BENEFITS ADVISORY COMMITTEE
MINUTES OF MEETING
JUNE 6, 2013

[In these minutes: Medica Annual Review, Continued Discussion of Proposed Changes to Health Benefit Design]

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

PRESENT: Gavin Watt (chair pro tem), Pam Enrici, William Roberts, Dale Swanson, Jody Ebert, Jennifer Schultz, Nancy Fulton, Joseph Jameson, Karen Lovro, Richard McGehee, Theodor Litman, Rodney Loper, Dann Chapman

REGRETS: Tina Falkner, Sandi Sherman, Susann Jackson, Amos Deinard, Roger Feldman, Judith Garrard, Fred Morrison

ABSENT: Sara Parcells, Sheldon Taylor, Carl Anderson, Kathryn Brown, Aaron Friedman, Keith Dunder

OTHERS ATTENDING: Linda Blake, Karen Chapin, Susan Diekman, Kurt Errickson, Betty Gilchrist, Ryan Gourde, Cherrene Horazuk, Kathy Pouliot, Curt Swenson, Jody Thronson, Laurie Warner

GUESTS: Medica Representatives: Dr. Timothy Crimmins, medical director; Mary Beth Galey, director, Strategic Accounts; John Naylor, senior vice president, Commercial Markets; Judy Reger, senior strategic account executive; Christel Webber, senior strategic account manager

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

II). Mr. Watt welcomed today's guests from Medica, Dr. Timothy Crimmins, medical director; Mary Beth Galey, director, Strategic Accounts; John Naylor, senior vice president, Commercial Markets; Judy Reger, senior strategic account executive; Christel Webber, senior strategic account manager. Mr. Naylor began by introducing his colleagues and providing an agenda overview.

Next, Ms. Galey provided the committee with customer service statistics for 2012 and noted that Medica either exceeded or met all of its service metrics. Highlights from her presentation included:

- Medica handled just under 40,000 UPlan calls.
- The answered call rate was 98.74%.
- The abandoned call rate was 1.67%.
- Average call wait time was 27.93 seconds.

- Call quality, e.g., providing accurate information, was 98.44%.
- First call resolution rate was 92.33%.
- On a scale of 1 – 5, member survey results rated their customer service experience 4.54, which indicates an overall high level of satisfaction.

Ms. Webber then provided information about the member satisfaction survey that Medica conducts annually. She noted that the survey is sent out each fall to a random sample of 10% of plan participants in each of the plans, except the HSA plan in which case all members are surveyed. Salient highlights from her presentation included:

- Total mailed surveys were 1,992.
- Total responses were 318, which is a response rate of 16%.
- Of the respondents, three people requested a call from the service team to discuss an issue.
- Eighty six percent of members who were enrolled in Medica for more than two years gave Medica a rating of four or five for overall satisfaction, and, of those people, 90% had received health care services in the past six months.
- Areas receiving the highest satisfaction were 1) customer service, 2) provider network, and 3) claims processing.
- Areas receiving the lowest satisfaction ratings were 1) website, 2) explanation of benefits, and 3) providing clear and easy to understand information about the various plans.

Moving on, Dr. Crimmins provided information on utilization trends. Using data, reported on an annualized basis, for three calendar years (January 2010 – December 2012), Medica estimates that UPlan medical trend (excluding pharmacy) for 2013 will be 6.2%.

Mr. Roberts commented that he was under the impression that based on previous reports to the BAC that the UPlan trend was substantially lower than the 6.2% projected for 2013. Mr. Chapman pointed out that pharmacy data is not included in this projection; therefore, the positive generic utilization results that have helped reduce the total overall UPlan trend, is not included in this calculation.

Dr. Crimmins went on to highlight that over the past three years, the UPlan paid per member per month increased at an annual rate of 3.6%, and the member out of pocket percentage paid for medical benefits has not changed in over two years (4.2% in 2012). Mr. Naylor noted that this 4.2% member paid is significantly lower than Medica's other large employers, which average 10% - 15%.

Regarding the health of the UPlan population, noted Dr. Crimmins, it is fairly healthy on average. Non-high cost members (<$50,000/year) are increasing at an annual rate of 3.5%. Ninety nine percent of UPlan members are non-high cost. High cost members (>$50,000/year), on the other hand, are a cost driver for the plan, and are increasing at an annual rate of 6%. From 2010 – 2012, high cost members increased from 251 to 422, noted Mr. Naylor, which is approximately 40% higher than Medica's book of business average. According to Dr. Crimmins, the technology used to keep people alive is

becoming more and more advanced, and, as a result, it is also very expensive. Mr. Naylor added that Medica has a significant emphasis on large-case care management, which focuses on delivering personalized services to patients to make sure they get the best and most appropriate care possible.

Other statistics shared by Dr. Crimmins included:

- Physician plan paid increased at an average annual rate of 3%, which is at inflation.
- Physician cost per event increased at an average annual rate of 3%.
- Outpatient plan paid increased at an average annual rate of 4%.
- Outpatient cost per event increased at an average annual rate of 9% (number of events decreased 4% per year).
- Inpatient plan paid increased at an average annual rate of 3%.
- Inpatient cost per admission increased at an average annual rate of 12% (admissions decreased 7% per year).

Dr. Crimmins summarized by saying that a lot of these figures simply represent insurance risk, and are not necessarily preventable. This year, the UPlan has extra high cost cases. Medica will continue to analyze the UPlan data to see if there are any interventions that can be done to prevent catastrophic events and reduce risk, e.g., large-case care management, and health coaching through University Wellness Program options. Mr. Naylor added that he believes Medica's total cost of care contracts that incent and reward care systems for cost and quality management are helping to manage costs overall.

Mr. Jameson asked about the number of hospital rooms and surgical space that are not being used because more and more procedures are being done at outpatient centers. In his opinion, competition between hospitals and clinic systems is creating inefficiency in the system. Dr. Crimmins stated that this is a complex question. He noted that there are licensed beds and staffed beds (filled and unfilled) and this is where the inefficiency comes in. In Dr. Crimmins opinion, he believes over the past decade staffed bed efficiencies have become more efficient in their labor strategies; however, in any hospital setting there is a flux in volume that cannot be anticipated. Hospitals always have to have excess staffing because they cannot predict when they will get multiple admissions. Over the last decade hospitals have become more efficient, but there are still more supply chain efficiencies that hospitals can achieve. Mr. Naylor noted that hospitals are looking at operational efficiencies, e.g., staffing levels, etc. Capacity remains an issue for hospitals, and he believes they are doing a pretty good job not forcing utilization of that capacity because this would artificially increase costs. The goal is to have health systems be mindful and responsible for total cost of care. Mr. Jameson requested Medica share hospital utilization statistics with the committee.

Moving on, Mr. Naylor took a few minutes to talk about accountable care organizations (ACOs). He noted that an ACO is a healthcare organization that provides coordinated care to a defined population and is accountable for:

- Cost.
- Quality.

- Outcomes.
- Consumer experience.

The ACO model requires participating healthcare systems to make a commitment to the entire continuum of care. Currently, health care systems focus on caring for the sick. Going forward, the focus will be on improving the health and wellbeing of a population for a lifetime – cradle to grave care. ACOs are transforming care in Minnesota.

Mr. Naylor stated that it has been interesting for him to be part of the ACO executive team discussions. Medica is working with its ACO partners (Fairview, Park Nicollet, Ridgeview, HealthEast Care System) to improve cost and quality of care. Results of recent ACO reviews indicate that performance is good. Cost sharing incentives help to drive down the total cost of care. Currently, My Plan by Medica has 23,000 members enrolled and its service area is limited to the metro area. Medica is anticipating that enrollment will likely double by January 1, 2014 given the interest by employers in the defined-contribution concept. Medica's data indicates that when employees are given a choice between an open access product and an ACO, about 40% - 45% choose an ACO. Part of their decision, noted Mr. Naylor, may be because ACOs are less expensive, which is attributable to, at least in part, to the much narrower network of providers.

Professor McGehee stated that based on what he has heard about ACOs that they seem to be more about limiting access options versus improving the quality of care they deliver. Mr. Naylor clarified that from an employee perspective cost is oftentimes the first factor taken into account, and secondly whether the members' doctor(s) are in the network. The consumer experience usually ranks third or so. Care systems are focusing on the consumer experience and want members to have the best possible experience because they are looking at it from a cradle to grave perspective. In Mr. Naylor's opinion, over time members will chose to go with an ACO because of the higher quality of care and it is less expensive. The care systems are creating brand loyalty as part of this initiative, and Medica is acting as the conduit to make it happen.

What are the demographics around who is and who is not choosing to participate in ACO, asked Ms. Fulton? Early indications are that healthier than average people are choosing to participate in an ACO, stated Mr. Naylor.

Next, Ms. Reger provided enrollment and claims cost information. She turned members' attention to a chart that highlighted enrollment numbers from March 2010 – March 2013. Elect/Essential (base plan) participation increased year over year and currently over 62% of UPlan subscribers are enrolled in Elect/Essential. She reminded members that back in 2011, the plan became one network, which makes it easier for members and their families to join Elect/Essential because they can choose different care systems. Insights by Medica has the second highest enrollment (19%) followed by Choice National (10%), Choice Regional (7%) and HSA (2%).

Ms. Reger noted that the UPlan covers just over 18,000 employees and has about 39,000 total members (employees and their dependents). There are a lot of dependents covered on the UPlan, which is likely attributable to the plan design and/or the premium

contribution. With respect to annualized per member per month claims costs, in 2010 this figure was $335, and this number has increased ($354 for 2011, $359 for 2012, and $366 as of first quarter 2013). Compared to Medica's self-insured book of business, the UPlan's per member per month claims costs are higher. She reminded members that the UPlan has a fair number of high claimants. In 2012, for example, there were three members with claims over $800,000.

What is the average copay of Medica's self-insured book of business, asked Ms. Ebert? Ms. Reger stated that the University has the lowest office visit copay of any of her other accounts. Most employers have office visit copays ranging from $20 - $30, and a lot are moving to a deductible (80%/20% or 70%/30%). A lot of companies are redesigning their benefit plan and shifting additional costs to their employees. Mr. Chapman added that the reason the UPlan costs more is because of higher health risks (the UPlan population is sicker) than the Medica book of business population.

Mr. Roberts asked about the member paid out of pocket percentage for Medica's book of business. On average, stated Ms. Reger, member paid out of pocket percentage for their book of business is 12% - 15% as compared to the University, which is at 4.2%.

Ms. Reger stated that UPlan costs increased by almost 10% from 2010 to first quarter 2013. This relatively minimal increase is likely due, in part, to the large number of people who are enrolled in Elect/Essential, which is a care system driven plan.

Regarding member feedback, Ms. Reger walked members through the feedback the University solicited. Of the 712 responses, 457 or 64% were satisfied with the plan. Additional feedback included:

- A slight increase (1%) over 2012 in billing and claims issues.
- Communication/product knowledge concerns ticked up to 10% from 7% in 2012. (In Ms. Reger's opinion, sometimes people elect a plan thinking they can make it fit their needs, but it usually does not end up working out that way. People need to understand the plan options before they elect one plan over another.)
- Network access (e.g., mental health, substance abuse) issues decreased by 2% from last year.
- Referral problems totaled 5 this year or 1% as compared to last year when there were 7 problems. (Referral problems can result from members not understanding the product they chose in terms of how referrals are handled).
- Miscellaneous issues, e.g., copays, premiums, website, additional benefit coverage, totaled 112 or 16%, the same percentage as last year.

Ms. Reger continued to share additional member feedback and Medica's response/next steps.

Lastly, Ms. Reger highlighted Medica's 2013 commitments to the University:

- Bi-monthly meetings with the University's benefits team.
- Conduct annual member satisfaction survey (fall 2013).
- Business and Community Economic Development (BCED) contribution.

- Continued support and integration with the University's wellness partners, Nurseline and StayWell.
- Continued joint Medica and University of Minnesota customer service training.
- Continued partnership with the University.

Professor McGehee asked what a UPlan participant would need to do if he/she wants to enroll in an ACO plan. Ms. Reger stated that the University and Medica will be offering educational sessions to help UPlan members understand the ACO product. When members go online to enroll, they will be prompted for a network number. This number designates which ACO the person is enrolling in (Fairview, Park Nicollet, Ridgeview, HealthEast Care System). Ms. Reger emphasized that all family members must enroll in the same ACO. Unlike Elect/Essential where family members can chose different care systems, all family members must enroll in the same ACO. Ms. Chapin added that the ACO election is an annual election and participants cannot change their election monthly as they can under Elect/Essential.

Professor Schultz requested that in the future the annualized per member per month claims costs include member out of pocket costs and plan costs as well as provide trend information comparing the University to Medica's book of business. Mr. Chapman stated that similar information (per employee per year basis) is provided to the Board of Regents and is also shared with the BAC annually. Professor Schultz stated that she is interested in looking at the health of UPlan members over time so that is why she wants the comparison data. Mr. Chapman stated that he can see how this information could be useful and promised to share it with the committee going forward.

Ms. Horazuk, president, AFSCME Local 3800, noted that it is her understanding that the ACO option will only be available to UPlan participants in the metro area, but not Greater Minnesota. Yes, stated Mr. Naylor, that is currently correct, but Medica is in negotiations with non-metro care systems to create ACOs in Greater Minnesota.

Ms. Enrici asked what happens if a UPlan member has a child away at college or is covering adult children up to age 26 and elects an ACO. The ACO option, noted Ms. Reger, would not be a good option for UPlan members who live outside the metro area. All family members must access the same ACO network. If the adult child is out of state at school, for example, they would use the ACO travel benefit to access medical services. Ms. Enrici stated that this needs to be made very clear to potential ACO enrollees.

Professor McGehee asked what would be the difference in how he were treated if he chose the ACO option and elected HealthEast versus choosing the HealthEast care system under Elect/Essential. Mr. Naylor stated that, as a patient, there would be no difference. The care system would not change its quality of care for a patient coming in for service. The difference will be in the convenience services, e.g., outreach and work with member on wellness activities, and will focus on the consumer experience. When seeing a doctor, the member will receive the best care possible regardless of which product he/she has, e.g., ACO, Elect/Essential. Medica is providing the care systems

with a lot of data and analytics and working with them to improve the health of their entire patient populations.

Professor McGehee asked if care systems are going to continue to provide the same services to patients, and, if so, how are they going to save money. Mr. Naylor stated that the care systems will drive efficiencies across the entire system. Because Medica will not have all care systems in a given service area in its ACO options, participating care systems will have a market share advantage. The care systems will make investments in the hopes of getting more members and getting them for life. Becoming an ACO is a business decision for the care systems. Professor McGehee stated that this model reminds him of the old HMO model and he believes that once they get a large number of members that they will cut back on the services they offer. He added that initially he was excited about the ACO model but the more he hears it sounds like a ploy for getting members.

Ms. Ebert concurred with Professor McGehee and asked if ACO members, for example, who have access to same day service, what will happen to patients who are not in the ACO, will they get next week service. Or, what if a patient doesn't like the specialists in the ACO network they have chosen? Mr. Naylor stated that ACOs are not a good choice for everyone for a variety of reasons. Medica's commitment to the University is that when the ACO option is rolled out to the University community, it will educate the University population to help people make informed decisions about whether an ACO is the right choice for them.

Mr. Watt thanked the Medica representatives for their presentation. Next, he called on Ms. Enrici, Mr. Roberts and Mr. Swanson to summarize the comments they collected. Mr. Roberts stated that he reviewed the Insights and HSA comments. A fair number of former HealthPartners members are enrolled in Insights and overall they expressed satisfaction with Insights. Regarding the HSA comments, of the 13 comments received, four complained about Wells Fargo Bank and how they handled their money. Mr. Swanson noted that he reviewed Choice National and Choice Regional. Overall, the Choice Regional comments were positive and many of the negative comments had to do with plan design versus the actual product, e.g., copay too high. Similarly, the biggest complaint about Choice National was the copay. Ms. Enrici noted that she reviewed the Elect/Essential comments, and overall people were satisfied. The number one complaint regarding Elect/Essential was about referrals, another plan design issue. Other complaints included but were not limited to multiple copays for people with chronic conditions, poorly designed website, enhanced vision benefits, and lack of alternative medicine providers.

Ms. Chapin noted that all members who had concerns that left their contact information were contacted by a member of Ms. Pouliot's team. Ms. Pouliot stated that while she doesn't have statistics with her, the benefits specialists followed up on a number of cases, many of which were able to be resolved. Mr. Chapman stated that he continues to find it striking that a number of employees do not realize that Employee Benefits is available to help them. Employee Benefits welcomes and encourages members of the University

community to contact them with their benefit-related issues. He suggested looking into how to get the word out to employees about the services that Employee Benefits offers. Ms. Ebert suggested putting a link on people's paychecks to a form that employees can fill out and submit to Employee Benefits.

Ms. Enrici also recalled receiving a fair number of complaints about people receiving both a facilities charge and a copay. Ms. Chapin stated that Employee Benefits is aware of this issue and learned that the reason it is billed this way has to do with Medicare rules. She stated that Employee Benefits will continue to look into this matter further.

III). Mr. Watt introduced the next agenda item, continued discussion of proposed changes to the benefit plan design. Two handouts were distributed to help facilitate the discussion.

After consulting with a number of different groups on the proposed plan design changes, noted Mr. Chapman, most groups agreed with the need to have a cost differential between primary and specialty care copays, but thought the $25/$40 differential proposed for the base plan was too much. Additionally, Professor Feldman had noted that putting high tech imaging services (MRIs/CT Scans) under the deductible would actually lower the patient responsibility for these images when compared with the current copay structure that is in place now. Based on his input, Employee Benefits modeled a couple of other copay options:

- Proposal #1: Reduce the primary care copay to $20 and the specialty care copay to $35, but introduce a $175 copay for high tech imagining services.
- Proposal #2: Keep the primary care copay at $25 and have the specialty care copay be $35, but introduce a $50 copay for high tech imaging.

The current proposal on the table is a $25 primary care copay, a $40 specialty care copy and no copay for high tech imaging; MRIs and CT scans would be put towards the member's deductible.

Mr. Chapman asked members their opinions on the three proposals, current, proposal #1 and proposal #2. Mr. Roberts stated that he does not like proposal #1 with the $175 copay for high tech imaging services. He would prefer the current proposal or proposal #2. Mr. Chapman stated that the $175 copay would not be unusual across the industry in terms of the out of pocket exposure people frequently have for high tech imaging services. Professor McGehee reminded members about the committee's commitment to being mindful of the impact its decisions have on the sick people in the plan. Lowering the copay for all plan members but charging the sick who need these services seems to fly in the face of the committee's "green" philosophy. Mr. Chapman stated that it is an interesting dilemma. A substantial high tech imaging copay could have a deterrent effect, and may result in plan members asking for an x-ray instead. As a result, the deterrent effect could cause a behavior change over time.

Ms. Ebert stated that doctors usually order high tech imaging services for a reason, and raising the copay so high punishes people that need these services. Ms. Ebert went on to

say that $175 for a copay is a lot of money for people who do not make a lot. Having to pay a $175 copay could mean people would decide to forego buying their medications. In response to these comments, Mr. Chapman noted that Ms. Ebert makes this argument all the time, but the University's utilization statistics simply do not support her claims that people are foregoing needed care. Ms. Horazuk stated that AFSCME Local 3800 regularly hears from members who say they are deferring health care because of the copay costs. Rather than looking to utilization statistics to see if people are deferring care, the University should be asking UPlan members directly. If lower paid employees stop seeking care, it will be catastrophic for the University.

Mr. Errickson asked about the average number of MRI/CT scans in a year. Mr. Gourde, health programs financial manager, stated that there were not many scans relative to office visits. For the year he pulled the data, there were slightly over 2,000 scans in that year, which is well under one per person per year. Ms. Enrici added that besides the cost, there is also the pain issue to consider. In her opinion, it would be better to identify and resolve the problem sooner rather than later.

After a fairly lengthy discussion regarding the pros and cons of the three copay proposals, Ms. Fulton made a motion requesting that Employee Benefits give serious consideration to proposal #1 ($175 deductible). Not hearing a second to her motion, Ms. Fulton made another motion and asked Employee Benefits to give proposal #2 serious consideration. Mr. Roberts seconded this motion. To be clear, stated Mr. Chapman, the motion is saying that the committee prefers proposal #2 over the current proposal, where there is no copay for high tech imaging (under the current proposal these services would be charged against a member's deductible). Ms. Chapin clarified that deductibles apply to all non-copay items, e.g., lab charges. Under proposal #2, noted Mr. Chapman, MRIs and CT scans would not be subject to a deductible, but would have a $50 copay (base plan). Ms. Ebert requested that as non-voting members of the BAC that the minutes reflect that the unions are completely opposed to this motion. Mr. Swenson, representing the Teamsters, said the Teamsters also oppose the motion. Ms. Horazuk called on BAC members to seriously think about their recommendation to the administration. This is a significant cost shift to employees overall, and particularly impacts the lowest paid employees and those with chronic health conditions. She went on to voice another concern, which was that the ACO option will not be available to employees in Greater Minnesota. Mr. Chapman interjected that this concern is off point as it relates to the motion being discussed. He suggested Ms. Horazuk raise this concern when the time is more appropriate. Mr. Chapman also noted that the copay options that have been proposed are cost neutral and are not a cost shift from the employer to employees. The cost shift that the bargaining units are objecting to is happening overall in various ways as a result of having to move costs outside of the plan. Because costs need to be shifted out of the UPlan because of the ACA, these proposals represent different ways of distributing these costs among employees, and it is not a matter of whether employees or the University will pick up more or less of the costs in the plan. Professor McGehee requested that the minutes also reflect that voting on this motion does not mean that members endorse any of the three proposals that have been put forward. He used the analogy that the committee is being forced to choose between dying by firing squad or being hung.

In response to a question from Mr. Jameson about whether labs are applied towards the deductible in all the proposals, Ms. Chapin confirmed this and stated that this is because labs are non-copay items. Mr. Chapman clarified that all three proposals have deductibles, but proposals #1 and #2 have copays for MRIs and CT scans whereas under the current proposal, charges would be applied towards the deductible.

In response to a question from Ms. Enrici, Ms. Chapin explained that primary care providers are general practitioners, internal medicine providers, pediatricians, and OB GYN physicians. In addition, therapists, e.g., physical therapy, occupational therapy, speech therapy, mental health therapy, chemical dependency, chiropractic care and acupuncture. All e other providers will be considered specialisst in the UPlan.

Hearing no further discussion, Mr. Watt called for the vote on the motion to have Employee Benefits seriously consider proposal #2. Initially, the vote was four in favor and four opposed. Then, a few minutes later, Professor Loper joined Professor Litman and abstained from voting; as a result, the motion carried. Given the closeness of the vote, Mr. Chapin stated that he would be interested in hearing other ideas that members have that Employee Benefits could potentially model. A few ideas were mentioned but, unfortunately, most were not feasible, in part, due to system limitations at Medica. Mr. Chapman noted that Medica's system requires that a service either have a copay or a deductible (or deductible plus coinsurance) but is unable to handle a deductible and a copay. Ms. Lovro then suggested modeling a minimal increase in the deductible of each plan in order to keep the copays lower. Mr. Chapman stated that Employee Benefits would be happy to model this idea, and bring it back to the committee when they meet later this month.

Rather than moving on to talk about the change in the 2015 out of pocket maximum, Mr. Chapman suggested letting Ms. Horazuk voice the concern she tried to raise earlier when the motion was being discussed. Ms. Horazuk stated that her concern about the ACO option, a low cost alternative to the base plan, is that it will not be available to employees in Greater Minnesota. AFSCME represents people across the entire state and a lot of the concerns it hears from its constituents come from those living in Greater Minnesota. She added that she recently attended a forum at the Center for the Study of Politics and Governance (http://www.hhh.umn.edu/centers/cspg/events/2013/healthreformseries2013.html), which addressed health care costs overall and ACOs. One of the panelists from the Urban Institute, Dr. Berenson, commented that he did not believe the ACOs would lead to premium reductions in the future because as soon as they gain market share, they will raise their prices. With respect to ACOs not being offered outside the metro area, stated Mr. Chapman, the University cannot create ACOs where they don't exist. The ACO has to be a new service/delivery model that is adopted, embraced and created by a care system. The core idea behind the ACO concept is improving the health and wellbeing of a population for a lifetime or population management. Therefore, in theory, the ACO model should reduce the cost of health care and, in turn, reduce premiums. The University is faced with a choice in this ever-changing health care market to either offer

ACOs where they are available, or not offer ACOs and pay more because people in Greater Minnesota do not have the same access at this time. Ms. Enrici noted that the salaries of non-metro employees are predicated on the notion that it is cheaper to live in Greater Minnesota than in the Twin Cities. If the health insurance costs of those in Greater Minnesota go up and the costs in the metro area go down because they have access to ACOs, Greater Minnesota residents are losing. This is a salary and a fairness issue. Professor McGehee stated that in his opinion, the more he hears about ACOs, the more they seem like the old HMO model.

Before adjourning, Mr. Watt called on Ms. Horazuk to briefly provide information on the AFSCME and UEA letter that these groups are sending to President Kaler. Ms. Horazuk noted that the letter opposes the proposed UPlan cost shifts to employees that the University claims are necessary because of health care reform, which they adamantly do not believe. She welcomed any others who would be interested in signing on to the letter, which will be sent soon.

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

Renee Dempsey
University Senate