the comments, conclusions, or actions reported in these minutes represent the view of, nor are they binding on the Senate or Assembly, the Administration, or the Board of Regents.]

PRESENT: Fred Morrison (chair), Linda Aaker, Gavin Watt, Pam Wilson, Karen Wolterstorff, Ronald Enger, Joseph Jameson, Carla Volkman-Lien, Gailon Roen, Susan Brorson, Richard McGehee, Peh Ng, Theodor Litman, Rod Loper, Dann Chapman

REGRETS: Peter Benner, Don Cavalier, Wendy Williamson, George Green, Steve Chilton, Amos Deinard,

ABSENT: Jody Ebert, Carol Carrier, Frank Cerra, Keith Dunder

GUESTS: Tina Frontera, PatientChoice; Jay Coldwell, Wausau Benefits; Susan Affeldt, Wausau Benefits; Cindy Watson, Wausau Benefits; George Klos, Wausau Benefits; Laurie Gering, Wausau Benefits; Tammy Wittenberg, Express Scripts; Dana Johnson, Express Scripts; Jill Noehren, Express Scripts

OTHERS: Linda Blake, Ted Butler, Karen Chapin, Patty Dion, Jennifer Durocher, Rhonda Jennen, Shirley Kuehn, Kathy Pouliot, Ruth Rounds, Jackie Singer, Melinda Soderberg, Lori Theis

I). Professor Morrison called the meeting to order.

II). Professor Morrison began by extending a welcome to:

- Rhonda Jennen representing AFSCME Local 3260.
- Lori Theis, Benefits Specialist.

- Melinda Soderberg, Benefit Counselor.
- Shirley Kuehn, Manager of Support Services in Employee Benefits.

III). Professor Ted Litman provided an introduction to the PatientChoice presentation. He highlighted the following reoccurring comments he received from a survey he conducted of UPlan PatientChoice members:

- In 2004, premium costs increased substantially, particularly for Tier III.
- Enrollment in PatientChoice decreased in 2004. This can be attributed, in part, as a reflection of the price sensitivity of UPlan members.
- Several PatientChoice members have expressed concern over getting claims paid in a timely manner.

The meeting was then turned over to Tina Frontera of PatientChoice who shared the following information:

- Medica has recently acquired PatientChoice. PatientChoice will continue to be run as an independent, separate unit within Medica. From a member perspective nothing changes. This merger puts PatientChoice in a position to grow.
- The purpose of the PatientChoice product is to differentiate providers. The role of PatientChoice is to expose the wide variance in the way that providers practice medicine and in their efficiencies. Through ongoing studies, PatientChoice is able to identify the most efficient providers. For example, Tier II providers are 11.7% more expensive in terms of cost and utilization than providers in Tier I. Likewise, Tier III providers are 28.6% more expensive than Tier I providers. In PatientChoice[1]s book of business (BOB) 50% of their members are in Tier I.
- PatientChoice aligns incentives for providers to encourage them to increase their efficiencies and cost effectiveness. Efficiency is measured by taking into account cost and utilization. Ms. Fontera illustrated this on a PowerPoint chart.
- Some inefficiencies associated with the University of Minnesota care system, which is in Tier III include:
    - Turnover in residents and interns.
    - Teaching institutions typically conduct more repeat tests.
    - Charges for the doctor visit as well as for the building/facility.

- If members are driven by the premium structure to go to more efficient care systems, it will cost the community/University less.
- Ms. Frontera turned the Committee's attention to a PatientChoice brochure, which outlines care system satisfaction. She stated that satisfaction is the perception of the member and may not necessarily be a clinical quality indicator. After reviewing the brochure Mr. Chapman noted that overall there tended to be more care system satisfaction for members in Tier I and Tier II than for those in Tier III.

Next, Jay Coldwell and his colleagues from Wausau Benefits shared the following:

- Similar to the Buyers Health Care Action Group (BHCAG), the University is migrating to lower cost care systems.
- In 2002, University claims were 2.5% lower than projected, and, in 2003, University claims were 2.1% higher than projected. For 2004, Wausau Benefits is projecting claims will be similar to 2003 because of the change of member demographics and the change in the providers being used. In the past, a much greater proportion of the University's population was using high cost care systems whereas now a larger percent of the population is using lower cost care systems. In 2005, a trend increase is expected.
- It was noted that University employees are an expensive population compared with the benchmarks provided. This was illustrated in a slide that depicted the University's 2003 costs of care by category compared to Wausau Benefits' BOB. The University has approximately a 20% over-average illness burden, which is based on diagnosis, other demographic factors, etc. One component of this illness burden figure could be adverse selection.
- Claims for the University based on a per member per month (PMPM) basis are considerably higher than BHCAG claims.
- The University has higher utilization than average e.g. 82 hospital admits per 1,000 compared to an average of 64 per 1,000.
- Top 10 combined medical and pharmacy claims were highlighted.
- One way to stave off medical claims is for members to take advantage of the disease management programs offered by the provider systems. It was noted that Wausau Benefits also offers a disease

management program which is not part of the University¹s current benefit offering.

- A disease prevalence report was distributed. Currently, 18% of the University¹s population spends 39% of its claims dollars. The top three conditions within the University population are depression, hypertension and asthma.
- Suggestions were made on how the University could save claims dollars e.g. reducing benefits levels from 100% to 90%.

Next, Express Scripts representatives highlighted the following information:

- Express Scripts is one of the only pharmacy benefit managers that does not have a drug affiliation. This means that Express Scripts is solely independent as an organization and that it does not accept Œpharma funding¹ or have an affiliation with a drug manufacturer.
- Under the Medicare Modernization Act (MMA) of 2003, Express Scripts has applied for endorsement for the new Medicare card. If Express Scripts receives endorsement, it will be able to offer Medicare members a discount up to 20% off drug ingredient costs at local retail pharmacies.
- Drug re-importation remains legal. FDA concerns regarding these drugs is that many of these medications do not have the same brand name as they do in the United States.
- Express Scripts recently purchased CuraScript, which handles high-cost, injectible medications.
- More and more drugs that were once only available through prescription are now available over the counter (OTC) e.g. Claritin, Prilosec.
- A widespread patent expiration cycle is underway; by the year 2007, 40 key drugs are due to have their patents expire. This means there is a potential to save over $30 billion by 2007.
- Significant new drugs are coming into the market. New drugs to watch for in 2004 include: Avastin & Erbitux, Caduet, Estorra, Cymbalta, Cinacalcet.
- The University¹s utilization of non-sedating antihistamines for 2002 and 2003 was used to highlight potential savings for the UPlan with the availability of Claritin being sold OTC. Based on this information, Express Scripts suggested, as a way to save the UPlan money, that

the University consider attaching a different co-pay to prescription non-sedating antihistamines because an OTC non-sedating antihistamine is available or possibly not covering prescription non-sedating antihistamines at all.

- Key statistics comparisons between 2002 - 2003:
    - The average number of members decreased by 3.4%.
    - The number of members that actually utilized the plan dropped by 1.8%.
    - Total plan costs rose by 9.4%.
    - Total number of prescriptions filled remained constant.
    - Plan costs per member rose by 13.2% compared with Express Scripts BOB, which rose 10.6%.
    - Number of prescriptions per member rose about 3.5%.
    - Generic drug distribution rose by 11.9%.
    - Mail order utilization rose by 12.2%. This is a great cost savings for both the UPlan as well as members.
    - The University¹s member cost share eroded by about 1.2% to 14.5%. Express Scripts average BOB cost share averages 23% - 30%.
- The University¹s top 10 drugs were highlighted.
- The University¹s top 10 disease states were noted. The University is very similar to Express Scripts¹ BOB.
- Express Scripts conducted a co-pay analysis and manipulated the University¹s current co-pay structure in order to share with the Committee areas where savings may be able to be realized.
- Express Scripts highlighted its Mail Choice program, which is designed to increase mail utilization for the plan. Both the plan as well as members would realize savings through this program. This program targets members that are taking maintenance medications and having them filled through their retail pharmacies.
- Express Scripts is able to offer the University a suite of programs, which, in the interest of time, were not fully detailed. However, two programs were highlighted: Prior Authorization (PA) and Step Therapy. Prior Authorization involves the process of obtaining a certificate for coverage for certain drug products, prior to dispensing, and utilizing the guidelines as established by the University. Then, the Step Therapy program encourages the use of

cost-effective first line alternatives before coverage of a second line product when medically acceptable.

- In 2003, Wausau Benefits received 39 formal claims appeals. Of these 39 appeals, approximately 24% were overturned and paid after further investigation or if the University instructed Wausau Benefits to pay a particular claim.
- Wausau Benefits prides itself on its accuracy, turnaround time, and customer service. Next, Mr. Klos shared the following performance statistics with the Committee: quality statistics, first call resolution data, customer survey satisfaction rates, and claim processing turnaround time information.

Express Scripts briefly summarized what was covered in their presentation today and thanked members for their time.

Questions/comments from members included:

- As more and more drugs are being made available OTC, costs are being shifted away from the plan and onto the member. According to the Express Scripts representative, it depends on how an employer has their plan set up. However, in the University¹s case it would be cheaper for an employee to purchase e.g. Claritin with a co-pay versus purchasing it directly over the counter. It was noted that Walmart and Walgreens have their own branded version of Claritin called Wal-itin, which can be purchased OTC very inexpensively. Professor Morrison stated that as more and more drugs become available OTC, the University needs to decide if it should continue subsidizing these drugs or not.
- Why would the Mail Choice program be able to save the plan and members money? Express Scripts owns its own mail service pharmacy and they are able to buy in bulk. Buying in bulk saves Express Scripts money and these savings are passed on to the plan and its members. Also, there are no dispensing or administration fees associated with this program.
- Express Scripts¹ PA program was discussed. An Express Scripts representative noted that this program is an opportunity to identify when inappropriate medications are being prescribed to treat certain conditions; thus a way to save the plan money. A member suggested that this program should be targeted at the physician rather than the

patient. An Express Scripts representative reminded the Committee that physicians work with multiple plans, each with their own formularies; therefore, physicians cannot be expected to know which plans allow what. Another member added that if the pharmacist is not permitted, under this program, to fill a prescription the physician will need to be contacted either by the patient or the pharmacist which results in a cost. Express Scripts noted that oftentimes the pharmacist would intercede on behalf of the patient and help to facilitate a different prescription. A member stated in his opinion this program does not reduce costs but rather shifts costs.

- It was noted that if Express Scripts does not have prior claim information for a patient with prescription allergies/complications, this would be a pitfall of the Step Therapy program. Express Scripts stated this program has a manual override step in such instances.

Next, George Klos, director of Claims Services at Wausau Benefits spoke about the claims processing practice at Wausau Benefits. He highlighted the following:

- Claims can be suspended and/or denied for a variety of reasons; however, the two main reasons are because the claim is not a covered benefit and because Wausau Benefits lacks sufficient information to process the claim. Mr. Klos emphasized that a vast majority of the claims that are initially suspended, are eventually paid. The percentage of claims that are truly denied is approximately 12% and this is average for the industry.
- It is the goal of Claims Services to only handle a claim once for efficiency reasons.
- Claims are often suspended because other information needs to be collected such as other insurance information, accident details or student status. Wausau Benefits immediately suspends these claims and sends out an Explanation of Benefits Notice to the member stating that the member must contact Wausau Benefits in order for their claim to be considered. If the member fails to respond in a specified period, Wausau Benefits notifies the provider that the claim has been denied. The provider then proceeds to balance bill. Once the member receives the balance bill from the provider, it is typically at this point that the member contacts Wausau Benefits. Of all the

claims processed overall approximately 6% are suspended for other insurance reasons.

- Wausau Benefits checks for other insurance once per year unless conflicting information is received.
- Wausau Benefits checks twice per year for student status changes.
- Once information is provided concerning accident details, Wausau Benefits pays these claims. However, with respect to motor vehicle accident claims, Wausau Benefits must wait to see what the automobile insurance carrier will cover because, in a no-fault state such as Minnesota, automobile insurance companies are primary.

Comments/questions from members included:

- It is not surprising that PatientChoice/Wausau Benefits receives so many complaints about their claims processing if they are required to check for other insurance every year when a member has already indicated they do not have other insurance. Isn¹t there another way to handle this? Mr. Klos stated that Wausau Benefits does not check for Œother insurance¹ for active employees, but only for their dependents. A member pointed out that Employee Benefits, during open enrollment, collects this information and provides it Wausau Benefits, so why does Wausau Benefits need to collect this information again? Mr. Klos stated that not all employees complete this information for Employee Benefits and/or it could be a matter of timing with respect to when this information is provided by Employee Benefits to Wausau Benefits. Mr. Chapman pointed out that employees do not necessarily provide this information every year e.g. if they do not make any changes to their benefit selection they are not required to complete the open enrollment form where this information would typically be provided.
- The Explanation of Benefits Notice does not conspicuously place instructions to the member to contact Wausau Benefits to provide additional information so that the claim can be processed. Wausau Benefits was encouraged to review and redesign this form to make this requirement more apparent.
- Tina Frontera of Patient Choice asked Mr. Klos whether the other insurance query could be conducted once every two years versus every year. Mr. Klos stated that this can be looked at, however, this puts

the University at risk because claims that should not be paid because of other insurance, will be paid.

- None of the other UPlan administrators received a 48% dissatisfaction rate with their claims processing process. Does Wausau Benefits survey its members to determine their satisfaction with this process? If so, what do these survey results indicate? Next, this same member asked Employee Benefits personnel whether they receive more complaints regarding the claims processing practice of PatientChoice versus the other plans, HealthPartners, PreferredOne and Definity?
- Dann Chapman requested a report from Wausau Benefits indicating how much the University would have spent if Wausau Benefits had not been so diligent about checking for other insurance. He added that if members in other plans are not experiencing this same problem, it would be interesting to ask whether the other administrators are doing their job in checking for other insurance. Is the University paying for claims that are not its responsibility? This information should be uncovered in the claims audit the University plans to conduct shortly. Mr. Klos stated that Wausau Benefits deals strictly with self-funded customers and it takes the stewardship of its customers¹ checkbooks very seriously.

Susan Affeldt of Wausau Benefits stated that based on feedback received from the University it will take the following steps in order to address the claims processing problems, which were identified today:

- Re-examine Wausau Benefits¹ criteria for suspending claims.
- Evaluate the language on the Explanation of Benefits Notice to make it more Œreader-friendly¹.
- Review the survey process for collecting other insurance information, student status information and accidents details.
- Speak with the other plan administrators to learn how they process their claims and uncover why their process seems to work better than Wausau Benefits¹ process.

In closing, it was noted that the University of Minnesota/PatientChoice business relationship is relatively young. Ultimately, it is the goal of PatientChoice to have its members perceive it as a plan that is easy to use. PatientChoice will work diligently to make this a reality.

Professor Morrison thanked the PatientChoice/Wausau Benefits and Express Scripts representatives for their presentation.

IV). Professor Morrison announced that the next BAC meeting would be Thursday, May 6, 2004 in room #385 Mondale Hall. At this meeting Wellness Coordinator Ruth Rounds will provide members with a wellness/walking program update. Also, at this meeting UPlan Guiding Principles will be reviewed and discussed to determine whether these principles should remain the same or whether they need to be amended.

V). Hearing no further business, Professor Morrison adjourned the meeting.

Renee Dempsey
University Senate