BENEFITS ADVISORY COMMITTEE
MINUTES OF MEETING
MAY 6, 2010

[In these minutes: Medica Annual Review, Medical Coverage to Age 26, Additional Comments on Medica Review]

[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: Richard McGehee (vice chair and chair pro tem), Pam Enrici, Tina Falkner, William Roberts, Dale Swanson, Sharon Binek, Jody Ebert, Jennifer Imsande, Joseph Jameson, Carl Anderson, Judith Garrard, Fred Morrison, Michael O'Reilly, Rodney Loper

REGRETS: Gavin Watt, Sandi Sherman, Nancy Fulton, Michael Marotteck, Amos Deinard, George Green, Theodor Litman, Dann Chapman

ABSENT: Sara Parcells, Sam Firoozi, Carol Carrier, Frank Cerra, Keith Dunder

OTHERS ATTENDING: Linda Blake, Karen Chapin, Betty Gilchrist, Ryan Gourde, Shirley Kuehn, Kathy Pouliot, Kelly Schrotberger, Sheri Stone, Curt Swenson, Jill Thielen

GUESTS: Medica representatives: Lynn Altmann, vice president, Customer and Provider Service; Dr. Charlie Fazio, chief medical officer and senior vice president; Christine Finn, vice president, Strategic Accounts; Judy Reger, senior strategic account executive; Dr. Kevin Ronneberg, medical director; and Christel Webber, senior strategic account manager

I). Professor Dick McGehee, vice chair and chair pro tem, called the meeting to order and welcomed those present.

II). Professor McGehee welcomed today's guests from Medica who were invited to provide the committee with a review of calendar year 2009. He turned to Judy Reger, senior strategic account executive, Medica, and requested she introduce her colleagues. Ms. Reger made the following introductions:

- Lynn Altmann, vice president, Customer and Provider Service
- Dr. Charlie Fazio, chief medical officer and senior vice president
- Christine Finn, vice president, Strategic Accounts
- Dr. Kevin Ronneberg, medical director
- Christel Webber, senior strategic account manager

Ms. Altmann began by explaining that the University has a designated team of customer service representatives that handle its calls. This team is comprised of 9 people, which includes a designated team lead, a University client specialist and a supervisor. Staff are provided with on-going training, and are incented for quality, availability to University employees, overall speed of answer, first call resolution rates, and customer satisfaction rates. Next, Ms. Altmann turned members' attention to a chart with customer service statistics.

Ms. Altmann then shared Medication Therapy Management (MTM) program information. The program was conducted from November 2009 through March 2010. Over 3,300 plan members were introduced to the program via the mail and over 1,100 were contacted by phone. In the end, 256 members expressed an interest in participating in the program. Program feedback was overall very positive.

Moving on, Ms. Reger shared information about the methodology behind the member satisfaction survey that Medica conducted. In 2009, Medica sent out 1, 268 random surveys and 216 were sent back, which represents a 17% response rate. Member satisfaction improved from 2008 to 2009. The areas of Medica's health plan garnering the highest satisfaction rating included the extensive network, friendly and prompt customer service, and accurate claims processing. The plan areas with the lowest satisfaction ratings included the Medica website, help finding a doctor, and easy to understand Explanation of Benefits. The 2010 survey will be sent out in September, and results will be shared with the BAC next year.

Professor O'Reilly, who collected and summarized a segment of the Medica comments, reported receiving comments about claims processing problems. Ms. Reger stated that a fair number of the claims processing complaints have to do with referrals. In a number of instances, members either do no know how to obtain a referral or the provider does not submit the referral on a timely basis. A majority of members are on the base plan, which is a referral-based product. This could be an educational opportunity for Medica to educate UPlan members on the referral process given Medica offers several different products to the University. Ms. Finn stated that this is a noted area of opportunity for Medica to work on improving its communication about referrals. Ms. Chapin agreed, and noted that in several instances, members are choosing the base plan when it clearly is not the right option for them.

Dr. Ronneberg then provided information on utilization trends. Using a series of charts and graphs, Dr. Ronneberg highlighted the following:

- The University's demographic profile matches very closely to Medica's commercial book of business.
- In terms of inpatient, outpatient and physician costs, the University's experience with physician costs compares very closely with Medica's aggregate numbers, and while the University's inpatient costs are slightly lower, its outpatient costs are slightly higher.
- Physician and professional visits increased slightly from 2008 – 2009.

- Urgent care/convenience care utilization ticked up slightly over 2008, but emergency room utilization dropped slightly. Getting the right care at the right place is key to controlling costs.
- Inpatient hospital utilization was up slightly over 2008, but when compared to 2007 utilization was down.
- Outpatient utilization has been trending up since 2007. In 2008, outpatient utilization was up almost 8% over 2007 and in 2009, outpatient utilization was up almost 7%. This increase can be attributed to several factors including but not limited to the number of cancer cases requiring outpatient evaluation, preventative screenings such as colonoscopies, etc.
- The top ten cost drivers for the University is not dramatically different from 2008 or from Medica's book of business.
- The University's predictive health risk mirrors that of Medica's book of business. Medica uses a tool developed at Johns Hopkins University to calculate this score.
- Medica not only focuses on people with disease, but strives to prevent and avoid disease for its members.
- There has been a drop in the percentage of individuals with certain chronic diseases at the University, e.g., depression, hyperlipidemia (high cholesterol), and hypertension (high blood pressure). While this is good news in terms of cost and experience, these are conditions that just do not go away, noted Dr. Ronneberg. The prevalence of these conditions will need to be monitored going forward. He had to explanation for this down turn.
- There was an increase in the number of high dollar claims from 2008 – 2009, particularly for members with claims over $100,000. The University's high claims are slightly higher than Medica's book of business.

Questions/comments from members:

- Why is the University's physician and professional utilization so much higher than Medica's book of business? Dr. Ronneberg stated that utilization can have several drivers such as plan design, disease profile, personal preference and utilization patterns. For example, some plan designs put more costs on the member, which results in fewer visits. Ms. Reger stated that the University's plan design is richer than Medica's book of business. She added that the University also continues to cover early retirees, but much of Medica's book of business no longer covers this population. Having said this, with age people tend to see doctors more often than when they are younger. Ms. Chapin stated that another factor may be that the University does not have any caps on preventive care whereas many other plans do.
- Regarding the University's comparative health risk score, could it be higher because the University has an older population? Yes, stated Dr. Ronneberg, the fact the University has early retirees in its plan could serve to skew the University's score relative to Medica's book of business.

Next, Dr. Fazio shared information about total health management approaches. He cited the DIAMOND initiative as an example of a collaborative effort in the community to change the delivery of health care for depression. Results indicate patients are getting

better care, and having better outcomes at the same time the cost of providing this care is less than that of those who are receiving traditional care.

In terms of how care is paid for, noted Dr. Fazio, Medica has been on a progression. Initially, there was pay for performance, which has evolved into other forms of payment approaches. For example, an increasing number of provider groups are being financially rewarded for successfully managing the care of their patients with chronic illnesses. Additionally, some of Medica's contracts have moved to a total cost of care model which puts an emphasis on providing the right amount of care in an efficient way so people are as healthy as they can be. Dr. Fazio turned members' attention to chart, which illustrated the results of a pilot in which four of Fairview's clinics are being compensated based on outcomes. The grant from Medica to Fairview changed how practitioners in these four clinics are being paid. Previously, practitioners were paid based on how many services they provided, which led to more services. Under this model, practitioners are paid based on health outcomes using a formula that takes into account how many patients are being managed by the clinic, the health of the patients, patient satisfaction with their care and clinic, and how efficiently care is delivered. Increasingly, Medica is paying practitioners based on total cost of care and quality. The goal over time is to pay for the care of a patient as opposed to paying for services.

A member commented that it must be confusing for a physician who accepts payment from a variety of third party payers some of who pay based on outcomes and others who pay based on the number of services that are delivered. Yes, stated Dr. Fazio, it is indeed confusing for physicians, and this was one of the reasons Medica gave Fairview the grant. Receiving the grant allowed Fairview to treat all their patients the same and focus on health and efficiency. The burden is on provider organizations to try and change their contracts in an effort to stop worrying about the number of services it should perform or what the unit cost is. Dr. Fazio stated that it is his sense practitioners feel better about delivering health care under this total cost of care model.

How will this total cost of care model impact the number of co-pays a patient has to pay, asked a member? Dr. Fazio stated that he believes once the success of this model has been measured, he expects the findings will show that the number of patient/doctor visits will be less because more will be able to be done over the phone, and more will be done with staff other than physicians, nurse practitioners and physician assistances. He added that he thinks there will actually be lesser co-pay requirements under this model.

In response to a question about whether under the total cost of care model a clinic would be more apt to experiment with different tests, treatments, etc., Dr. Ronneberg stated that this model pays providers for keeping their patients healthy. With this said, depending on the test or treatment, it would be reviewed and a decision about coverage would be made.

To conclude, Dr. Fazio stated that while Medica does not actually provide care, it continues to shape the environment that supports better and more efficient care.

Moving on, Ms. Reger briefly highlighted enrollment and claims costs information. Enrollment continues to increase year over year. Sixty percent of the University population is enrolled in the base plan, Medica Elect/Essential. In terms of per member per month claims costs, the University's costs are slightly higher than Medica's self-insured book of business. Ms. Reger asked the committee, however, to bear in mind that the University's plan design is richer than Medica's book of business for its self-insured products. A richer benefit set increases the per member per month claims costs. Also, she reminded members that the University also covers early retirees, which a lot of the Medica book of business does not. Overall, the per member per month aggregate plan cost increased from $310 in first quarter 2009 to $330 in first quarter 2010.

A member asked whether it would be possible to reduce the cost of the Medica Choice Regional plan given that the cost of living in outstate Minnesota, on average, is lower than living in the cities. Ms. Reger stated that Medica Choice Regional has the Mayo Clinic as part of its network. Also, because there is less competition in outstate Minnesota, Medica's provider discounts are not as great as in the Twin Cities where there is more competition. Lastly, there are only 1,200 people enrolled in the Choice Regional plan, and there are a few high claimants in the plan, which can skew the numbers. The Choice Regional plan has very rich benefits.

Christine Finn then shared information about Medica's continued commitment to and partnership with the University's Business and Community Economic Development (BCED) office. From the onset, the goal for Medica and the University has been to:

- Promote and advance the development of health care leaders.
- Provide continued support for community and economic development.
- Focus on health care needs of Greater Minnesota and other community priorities.

To date, Medica has allocated nearly $700,000 to the University for health care related research, internships, and scholarships for students.

Ms. Chapin added that as part of the RFP process, the University evaluates vendor commitments to the BCED initiative. It is important to the University that vendors keep their commitments to this initiative.

Finally, Ms. Reger took a few minutes to summarize the Medica comments that were collected. Seventy one percent of respondents voiced satisfaction with their plan. Examples of concerns and areas for improvement included:

- Billing claim problems (4%).
- Communication and product knowledge (9%).
- Network access, particularly for behavioral health and chiropractic services (4%).
- Referral issues (2%).

Additional member feedback included:

- Appreciation for the wellness initiatives offered through the University.
- Confusion with Medica's website.
- Request for vision coverage.

Professor McGehee thanked Medica for their presentation. He then turned to Professor O'Reilly and Professor Imsande, who collected and summarized the comments, to see if they had any comments. Professor O'Reilly thanked Employee Benefits for clearing up an issue related to acupuncture that had been raised. Professor Imsande stated that since the last time she summarized comments, she has noticed that the number of people wanting to practice due diligence has increased. An increasing number of people are asking for information so they can make smarter choices when it comes to their health.

In closing, Ms. Finn stated that Medica appreciates the opportunity to come before the Benefits Advisory Committee every year, and looks forward to continuing to work with the University going forward. The University of Minnesota partnership is very important to Medica.

III). Professor McGehee called on Karen Chapin to talk about extension of UPlan coverage for dependents to age 26. The University, noted Ms. Chapin, has decided to expand its coverage for dependents to age 26 for a variety of reasons:

- Encouragement from the federal government to expand the coverage.
- Several major employers have made the decision to expand their coverage to age 26.
- Employee Benefits has received a fair number of requests from University employees requesting expansion of the coverage.

Under health care reform legislation, expansion of coverage to age 26 would begin January 1, 2011, but the University intends to implement this coverage as of June 1, 2010, assuming implementation can be completed by that date.

Carl Anderson stated that part of the rationale for implementing this coverage has to do with benefits continuity of coverage, which will likely save administrative costs and claims costs.

As part of the health care legislation, noted Ms. Chapin, there are additional changes that the University is required to implement, which include:

- Offer coverage to married dependents (but not their spouses).
- As of March 30, 2010, the University was required to change its procedure so that irrespective of whether a dependent is a tax dependent, the University no longer needs to charge the imputed income for the cost of coverage.
- Dependents are technically not eligible for Flexible Spending Account (FSA) coverage after age 26, but FSA claims can be submitted through the end of the year that the dependent turns age 26.

Employee Benefits will have a mid-year open enrollment for this change. Information will be sent to people in the Employee Benefits' database who had covered dependents previously until they had to be taken off the plan, and Employee Benefits will also communicate this information in a newsletter that will be coming out dealing with health care reform.

Can a UPlan member change their plan as part of this mid-year open enrollment, asked a member? Ms. Chapin stated that Employee Benefits will consult with its attorney about this, but she believes the mid-year open enrollment will only apply to the addition of dependents to a member's current plan.

Ms. Chapin also noted that while expansion of coverage to age 26 definitely applies to medical coverage, Employee Benefits is checking to see if it applies to dental coverage as well. With respect to life insurance coverage, the University would like the dependent eligibility to read the same as it does for all others, but Employee Benefits needs to hear back from Minnesota Life to know if this will be possible.

In light of stipulations in the health care reform legislation, noted Ms. Chapin, the University will be able to purchase stop/loss coverage for unlimited coverage as of January 1, 2011, when the University's $5 million maximum coverage will be replaced with unlimited coverage.

IV). Other business: A member commented that Medica's commitment to the BCED did not seem like very much in light of the amount of business the University gives them. Ms. Chapin reminded the committee that the University only pays Medica administrative fees for processing claims. She added that Medica's administrative fees are significantly lower than HealthPartners' fees, and Medica's BCED commitment is much higher than HealthPartners' commitment. Medica's BCED commitment is the largest of all University vendors.

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

Renee Dempsey
University Senate