BENEFITS ADVISORY COMMITTEE
MINUTES OF MEETING
DECEMBER 1, 2005

[In these minutes: Employee Benefits Announcements, Minnesota Community Measurement Presentation by Jim Chase, Election of 2006 – 2008 BAC Chair & Vice Chair]

[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), William Roberts, Jody Ebert, Curt Swenson, Don Cavalier, Michael Marotteck, Carla Volkman-Lien, Carl Anderson, Richard McGehee, Fred Morrison, Peh Ng, Rodney Loper, Dann Chapman

REGRETS: Linda Aaker, Karen Wolterstorff, Eileen Zeitz, Joseph Jameson, Amos Deinard

ABSENT: Pam Wilson, Peter Benner, Rhonda Jennen for Rita McCue, Carol Carrier, Frank Cerra, George Green, Theodor Litman, Keith Dunder

GUESTS: Jim Chase, executive director, Minnesota Community Measurement

OTHERS: Linda Blake, Ted Butler, Karen Chapin, Ronald Enger, Nancy Fulton, Shirley Kuehn, Kathy Pouliot, Jackie Singer

I). Gavin Watt called the meeting to order.

II). Employee Benefits Announcements:

a). Dann Chapman noted that on December 8, 2005 Employee Benefits will provide the Board of Regents Faculty, Staff & Student Affairs Committee with a semi-annual update on the UPlan, and share information on the Wellness Program/health improvement initiatives.

b). Dann Chapman reported that Employee Benefits staff uncovered an error in open enrollment dental rates. The published rate for the Twin Cities and Duluth tier 4 dental was $17.30 per pay period, but in Greater Minnesota the published rate was $19.20. It remains a mystery how this error occurred, and how it went unnoticed for so long. Because it would be dangerous to go into the open enrollment system while it is still operational, Employee Benefits will retrospectively correct this mistake. Besides notifying and correcting the rate for those employees that chose this coverage, a letter will be sent to those employees that were eligible for this plan, but did not choose it. This

correspondence will inform these employees about the pricing error, and give them an opportunity to change their election.

c). Karen Chapin distributed copies of the brochure promoting the UPlan Wellness Program, which will be administered by Harris HealthTrends. The idea behind this brochure, *HealthConnections*, is that employees will ÔconnectÕ to wellness programming through a wellness assessment. While most employees who choose to complete the wellness assessment will likely do so on-line, a paper option will also be available. A $65 incentive will be given to employees that complete the assessment.

The wellness assessment will then be used as a starting point for employees and their dependents to take advantage of several lifestyle and disease management programs. These programs vary in length and give participants the opportunity to engage in either on-line, self-paced health improvement programs, or work with degreed health professionals over the phone.

Before closing, Ms. Chapin also noted the following:

- Effective January 1, 2006 UPlan participants will have access to a 24-hour nurse line, *Ask Mayo Clinic*.
- *Take Time* activity logs can still be turned in for a University Bookstore certificate.

Questions directed to Ms. Chapin included:

- What do employees need to do to receive the second $65 incentive? Ms. Chapin stated to receive the second $65 incentive, employees can:
    - Complete either a phone or web-based lifestyle management program.
    - Complete a disease management program.
    - Participate in the *Health Action* program that will be rolled out next fall. This program will be similar to the *Take Time* program.
- Will the $65 incentives be taxed? Yes.
- Can an employee who is already participating in a lifestyle or disease management program through his/her clinic receive the incentive without participating in one of the Harris HealthTrendsÕ programs? No, employees must participate in one of the programs offered through Harris HealthTrend programs to receive the incentive. UPlan participants, however, are welcome to continue to work with their respective clinics in health improvement programs.
- When do employees receive compensation for participation in one of these programs? Employees will receive compensation once they have graduated from a program.

Ms. Chapin added that Employee Benefits will soon be recruiting for a new wellness program manager. Members who know of individuals interested in this position should contact Linda Blake (blake@umn.edu) for a job description.

d). Open Enrollment – In response to an inquiry by Dann Chapman members shared their observations regarding this yearÕs open enrollment process:

- Explore improving communications with that portion of the University population that does not use email as their primary means of communication.
- Improve the user-friendliness of the open enrollment website.
- Investigate why some employees, (and not only new employees) did not have passwords set-up. Passwords are required to access the open enrollment website.
- Amazement by some University employees that failure to make medical and dental elections meant no coverage.
- Confusion over the HRA/HSA options.
- Puzzlement over the plan names.

Mr. Chapman reported that from his perspective overall the open enrollment process ran smoothly, however, he did hear two major complaints:

- The open enrollment website was not as user-friendly as it could have been.
- Employees had problems finding clinic numbers.

Mr. Chapman responded to these concerns by noting the following:

- The University decided to limit the number of modifications it made to the PeopleSoft and BenAdmin applications, and, to a degree, this decision impacted the user-friendliness of the open enrollment website. This decision was done as a cost saving measure. Mr. Chapman added that an upgrade to BenAdmin, a PeopleSoft module, is expected before next yearÕs open enrollment, and hopefully this will improve the user-friendliness of the site.
- The same system for finding clinic numbers was used last year as this year, and not one complaint was received last year. Difficulties in obtaining clinic numbers may have been attributable to the fact that an increasing number of computers have pop-up blockers installed.

Additionally, Mr. Chapman reported that Employee Benefits intends to explore how best to accommodate the multitude of browsers that are used by the University community in order to reduce the number of problems employees encounter when using the on-line open enrollment site in the future.

Mr. Watt added hearing a concern that because the 2006 Summary of Benefits was not yet available, it made it difficult to make informed election decisions. Mr. Chapman noted that the Summary of Benefits it not an informational document, which is to be prepared and distributed prior to open enrollment. The Summary of Benefits is a certificate of coverage that is distributed to individuals once they have made an election.

III). Mr. Chapman introduced Jim Chase, executive director, Minnesota Community Measurement. Mr. Chase began by noting that Minnesota Community Measurement was established in 2002 and is dedicated to improving the quality of health care in Minnesota by providing public reporting. The impetus for the establishment of Minnesota Community Measurement relates to the fact that there exists a significant gap in the quality of care that is being delivered throughout Minnesota. There is a lot of room for improvement when quality data is made public.

Mr. Chase noted that medical groups are currently Minnesota Community MeasurementÕs largest customers primarily because they are interested in learning how they compare to their peers. A challenge facing Minnesota Community Measurement is to make sure its consumers e.g. health plans, patients, etc. are effectively using the information it produces. A New Yorker article, *The Bell Curve* (http://www.newyorker.com/fact/content/?041206fa_fact was referenced by Mr. Chase for members interested in more detailed information on this topic.

The data collected thus far by Minnesota Community Measurement indicates that there exists a significant variance between health plans in terms of quality measures. Ultimately the goal is to uncover why these differences exist and how the plans can unilaterally improve their performance.

The State of Minnesota is one of the first states to conduct a statewide, community driven review of its medical groups and to collect data that reflects its entire population e.g. data from all seven health plans operating in the state, fully-insured data, self-insured data, Medicaid data, and Medicare data. Currently, however, Minnesota Community MeasurementÕs data set has insufficient information from the following groups: Medicare Fee-For-Service, the uninsured and Medicaid Fee-For-Service.

Public reporting is important for several reasons:

- Improvement requires measurement.
- Provides recognition for health plans that are doing well.
- Motivates plans that are not doing well.
- Increases the desire by all plans to provide excellent patient care.

2005 results indicate that quality of care in Minnesota is improving. This in turn means that hundreds of people in Minnesota will avoid serious adverse outcomes. Medical groups, employers and payers are all taking notice of the results that are being published.

Examples of medical results that are being tracked by Minnesota Community Measurement include, but are not limited to:

- Diabetes
- Asthma
- Depression
- Childhood Immunizations
- Blood Pressure Treatment

The results measured by Minnesota Community Measurement are both outcome-based, and process-oriented. An on-going debate with the medical groups is whether or not they should be held accountable for circumstances that they cannot control e.g. did the patient take their medication. Minnesota Community Measurement believes that both outcome-based and process-oriented results are important because the ultimate goal is to have healthier patients.

Mr. Chase encouraged members to visit Minnesota Community MeasurementÕs new website at: http://www.mnhealthcare.org/. The site has a new home page with improved

navigational abilities. Additionally, starting this year, the site makes it possible to compare results between health care providers.

Issues for the future facing Minnesota Community Measurement include:

- Determining what information consumers will find useful.
- Deciding how to recognize results and encourage improvement by medical groups.
- Deciding upon new measures e.g. treatment for children with URI, optimal coronary artery disease (CAD), etc. There should exist consistent measures in order to reduce confusion amongst providers.
- Determining the level of measurement. Currently, Minnesota Community Measurement measures results at a medical group level versus an actual providerÕs performance. Individual provider level reporting would cost significantly more, and it is unclear whether the results would justify the additional expense. Many of the results that are being currently measured are system issues within a medical group rather than an individual physicianÕs performance.
- Incorporating new data sources e.g. hospitals, specialists, electronic medical records, etc.

Comments/questions from members:

- IsnÕt it possible that certain medical groups may have poorer results because they have more high-risk patients? This should this be factored in when rating performance. How does Minnesota Community Measurement select the patient data it decides to report on? Mr. Chase noted that Minnesota Community Measurement looks at all patients in a particular sample and these results are attributed to the medical group where the patient received most of his/her primary care. Recognizing that the system for collecting data will never be perfect, it is important to realize that this information is better than no information at all. This issue is of particular concern when it comes to coordination of care issues e.g. patients being seen at multiple sites.
- How is Minnesota Community Measurement funded? Mr. Chase stated that the Minnesota Community Measurement funding base is primarily made up of membership fees collected from the health plans and the Minnesota Medical Association. With the advent of collecting data via electronic medical records rather than getting this data from the health plans, a question for the future will be how should Minnesota Community Measurement be funded e.g. patient fees, provider fees, health plan fees, or a combination of all or some of these sources. Mr. Chapman added that the health plans have been primarily responsible up until now for funding this initiative because they recognize the value for the Minnesota community in improving quality of care.
- Please comment on the composition of the Minnesota Community MeasurementÕs Board of Directors. Mr. Chase noted that the volunteer Board is comprised of members representing employers, consumer representatives, health plans, medical groups, hospitals, and ex-officio representation by quality improvement organizations in the Twin Cities. The Board, according to Mr.

Chapman, is responsible for ensuring that Minnesota Community Measurement has a degree of independence from any particular entity e.g. the health plans. This then again raises the issue of how should this organization be funded.

IV). Gavin Watt opened the floor for nominations for a BAC chair and vice chair for the term July 1, 2006 – June 30, 2008. Professor Morrison nominated Gavin Watt for chair and Professor Dick McGehee for vice chair. Members unanimously endorsed these nominations.

V). Other Business: Gavin Watt announced that the December 15th BAC meeting would be cancelled. The next BAC meeting will be Thursday, January 19th, 2006 from 10:00 – 12:00 in #101 Walter Library.

VI). Hearing no further business, Gavin Watt adjourned the meeting.

Renee Dempsey
University Senate