BENEFITS ADVISORY COMMITTEE
MINUTES OF MEETING
NOVEMBER 18, 2010

[In these minutes: Leadership Essentials in the Era of Health Care Reform Lecture Update, Open Enrollment Update, Discussion on Possible Health Care Benefit Changes Prompted by New Federal Legislation]

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

PRESENT: Gavin Watt (chair), Pam Enrici, Tina Falkner, William Roberts, Dale Swanson, Sharon Binek, Jody Ebert, Jennifer Schultz, Sandi Sherman, Nancy Fulton, Joseph Jameson, Karen Lovro, Michael Marotteck, George Green, Judith Garrard, Richard McGehee, Fred Morrison, Michael O'Reilly, Theodor Litman, Rodney Loper, Dann Chapman

REGRETS: Sara Parcells, Carl Anderson, Amos Deinard, Karen Chapin

ABSENT: Carol Carrier, Frank Cerra, Keith Dunder

OTHERS ATTENDING: Kurt Errickson, Betty Gilchrist, Ryan Gourde, Shirley Kuehn, Kathy Pouliot, Kelly Schrotberger, Sheri Stone, Curt Swenson

I). Gavin Watt called the meeting to order and welcomed all those present.

II). Mr. Watt noted that he and Dann Chapman, director, Employee Benefits, attended a very informative lecture (Leadership Essentials in the Era of Health Care Reform) delivered by George Halvorson, chairman and chief executive officer, Kaiser Permanente, the nation's largest nonprofit health plan and hospital system. Mr. Watt shared one takeaway from this presentation, which was that the fee for service model is a major contributor to escalating health care trend. Kaiser Permanente, on the other hand, uses a per capita model similar to how managed care organizations operate.
Mr. Watt encouraged members interested in this topic to read Mr. Halvorson's most recent book, *Health Care Will Not Reform Itself: A User's Guide to Refocusing and Reforming American Health Care*.

Mr. Chapman also shared his observations of Mr. Halvorson's presentation. He noted that Mr. Halvorson's overall theme was that health care will not reform itself. As currently aligned, the health care system is structured in such a way so businesses know how to drive their profits. Mr. Halvorson believes that health care reform, to be successful, will need to follow three steps, and in this order:

1. Everyone must have coverage.

2. Care needs to be reformed/re-engineered such that the “right thing” is easy to do; people default to what is easiest for them.
3. Revamp the health care cost structure. (Cost needs to be last in this 3-step process because if cost is first, the only place to go is rationing.)

Mr. Watt stated that he also took away from the presentation that any change needs to come from the market/consumers. As currently structured, the health care system has no incentive to change.

A member asked whether Employee Benefits has heard anything about substantial increases in long-term care costs. Some insurance companies are dropping out of the business, and some are talking about raising rates as much as 40%. Mr. Chapman stated that the University currently has a 3-year rate guarantee. Having said that, he has heard much of the same in terms of what is happening overall in the market.

III). Mr. Watt turned to Kathy Pouliot for an open enrollment update. Ms. Pouliot noted that the Benefit Service Center has been very busy. To date, the Benefit Service Center has answered almost 3,000 calls and emails. The total attendance from the health benefit fairs was at about 3,000 people (Minneapolis, St. Paul, Duluth and Morris). This year’s open enrollment event is running very close in numbers to the same period last year.

Generally, speaking 75% - 80% of employees enroll in the last three to five days of open enrollment. Currently, noted Ms. Pouliot, about 2,000 people have enrolled out of a total of about 8,000.

The first computer lab was held yesterday, Wednesday, November 17th and eight people came in between 7 a.m. – 7 p.m. It is expected that the remaining computer labs will better attended because the open enrollment deadline will be approaching.

In response to a question about the benefit fair hours, Ms. Pouliot reported that the Minneapolis and St. Paul fairs were open until 4:30 to accommodate second shift employees. She noted that the last hour was very slow, and that most second shift employees tended to come between 2:30 – 3:30. There are no current plans to change the benefit fair hours next year.

Ms. Pouliot also noted that flu shots were given at the benefit fairs. Roughly 1,600 flu shots were given (Duluth numbers are not included in this figure). Once the Duluth numbers are added in, the flu shot count at the benefit fairs is expected to be around 2,200.

IV). Mr. Watt reported that at the December 2nd University Senate meeting there will be a discussion about changes in health care benefits prompted by new federal legislation. This will also be the main agenda item for today’s BAC meeting. Following today’s discussion, members are being asked to give the issues more thought and to solicit input from their colleagues, and come prepared to continue the discussion at the December 2

BAC meeting. Hopefully, by the conclusion of the December 2 meeting, the committee will reach an overall consensus about where it stands on the issues.

Mr. Watt turned to Professor McGehee to share the concern he voiced at the last AWG meeting. Professor McGehee stated that senior University leadership will be faced with tough decisions about the University's budget. With that said, the BAC is always put in the position of advising the administration on whether co-pays should be increased, etc. Never, however, is the BAC asked whether benefits other than health care benefits should be cut, e.g., retirement benefits, salary reductions, etc.

In response to a question about who serves on the AWG, Mr. Watt stated that Dr. Frank Cerra chairs the AWG. He noted that the other AWG members are: Carol Carrier, Richard Pfutzenreuter, Keith Dunder, Les Johnson (Crookston), Fred Morrison, Dick McGehee, Dann Chapman, and himself.

A member agreed with Professor McGehee's observation about the choices that are brought to the BAC for consideration are spot on. That is why if the committee believes that cuts need to come from somewhere other than health care benefits it should say so. Cutting health care benefits are not the only options for dealing with the University's financial problems.

To set the stage for the discussion and to put it in context Professor Morrison provided the committee with background information about how this issue came about. Professor Morrison stated that he was asked by the Faculty Consultative Committee (FCC) to put together a few questions for the December 2 University Senate meeting to stimulate a discussion about the general financial situation of the University and the impacts of health care reform legislation, which will ultimately require the University to make health care benefit changes or suffer severe penalties. While it is unlikely that any of these questions will require decisions until spring/early summer, it is only responsible to start the conversation now so the process proceeds in an orderly fashion.

Next, Mr. Watt read aloud the questions that will be discussed at today's meeting and the December 2, 2010 University Senate meeting:

1. If the University is unable fully to cover increasing health care costs in 2012, how should we respond?
   (a) with across-the-board increases in the employee share of the premium cost?
   (b) with substantially higher co-pays or co-insurance?

2. If we impose higher employee premiums, should we cap the amount that an employee must pay for coverage as a percentage of salary, in order to avoid substantial federal financial penalties that would be imposed on the University beginning in 2014?

3. Should we substantially reduce the premiums or co-pays for employees who either (a) have satisfactory biometrics, or (b) are making real progress in improving their

biometric results through health improvement activities?

4. Should we offer, as an option, a network that consists only of providers who provide above-average quality of care at below average costs? Such a network might not be available in all locations.

Members began by discussing the fourth question. Mr. Watt noted that the University is actively investigating providers who provide above-average quality of care at below average costs. Professor Kralewski, Division of Health Policy and Management, School of Public Health, is conducting this research.

A member asked about the implications of not having this type of network available in all locations. In response, Professor Morrison raised the question whether the University should offer a network that would only be available to employees who live in areas where more economical and efficient health care systems are available or should the University only offer equal health care across the state. Mr. Watt stated that Twin Cities UPlan participants currently subsidize the more expensive health care that happens outstate. Assuming the University is able to create a better and cheaper network that is only available in some areas, asked Professor Morrison, should the savings from offering this network be spread across the entire UPlan or should the savings only be given to people who participate in the network? In addition to the base and buy-up plans offered in the UPlan, should the University offer a plan that ends up being cheaper than the base plan because the network only includes high-efficiency/low-cost providers, asked Mr. Chapman? It is unclear at this point whether such a network could be built with adequate capacity if all UPlan participants in a given area wanted to participate.

A coordinate campus member commented that offering this type of network in only select areas in the state seems discriminatory and deviates from University policy. It is also important to remember that salaries on the coordinate campuses, on average, are lower than salaries on the Minneapolis and St. Paul campuses. Therefore, the coordinate campuses are already being “penalized.”

Mr. Chapman added that there have also been discussions about requiring participants who enroll in this type of network to take more responsibility for their health and to be more actively engaged in improving their health. As an example, he noted that participants may be required to meet certain biometric numbers or demonstrate that they are making clear progress toward improving their biometric numbers. The data strongly suggests that health care costs people incur are significantly impacted by lifestyle behaviors. In response, the same coordinate campus member stated that simply because UPlan participants do not participate in one of the wellness programming opportunities does not mean they do not live a healthy lifestyle. Mr. Chapman stated that is what he meant when he said if people can demonstrate they are already healthy and/or are working at maintaining their health. Participants would not necessarily be required to participate in one of the wellness programming opportunities.

Given the limited size of any high-efficiency/low-cost network, will participants have a longer wait time to get an appointment to see a physician, asked a member? No, stated Professor Morrison, there would not be longer waits to get an appointment, but there would likely be longer waits to enroll in the network because there will probably be a limited number of slots.

A member voiced utter disapproval of stratifying people based on their biometrics. It simply is not acceptable to penalize people based on their health conditions. To illustrate, obesity is not as simple as eating too much. According to Mr. Chapman, the intent is not to penalize people, but to reward and incent people for taking an active role in improving their health. The objective is not to exclude people that cannot meet certain goals. However, just because people are unable to meet certain goals does not absolve them from having to work on improving their health outcomes.

A member stated that deciding who can enroll in a particular health plan based on their biometrics is making a moral judgment about that person and that is simply wrong. Playing the devil's advocate, Mr. Chapman stated that some people take the position that it is morally inexcusable to penalize people who take a vested interest in their health by exercising, eating right, not smoking, etc., and then must subsidize people who take little or no responsibility for their health whatsoever. This same member went on to say that insurance is a risk pool, and risk is spread across a population. Some people who engage in egregious lifestyle behaviors could possibly be afflicted with an addiction or some other type of problem. It would not be right to impose a moral judgment on these people. Mr. Chapman stated previous discussions by this committee on this subject have been based on a faulty interpretation of what it means to have an insurance pool. The notion of an insurance pool began with the purpose of helping people with catastrophic, unaffordable risk. Over the years, the idea of an insurance pool has expanded significantly from pooling only catastrophic expenses to covering all health care costs, similar to the outdated HMO model. Mr. Chapman added that the health insurance discussion that is taking place now on a national basis has come to the conclusion that the definition of an insurance pool is too broad, and needs to be curtailed, to a degree.

Looking at this issue from an economic perspective, a member suggested incenting sick people to enroll in the high-efficiency/low-cost plan rather than the healthy people.

What does "healthy" really mean, asked another member? A significant number of people's health problems are hereditary. Is the University going to base its hiring decisions, at least in part, on what diseases run in applicants' families and their lifestyle behaviors? What about people who are in a car accident, or pregnant women who give birth to babies with birth defects – how is it possible to justify penalizing these people? Penalizing these people would be outrageous. Why is it necessary to have this discussion now? Mr. Chapman stated that this discussion is taking place now because it is no longer possible to patiently wait for incremental change to occur in the health care system because waiting will bankrupt the U.S. economy. Reform is necessary. This is why these discussions are taking place now. In response, this member stated that for some BAC members their health care coverage was negotiated in good faith, and messing with

this coverage will not be tolerated. Mr. Chapman asked how offering a high-efficiency/low-cost plan penalizes people. According to this member, if people cannot get into such a plan without doing certain health-related things, then this is discriminatory. Professor Morrison added that health care reform legislation clearly articulates that premiums will be reduced by up to 33% for people who are conforming to wellness standards.

How frequently would the clinics and physicians in this high-efficiency/low-cost network be evaluated, asked a member? It will be important to keep in mind that people will not be interested in participating in a network if they are not confident they will be able to develop a long-term relationship with a clinic system/physician. Mr. Chapman stated that it is his sense that any sort of evaluation must be done over a period of time. He expects annual evaluations will be conducted, but trend information would be evaluated over a longer period of time.

Mr. Watt turned members' attention back to question four, should the University offer, as an option, a network that consists only of providers who provide above-average quality care at below average costs? He stated that this would be more or less a "buy down" plan. It is likely that this type of plan would not be available to outstate UPlan participants. A Duluth member stated that it will be important to measure quality for all the providers in all the networks because this would drive competition on quality and not simply on cost/price. Over time, it would seem likely that all care systems would want to improve their quality and health outcomes. Professor Morrison stated that while there is a good deal of work being done on measuring quality, not much is being done to publicize these results to consumers who are making health care choices.

A member commented that if the high-efficiency/low-cost providers are taken out of the base plan, then the premium for the base plan would go up. Taking the high-efficiency/low-cost providers out of the base plan in effect penalizes everyone else who is in the base plan.

Next, Mr. Watt asked members for their comments pertaining to the first question. A member stated that if the University is unable to cover increasing health care costs in 2012, it should shift the extra cost on premiums and only modestly increase co-pays if absolutely necessary. Increasing co-pays would disproportionately impact sick people who already have high medical expenses. The sick should not be asked to bear the brunt of these costs. With respect to co-insurance, this can be potentially backbreaking, particularly on hospitalization charges, which can be exorbitant. Coinsurance can expose people to very high costs in a catastrophic situation. Another member suggested raising premiums and co-pays by the same percentage. In response to a comment that none of the plans in the UPlan have coinsurance, a member reminded the committee that the HSA plan has coinsurance. Mr. Watt stated that often times coinsurance is capped once expenses reach a certain level. Having said that, are there areas where coinsurance might be appropriate, e.g., non-formulary drugs?

For the record, a bargaining unit member stated that employees should not be asked to help cover increasing health care costs. A substantial number of University employees earn $35,000 or less. Increasing the employee's share of health care costs will likely result in employees waiving coverage because they simply cannot afford it. A lot of people are really struggling. Increasing health care costs should not be put on the backs of employees. Instead, the University needs to re-budget and figure out some other way to get this money. Another bargaining unit representative suggested that employee health care contributions should be based on income. A class-based approach to health care where wealthy people have good health care and poor people have inadequate health care is not acceptable.

Professor Morrison stated that the University will reach the point shortly before 2018 when the Cadillac Tax will take effect, and, as a result, health care benefits in some plans will need to be reduced or the University will be required to pay a fine. The most effective way to modify the plan is by introducing co-pays and/or deductibles. Shifting the premium will not help.

A member noted that given the fiscal challenges facing the University, it is inevitable that there will only be so much money available for benefits in general. Therefore, it may be time for the University to look at having ala carte benefits.

A member explained that co-pays came about out of the moral hazard philosophy, which takes the position that people overuse care simply because they have health insurance coverage. Co-pays were introduced as a way to put a stop to overutilization. Increasing co-pays, however, would have an adverse affect on improving health because people will likely say they cannot afford to take their medications or see a physician when it is appropriate to do so. Instead, premiums should be increased assuming this is the only other choice, and if they are increased, they should be increased on a sliding scale fee based on income. Another member suggested not only basing premium increases on salary but on family size too. This member added that several years ago the co-insurance option was discussed by the BAC and rejected. Co-insurance is a misnomer because it is not co-insurance per se, but a reduction in insurance.

Moving forward, Mr. Watt asked members to weigh in on the second question and share their thoughts on whether the amount an employee pays for coverage should be capped based on a percentage of salary. A member noted that lower paid employees are currently getting a bigger percentage of support from the University based on percentage of salary than higher paid employees. The issue should be how to keep health care costs affordable for all employees.

As part of health care reform legislation, noted Professor Morrison, beginning in 2014 employers who charge low-income employees more than 8% of their salary for health care will be assessed a fee. This fee can be quite substantial and the University should try to avoid paying it.

With respect to capping the amount employees pay for health care based on a percentage of salary, such a calculation needs to look at an employee's entire household income. For example, a low-income employee could have a spouse/same sex domestic partner who earns a great deal. Does the 8% figure specified in health care reform legislation only take the employee's salary into account or the entire household salary? Professor Morrison stated that as currently structured, the 8% is for the household income. Having said that, there is no provision in the legislation for finding out what the household income is, or at least until the household goes to the exchange to buy the alternate policy. For each household that gets a voucher, the University would be billed approximately $10,000.

Is the University maintaining its status as a grandfathered plan, asked a member? Professor Morrison explained that there will be very few grandfathered plans by 2016 because the changes that plans are able to make are so severely limited. More than likely, the University will see a premium increase at some point in the future, which will void its current grandfathered status. Two health care legislation rules are of particular concern to the University:

1. In 2018, if University benefits are greater than a specified amount, it will be required to pay 40% of the excess amount of this value as a tax (Cadillac tax). Based on calculations by the University's consultants, the University would owe roughly $8 million in the first year, and this figure would increase rapidly thereafter. The plan needs to be configured in such a way, noted Professor Morrison, so the cost of the total benefits is less than the amount specified in the legislation. The only other option at this point would be to lobby the Congress to change the health care reform legislation.
2. In 2014, conforming plans (non-grandfathered plans) will be limited in terms of what they can charge low-income employees. Low-income is currently defined as 400% of the poverty rate, which is about $88,000/year. This means that employees who pay more than a certain amount of their salary (8% - 9.8%) for employer-sponsored coverage will be entitled to opt out of the UPlan and go into one of the federal exchange plans. These employees will receive a voucher to participate in one of the federal exchange plans. For each voucher issued, the University would be required to pay the amount of money the University would have paid, on average, for an employee to have UPlan insurance. This currently amounts to $5,519 for single coverage and $11,177 for family coverage.

Professor Morrison stated that based on what he heard at a meeting he recently attended with other large Twin Cities employers, he anticipates the University will see an increase in family coverage for 2011 due, in part, to changes other employers are making in their insurance coverage. At least one major employer is only going to offer a high deductible plan going forward. This employer is reporting about 10% of its employees are electing to waive their health insurance coverage. This begs the question, should the University continue to insure spouses/same sex domestic partners? As a self-defense move, the University may be left with no choice.

Next, Mr. Watt called on a handful of members who had not previously spoken up about either their thoughts on these questions or their constituents' thoughts. Comments received:

- Reward people for taking care of their health.
- Out-of-line for the University to set biometrics; this is too intrusive.
- Raise premiums rather than co-pays.
- Cap the amount an employee must pay for coverage as a percentage of salary if it is necessary to raise premiums.
- All terrible options.
- Who would manage the low-cost, high-quality plan? This seems like a very arduous job.
- Raise co-pays rather than premiums because it would advantage people who do not go to the doctor often.
- Don't cap the amount an employee must pay as a percentage of salary.
- Reduce co-pays and premiums for people who maintain satisfactory biometrics.
- Offer a low-cost, high-quality plan, but make sure there are other options available as well.

What is the motivation behind establishing a low-cost, high-quality network of providers from a big picture perspective, asked a member? Professor Morrison stated that health care change at the state and federal level is focusing on health homes and accountable care organizations. As a result, the pressure is on moving to this kind of model. The model, assuming it works properly, is expected to improve quality of care and improve unit costs by replacing these costs with global payments for managing and improving health conditions. An obstacle that the University is facing as it moves toward this type of model has to do with the fact that the health plan administrators are reluctant to offer narrow networks. In terms of who would run this type of network, clearly the management of the network would need to remain with the health plan administrators. Having said this, the University will likely play a bigger role than it has previously in selecting clinics in the network, etc. because the University has very good data, which comes from being self-insured. The University may very well end up being a leader in moving this type of model forward. Mr. Chapman noted that clinic system buy-in will be critical. It will be important to identify clinic systems that are interested in making this type of model work if a new plan design like this is to ever get off the ground. Currently, there are demonstrable differences in quality from clinic system to clinic system, and these differences do not correlate to cost.

A member briefly brought up the financial reimbursement of clinics. At one end of the spectrum is fee for service and at the other end is capitation. Having said that, there needs to be a way to tie reimbursement to outcomes.

In light of time, Mr. Watt stated that these questions will be brought to the University Senate meeting for discussion on the afternoon of December 2. The committee's next meeting is also on December 2. Members were asked to come prepared to continue this discussion at the next meeting.

V). Hearing no further business, Mr. Watt adjourned the meeting.

Renee Dempsey
University Senate