BENEFITS ADVISORY COMMITTEE
MINUTES OF MEETING
MAY 5, 2011

[In these minutes: Medica/HealthPartners' Negotiations Update, Retirement Incentive Option (RIO) Update, Wellness Assessment Deadline Extended, Medica Plan Review, 2010 UPlan Medical Financial Summary Highlights]

[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, Jody Ebert, Patricia Miller, Sara Parcells, Jennifer Schultz, Sandi Sherman, Nancy Fulton, Joseph Jameson, Michael Marotteck, Carl Anderson, Amos Deinard, Judith Garrard, Richard McGehee, Michael O'Reilly, Theodor Litman, Rodney Loper

REGRETS: Karen Lovro, George Green, Fred Morrison

ABSENT: Carol Carrier, Aaron Friedman, Dann Chapman, Keith Dunder

OTHERS ATTENDING: Karen Chapin, Betty Gilchrist, Ryan Gourde, Deb Kangas, Shirley Kuehn, Kathy Pouliot, Kelly Schrotberger, Sheri Stone, Curt Swenson, Laurie Warner

GUESTS: Medica representatives: Tom Davis, director, Customer Service Operations; Charlie Fazio, M.D., chief medical officer and senior vice president; Mike Lenz, vice president, Management Finance and Provider Strategy; Judy Reger, senior strategic account executive; Robin Savageau, director, Strategic Accounts; Christel Webber, senior strategic account manager

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

II). Mr. Watt reported that the negotiations between Medica and HealthPartners continue. He then called on Medica representative, Mike Lenz, vice president, Management Finance and Provider Strategy, to provide an update on the status of the negotiations. Mr. Lenz noted that Medica continues to negotiate with HealthPartners to determine where the HealthPartners' clinics will be available in the plan offerings. The Medica Choice network currently has some HealthPartners' clinics in that plan, but not all of them. Medica Elect/Essential also has a subset up HealthPartners' clinics, but, again, not all of them. Currently, only Insights by Medica includes all the HealthPartners' clinics. Medica and HealthPartners are negotiating to try and arrive at a price point so that there is minimal disruption to UPlan members in terms of price and access to HealthPartners' clinics. Based on yesterday's meeting with HealthPartners,

stated Mr. Lenz, it is clear that HealthPartners is interested in continuing in the University's medical program as a provider through Medica.

Professor Garrard asked whether only HealthPartners-affiliated clinics would be available in the UPlan or whether HealthPartners-owned clinics will also be available. Mr. Lenz stated that in the negotiations that are taking place, all HealthPartners' clinics, HealthPartners-owned and affiliated, are being discussed.

In response to a question by Ms. Sherman about whether HealthPartners' clinics will need to abide by Medica's referral policies, Ms. Reger explained that depending on what network(s) HealthPartners-owned clinics become a part of will determine what policies they abide by. For example, if HealthPartners becomes part of the base plan, they will become their own care system within that plan, and each care system sets their own procedures for how they want to handle referrals.

Ms. Chapin reiterated that it is clear that HealthPartners is interested in continuing in the program as a provider through Medica; however, what is unclear is the price they will agree to participate at. It is a very realistic possibility that HealthPartners may not be able to price their services at the base plan level, and, as a result, UPlan members who elect HealthPartners' coverage may need to purchase one of the UPlan's buy-up plans in order to have this access.

III). Ms. Chapin announced that the Retirement Incentive Option (RIO) election period closes on May 15, 2011. Employee Benefits is busy processing the applications it has received thus far.

Ms. Chapin also noted that the timeframe in which to take the Wellness Assessment has been extended through May 31, 2011. She encouraged members to let people know that they still have time to take the assessment and earn the $65 reward if they do so by May 31.

Ms. Ebert asked why the Wellness Assessment deadline was extended. Ms. Chapin explained that because the participation rate was down slightly over last year, and because the University wants to do whatever it can to boost participation this year as it transitions to a new wellness program model, a decision was made to extend the deadline until May 31.

IV). Mr. Watt welcomed representatives from Medica to the meeting. To begin, each Medica rep introduced himself/herself and talked about their role at Medica.

A PowerPoint presentation was distributed, which Medica walked members through. Salient highlights from the presentation included, but were not limited to:

- Medica has a dedicated team of 12 customer care professionals that work exclusively on the University of Minnesota account. Besides their initial training, which lasts 8 – 10 weeks, these individuals receive U of M specific training to learn the nuances of the University's plans. Each customer care professional is

incented and rewarded for customer satisfaction, quality and first call resolution rates. A chart highlighting the performance statistics was shared with the committee. In an attempt to deliver the best possible customer service, Medica has installed a new system, Behavioral Analytics, a program that uses speech and word identification to improve upon how customer care professionals respond to plan participants.

- Medica mailed out slightly over 1,300 annual member surveys in September 2010. Two hundred and thirteen responses were received, which represents a 16% response rate. Medica satisfaction remained approximately the same from 2009 to 2010 with 86% of members rating Medica 4 or 5 with 5 being the highest rating. In addition, 88% of respondents indicated they would likely re-enroll with Medica, which represents a 1% gain over 2009. Highest satisfaction ratings were seen in the areas of processing claims correctly, friendly and courteous customer service, and customer service representatives providing information the enrollee was asking for. The survey uncovered that Medica has room for improvement in the following areas: user-friendly website, helping members find a doctor, Explanation of Benefits. The survey helps Medica improve its service to the University.
- Fifty two percent of the University's Medica population is female, which compares to 51.3% female for the rest of Medica's self-insured book of business. Inpatient utilization was at 24%, which was up slightly from 2009, but still below Medica's aggregate at 27%. Outpatient utilization was at 30% and physician utilization was at 40%, both of which are higher than Medica's comparison group. Emergency room utilization was down from 2009 to 5.8% in 2010. Urgent care utilization was also down in 2010 compared to 2009.
- The top three diagnostic categories by cost for the UPlan were neoplasms, musculoskeletal system and cardiovascular. Based on claims data, Medica develops a predictive health risk score for all members. The University's health risk scores decreased in 2007, 2008 and 2009, but went up slightly in 2010. While it did not increase a statistically significant amount, it could likely be attributable to the amount of chronic disease in the University population. Health risk scores are driven by chronic condition incidents (e.g., diabetes, high cholesterol) year over year. The University population without a chronic disease diagnosis is 55%, compared to roughly 60% for Medica's book of business. In addition, the University population with a high or moderate health risk is about 50% and that is higher than Medica's book of business, which is at approximately 33%.
- 0.60% of UPlan Medica members have incurred more than $50,000 in claims in 2010, which is higher than Medica's aggregate at 0.37%. In addition, 0.27% of UPlan members have incurred $75,000 in claims and 0.34% have incurred over $100,000 in claims, which is higher than Medica's book of business at 0.18% and 0.25%, respectively. While the University has a slightly higher number of high claimants than Medica's book of business, this is most likely attributable to the fact that the University covers early retirees, which most of Medica's clients do not. In terms of high dollar member distribution from January through March 2011, 2,328 members had no claims, 19,885 members had claims between $1 -

$10,000, 2,231 members had claims between $10,000 - $50,000, 215 members had claims between $50,000 - $100,000 and 85 members had claims over $100,000. Dr. Fazio noted that every population has 1% - 2% of its members who have catastrophic events, which cannot be predicted. Because of the unpredictable nature of these events, it is very important to make sure these individuals get the right care, in the right setting, and that there are no barriers for people when it comes to getting the care they need.

- There has been an evolution in terms of how physicians are paid over the last 5 – 7 years in an effort to achieve high quality care at a reasonable cost. Over the course of the last 3 – 5 years, Medica has developed a total cost of care model that flows directly into the Accountable Care Organization (ACO) model, which serves to make the market function more rationally. Historically, physicians have been paid using a fee for service model, but that is changing to a total cost of care model. While Medica, the health plan, does not provide care directly, it is able to influence the kind of care that patients receive by informing care, aligning physician incentives appropriately and giving providers the information they need in order to improve health outcomes.
- Enrollment in the base plan, Elect/Essential, has continued to increase from 2008 to 2011. Currently, 61% of UPlan members are enrolled in the base plan, which is a very cost effective plan. Choice Regional enrollment has also increased slightly from 2010 and the HSA plan's enrollment has continued to grow. Enrollment in Choice National, on the other hand, has decreased slightly as has enrollment in Insights.
- Annualized per member per month claims costs (employer paid) for the University have continued to increase over the last three years while Medica's book of business per member per month claims costs have decreased. The reason for the disparity is that a number of Medica's clients have made benefit design changes in order to keep their costs in line and to keep their employee's contributions reasonable.
- Medica continues its commitment to the University's Business and Community Economic Development (BCED) program. Members' attention was turned to a slide that outlined Medica's contributions to this partnership in 2008, 2009 and 2010.
- A summary of UPlan member feedback was briefly shared with the committee. There was a high level of satisfaction on the part of UPlan members with Medica and the University's benefits package as a whole.

Questions/comments from members:

- Are Medica's customer care professionals fluent in multiple languages to handle calls from non-English speaking members? Mr. Lenz explained that Medica uses a language line, TransPerfect Translation, for calls that require an interpreter.
- Can employees view the claims information for their dependents on-line? To be able to view dependent's claims, dependents need to sign a release unless they are under age 12. Dr. Fazio added that these are industry standard rules and not specific to Medica.

- Does Medica offer the Explanation of Benefits in a paperless format? Yes, stated Ms. Webber, but this feature has not yet been formally rolled out to UPlan participants.
- How does the University's emergency room co-pay compare to Medica's other self-insured customers? Most of Medica's other self-insured customers have either a $100 co-pay or have moved to a deductible and co-insurance model, noted Ms. Reger. A majority of Medica's customers have been offering leaner benefits in this area.
- Please comment on the reason for the drop in urgent care usage for both the University and Medica's book of business? Ms. Reger speculated that the economy could be a factor, or that members are using the nurse line more or choosing to go to their physician. Dr. Fazio added that he believes the economy played a role in the drop in emergency room and urgent care visits in 2010. Across Medica's book of business, collective spending was down in almost every category or postponed. For many people, elective spending might be a visit to the emergency room or urgent care. With that said, Medica is also changing how it pays practitioners by paying for total cost of care, which may also serve to reduce demand for emergency room and urgent care services.
- Is it possible to track emergency room usage for non-emergency care? Ms. Chapin noted that a few years back when the University had a spike in emergency room utilization, Employee Benefits looked at the data warehouse claim data to determine if the emergency room was being used appropriately. Since then, the University's emergency room utilization has dropped. This is something Employee Benefits can look at again if need be.
- Does Medica have data that breaks down claims cost by the different coverage tiers, e.g., single, single plus spouse/same sex domestic partner (SSDP)? Please provide an accounting-based analysis for how new premiums are set. Ms. Chapin stated that Employee Benefits has this information, and from the data, the University knows that spouses cost more to cover than employees and employees cost more to cover than children.
- Does the Medica "health care home" incorporate both medical and dental records or is the "health care home" still just a medical model? Mr. Lenz stated it is still a medical model at this point, which does not include dental records. Behavior health claims, however, are included in the model.
- Is Medica participating in the health information exchange (HIE) project? More needs to be done to provide knowledge-based cost effective care like this. According to Mr. Lenz, Medica is a supporter of the MN HIE project and then elaborated on what Medica is doing to improve the flow of information in an effort to improve health outcomes and the quality of care members receive.
- Has the Medicare and coordination of benefits issue that a number of UPlan members shared been resolved? Yes, stated Ms. Reger, this issue has been resolved.
- How will Medica's participation in the UPlan's Fitness Rewards program change in 2012? Beginning in 2012, noted Ms. Reger, Medica will reimburse members with family health club memberships for two $20-a- month credits, assuming they meet the criteria for the program.

- There remains room for improvement on the part of Medica when it comes to handling billing/claims issues.
- Will the Explanation of Benefits (EOB) issue ever be resolved? Ms. Reger explained that EOB is not only a problem for Medica, but for many insurance companies. Medica continues to work on making its EOB as easy to understand as possible. As of April 2011, Medica now offers its EOB on-line so members do not need to receive a paper copy in the mail. Medica has been working with the University to decide when it wants to roll out this new feature.
- Please explore making it as easy as possible for people to transfer their medical records from HealthPartners to Medica.

Mr. Watt thanked the Medica representatives for their presentation. He then turned to Pam Enrici and Jennifer Schultz, the BAC members who collected comments from UPlan members about their experiences with Medica. Ms Enrici and Professor Schultz provided an overview of the comments they received. Both noted that overall UPlan members were satisfied with their coverage. Issues of concern were shared with Medica, e.g., billing problems, referral concerns, and they were encouraged to look into them. Ms. Chapin noted that whenever people who had issues left their contact information, Employee Benefits followed-up with them to resolve any outstanding problems. Ms. Pouliot affirmed this and noted that 99.9% of the issues that were forwarded to Medica were resolved. The suggestion was made that when plan feedback is solicited next year that it be made clear that members who would like follow-up on their issue need to provide contact information.

Professor Deinard stated that the Medicare and Medica numbers on retiree's cards are not fully displayed and this is a problem. Ms. Chapin stated that she would follow-up with Medica about this concern.

V). Ryan Gourde used the last few minutes of the meeting to highlight information from the 2010 UPlan Medical Financial Summary report. He noted that medical claims increased from 2009 to 2010 by 6%, and pharmacy claims increased by 3.6%. Other expenses, e.g., stop loss insurance, administrative fees, however, decreased by 1.3%, which results in a total trend of 5.1% for the UPlan. Nationally, fully-insured and self-insured plans, are trending in the 7% - 8% range.

Next, Mr. Gourde turned members' attention to a chart with UPlan medical inception to date cash position figures and pointed out that in 2002 when the UPlan was created that total expenses were $91.7 million and in 2010 UPlan total expenses were $207.1 million. As of December 31, 2010, the gross cash position of the UPlan was negative nine million (-$9 million), but when IB&R (incurred but not reported) claims are factored in this adds another $14.6 million to the total for a negative net cash position of $23.7 million. Mr. Watt pointed out that if the employee out-of-pocket costs are added in the total 2010 UPlan expenditures would increase by another $10 million or so.

VI). Mr. Watt stated that the next meeting will be May 19 when HealthPartners will present. Hearing no further business, Mr. Watt adjourned the meeting.

Renee Dempsey
University Senate