BENEFITS ADVISORY COMMITTEE (BAC)
MINUTES OF MEETING
May 21, 2015

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

PRESENT: Tina Falkner (chair), Dale Swanson, (vice chair), Jean Abraham, Sophia Benrud, Karen Connaker, Amos Deinard, Jody Ebert, Pam Enrici, Ken Horstman, Theodor Litman, Rodney Loper, Amy Monahan, William Roberts, Karen Ross, Terri Wallace

GUESTS: Medica Team

OTHERS ATTENDING: Mary Austin, Karen Chapin, Betty Gilchrist, Kathy Pouliot, Ryan Reisdorfer, Luke Roszak

REGRETS: Carl Anderson, Joe Jameson, Susann Jackson

ABSENT: Fred Morrison, Jennifer Schultz

[In these minutes: Medica Plan Review; BAC Review of Employee Comments regarding Medica]

1. WELCOME & EMPLOYEE BENEFITS UPDATE

Dr. Falkner, chair, convened the meeting then introduced the speakers for the Medica Plan Review.

2. MEDICA PLAN REVIEW

Paul Crowley, vice president, commercial client retention and growth, Medica, began the presentation and provided an overview of the presentation. He encouraged members to ask questions throughout the presentation.

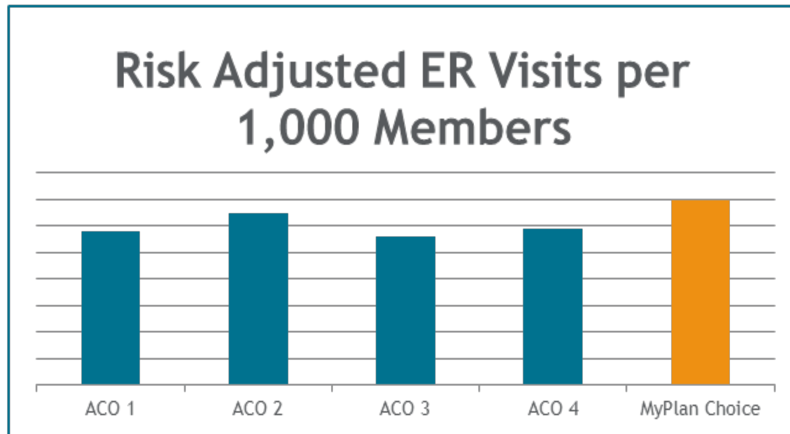
Kim Bachmeier, senior director, Contact Center Operations, provided a customer service overview:

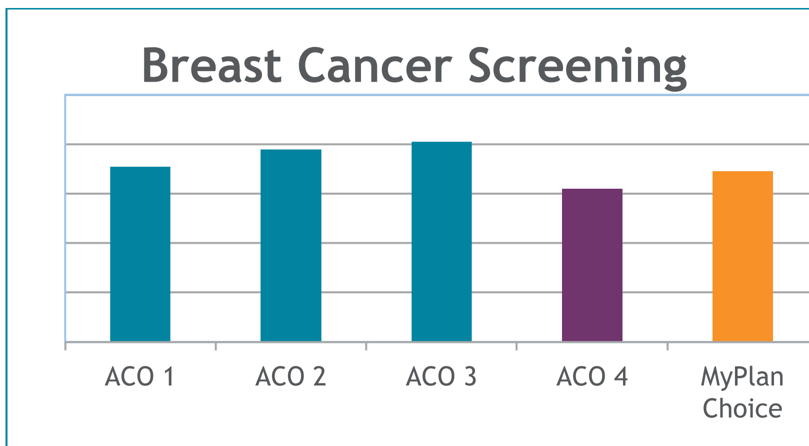
- There was a trend in provider and co-pay questions in member calls.
- Call quality is measured in technical skills and soft skills. Team members are audited ten times per year. Last year they received a 4.88 out of 5 on their member survey results.
- Member Service – Referrals into My Advocate:
    - My Advocate is:
        - A knowledgeable resource who “knows me” – the member doesn’t have to repeat their story every time

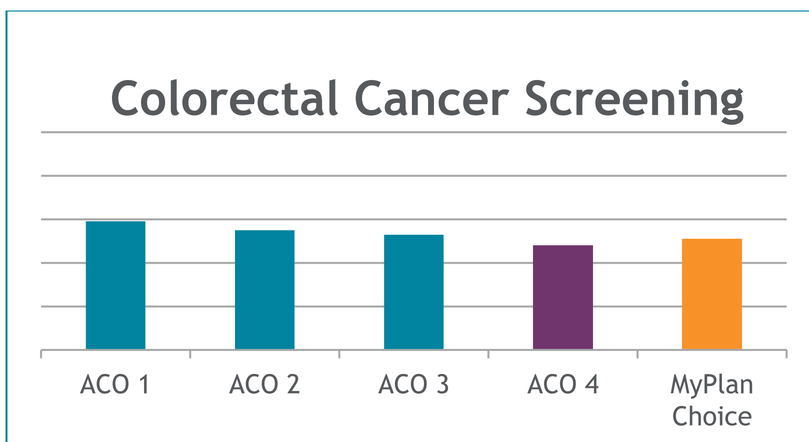
        - Partner to help navigate the system
        - Someone who represents the interest of the member and understands their needs
    - Members are referred from their employer if they have especially complex issues to be addressed. This service is meant for a limited group of individuals as needed.
    - Designated and experienced Health Plan Specialists serve as advocates for members with complex concerns.
    - Single-point of contact offers consistent and personal support
- Employer Service – Enhanced Support for U of M Benefits Team
    - Designated Service Center Representatives serve as direct contacts to help U of M Benefits team provide faster turnaround time to members.

Lisa Spann, director, Market and Product Efficiencies, presented information in regard to the Accountable Care Organization (ACO). In response to a question, Ms. Chapin explained that this option is available to early retirees on the UPlan.

- ACO Membership Trend for Medica overall
    - Over 60 Employers
    - Variety of sizes and industries
    - 50% of eligible My Plan members choose an ACO
- Most employers do not offer Elect/Essential plan in addition to the ACO.
- Partnership Health Management Model: Delivering Outcomes
    - Comprehensive membership information is sent daily to care systems.
    - Sharing data and analytics requires a member's consent.
    - Health Risk Assessments are used to help care systems target outreach to members based on their needs.
    - Medica is stratifying the population of the ACO members and coordinating their care.
    - In the ACO plan, Medica facilitates a closer relationship between the member and the provider. ACO members take a health assessment when they join if they choose, and this information is used to help them be categorized. If the member is determined to be high-risk, this information is shared with providers and outreach is then coordinated through this partnership with providers.
- Best Practice Alert
    - A Best Practice Alert (BPA) was added to Fairview's electronic medical record in August 2014, for ACO members only.
    - During the primary care visit, a BPA pops up on the provider's screen:
        - Providers are alerted to the health and wellness services available to University members of the ACO
        - With one click, they have access to the University of Minnesota's wellness resources and information
        - Since roll-out, the BPA has been activated 2,299 times

- 1,510 members that moved to an ACO plan in 2014, saw a decrease in Allowed Cost $PMPM and Health Risk
    - There are different financial models for each care system.
    - There was a 28% cost decrease and a 32% risk decrease for those members that switched to the ACO in 2014.
- Quality Measurement
- 

- 

- 

Dan Trajano, M.D., vice president, Population Health, provided the following answers to members' questions:

- It is important to educate members on the advantages and the limitations of the providers. Over the course of the past few years, enrollment has been increasing.
- There is not an accreditation process that is done exactly, but as a result of the ACA, providers have been encouraged to become ACOs.

Ken Dickson, director, Health Strategy Consulting, Medica Health Plans, presented the following UPlan Highlights:

- Utilization and Cost Summary
  - ACO membership has grown from 5% to 9% from January 2014 to March 2015
    - ACO members have experienced improvement in costs and health risk since migrating into these plans
  - Allowed cost decreased 3.3% from 2013 to 2014
    - The number of high cost members in 2014 decreased by 10% from 2013
    - Allowed cost of non-high cost members in 2014 decreased in all plan types from 2013
  - Member cost sharing increases were seen in all plan types
  - Choice is now the most expensive plan option, exceeding Insights in 2014
- ACO and HSA members are getting younger, Elect/Essential is stable since 2012
- Allowed costs and plan paid PMPM decreased
  - Increased member out of pocket, decreased cost of care
  - Allowed Cost = what the plan is paying in addition to what the members are paying
  - Mr. Horstman said that one of the challenges going forward, some members need a wider network than the ACO and would be benefitted by the HSA, but it is difficult to educate members in an individualized way.
- 10% decrease in "High Cost Members" from 2013 to 2014 is a cost driver
  - High Cost is defined as >$50,000 Total Allowed Costs in 12 month period
  - Are they concerned that members became lower cost because they were not accessing care appropriately?
    - Mr. Dickson explained that high-risk members are identified for case management services, and especially if they are in the ACO plan, they have significant contact with their providers. For these reasons they are not concerned that these members were not receiving needed care.

Health Management Initiatives:

- Medical Pharmacy
  - Expanded list of specialty medications requiring prior authorization for drugs administered in:
    - physician's office
    - outpatient setting
    - home infusion
  - To ensure evidence-based, nationally recognized clinical criteria and guidelines are being followed.
  - They will follow up with data that shows the pharmacy costs that are paid as part of the medical plan.
- Inpatient utilization management – Inpatient stays reviewed for:
  - Appropriateness of care
  - Care setting
  - Length of stay
  - Discharge plan
- Joint Replacement Surgery
  - Patient-friendly recovery with streamlined billing
  - Orthopedic providers partner with non-hospital aftercare venues for:
    - Upgrade recovery experience
    - Avoid high cost of hospital stays

Nancy Stieg, strategic account executive, presented UPlan member feedback. She explained that they surveyed the full ACO and HSA populations and highlighted the following:

- There was a decrease in overall satisfaction rate from 86% to 81%. She noted that the drop in satisfaction with the ACO plan could be the result of members needing more education about the limitations and benefits of the plan.
- Accomplishments and Commitments:
  - Medica met with BAC sub-committee to gather feedback on EOBs and identify opportunities
  - Created Tip Sheets to help understand the EOBs
  - Modified the EOB to remove ALL CAPS from appeals language to make it easier to read and added information about where to find the EOB Tip Sheet
  - Developed a Common Reason Code explanation to describe why a service wasn't covered
    - This has been posted to mymedica.com/UofMN
  - Made Preventive Care Tip Sheet available
  - Developed a process for members who want more detail than is included
  - Newsletter articles (Re-registering on medica.com; option for electronic EOBs; using MyChart)

  - The Medica Foundation has supported the University with 23 approved grants totaling $5.5 million between 2003 and 2014
  - BCED commitment of $1.8 million through 2014. Commitment for 2015 is nearly $400,000. Since 2007, 190 students have benefited from scholarships and more than 20,000 hours have been funded for internships and consulting projects.
  - Total Cost of Care Contracting (TCOC) resulted in $986,354 returned to the University since these contracts have been in place
  - Healthy Savings program has saved more than $19,000 for University employees since implementation in 2013
  - Continued support and integration with the U of M wellness partners, including Nurseline and Staywell
  - Customization of networks, communications, and processes

3. BAC REVIEW OF EMPLOYEE COMMENTS

Ms. Wallace presented an analysis of member comments on the BAC survey in regard to the Medica Elect/Essential survey responses. Members discussed the following points after reviewing the comments:

- Total responses: 422
  Positive: 234
  Negative: 190
- Ms. Chapin explained that the Benefits newsletter was mailed to home addresses and through internal campus mail.
- Ms. Chapin said that on active plans, members should not be paying two co-pays. She is not sure if this arrangement can be made for the over 65 retiree plans.
- In response to a question, Ms. Chapin clarified that if a referral is within the member's care system, it should be done without a problem. If the referral is for a provider outside of the network, a referral coordinator within the care system is needed. If the provider is outside of the plan completely, Medica has to approve it.
- Mayo is not included in the Elect/Essential network or the ACO.
- Dr. Falkner suggested that language be provided to members to explain the referral process.

Ms. Enrici provided information in regard to the responses related to the remaining Medica plans. She distributed a handout and commented on the following:

- Total responses: 70
  Positive: 42
  Negative: 30
- ADP was mentioned several times as being difficult to communicate with.
- Those with the National plan were most satisfied.

- Members cannot change plans mid-year if they are having a financial hardship, but they should call the Office for Employee Benefits to discuss options.

Hearing no further business, Dr. Falkner adjourned the meeting.

Jeannine Rich
University of Minnesota