BENEFITS ADVISORY COMMITTEE
MINUTES OF MEETING
FEBRUARY 18, 2010

[In these minutes: AWG Update, Employee Benefits' Announcements, UPlan Pharmacy Benefit Policy, Trends in Pharmacy Economics]

[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, Sharon Binek, Jody Ebert, Jennifer Imsande, Nancy Fulton, Joseph Jameson, Michael Marotteck, Amos Deinard, George Green, Judith Garrard, Richard McGehee, Fred Morrison, Michael O'Reilly, Theodor Litman, Rodney Loper, Dann Chapman

REGRETS: Sandi Sherman, Carl Anderson, Joyce Carlson, Karen Young

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

OTHERS ATTENDING: Linda Blake, Karen Chapin, Vickie Courtney, Kurt Errickson, Betty Gilchrist, Shirley Kuehn, Kathy Pouliot, Kelly Schrotberger, Sheri Stone, Curt Swenson

GUEST: Dr. Stephen Schondelmeyer, College of Pharmacy

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

II). The last Administrative Working Group (hereafter AWG) meeting was spent planning for the 'next big thing,' or, in other words, strategic planning, noted Mr. Watt. Tomorrow, AWG members and select Employee Benefits staff will attend a retreat at Towers Watson to look at health care, the University's health plans and the future of the UPlan.

III). Dann Chapman, director, Employee Benefits, called on Shirley Kuehn to update members on the federal government's COBRA subsidy that has been extended. The Department of Defense Appropriations Act was passed in early 2010, noted Ms. Kuehn. This legislation resulted in the extension of the federal COBRA subsidy provided earlier under the American Recovery and Reinvestment Act, commonly referred to as the Stimulus. The current legislation extends the timeframe for which people may receive the COBRA subsidy from 9 to 15 months. It also extends the eligibility period until February 28, 2010. Employers, including the University, are required to send out obligation notices, which informs former employees about their rights to this subsidy.

Will the University see any cash flow from this legislation, asked Mr. Watt? Mr. Chapman stated that the subsidy goes to the individual, but the University will get reimbursement from the federal government for extending the discounted COBRA rates.

IV). Mr. Watt introduced the next agenda item, the UPlan Pharmacy Benefit Policy. Copies of the policy were distributed to members for their review. Mr. Chapman suggested revisiting this policy at a future meeting after people have had an opportunity to absorb it. He added that this policy came about, in part, at the urging of Dr. Schondelmeyer who believes that written policies should be established in order to explain the rationale for how decisions are made rather than relying on institutional memory. An intent of the policy is to describe current practice, and to make clear the operational principles that have been developed in an effort to become more transparent.

V). Mr. Watt welcomed and introduced Dr. Stephen Schondelmeyer from the College of Pharmacy who was invited to provide information on the trends in pharmacy economics. Using a PowerPoint presentation, Dr. Schondelmeyer began by talking about drug access and expenditures.

Health care reform is society realizing the country has growing health care needs, while recognizing there are limited resources, noted Dr. Schondelmeyer. Current health care trends are not sustainable in terms of expenditure levels, price levels and the structure of health care. There are policy issues underlying health care reform that not only the University, but society in general will inevitably need to deal with.

In terms of where U.S. health care is headed, Dr. Schondelmeyer referenced a book by George Halvorson, *Health Care Will Not Reform Itself,* which advocates for reforming health care as opposed to leaving it to itself. Health care is a significant portion of the federal budget deficit problem. Likewise, state governments are also facing major deficits with Medicaid and health care consuming large budget resources. Dr. Schondelmeyer cited a quote from President Obama that he believes is particularly cogent to this topic, "The nation's economy and federal budget deficit cannot be fixed without meaningful health care reform." Using a series of charts and graphs, Dr. Schondelmeyer highlighted health care expenditures from 1950 – 2015, and national health expenditures as a percentage of GDP from 1950 – 2015. Health care expenditures are growing dramatically, stated Dr. Schondelmeyer, and are roughly doubling every ten years in terms of total health spend. As of 2009, the U.S. spent 17.3% of its total economy on health care. Given the University's budget is not increasing at this same rate, this means that health care costs for employees is a growing piece of its budget when in fact the University's budget is actually shrinking. As an institution of higher education, the University has worked hard to maintain a well-managed and generous health care benefit, stated Dr. Schondelmeyer.

To put these trends in a global perspective, Dr. Schondelmeyer turned members' attention to a chart dating back to 2007 when the U.S. was only spending 16% of its economy on health care. When comparing the U.S. to the other Organization for Economic Co-Operation and Development (OECD) countries, the next nearest country to the U.S. is

France, which spends approximately 11% of its economy on health care. There is no other major industrialized country that spends more of its economy on health care than the U.S. The U.S. spends at least 50% more on health care than any other country. These statistics beg the question of whether the U.S. is using its resources wisely. The average OECD country spends about 9% of its economy on health care, which is almost half of what the U.S. spends. With that said, despite the fact the U.S. is spending significantly more, it is not getting better health care results than the other OECD countries. For example, using child mortality as an outcome measure, the U.S. ranks last among major industrialized countries. Above and beyond this, none of the other 20 – 30 outcome measures rank the U.S. as number one in terms of quality or value either. Other countries are getting better outcomes for the resources they are spending. Therefore, the U.S. needs to think about whether it is managing health care as a matter of policy properly and as a nation properly. Before moving on, Dr. Schondelmeyer noted that outcomes are usually affected by elements unrelated to health care, e.g., sanitation, food, housing, how a country deals with poverty. Other public health measures have as much or more of an impact on health care outcomes than the actual delivery of health care.

A member speculated that the U.S.'s very heterogeneous population may have an impact on its outcome measures. Dr. Schondelmeyer concurred, and added that not only does gender, race, ethnicity, and sexual orientation play a role, but the fact that the U.S. has the greatest dispersion of income from highest to lowest as compared to other industrialized countries. While the U.S. has a lot of people with resources, it also has a lot of people without resources.

Where are the other major industrialized countries spending their money on health care that is different from the U.S., asked a member? While the percent distribution can be looked at, noted Dr. Schondelmeyer, it is important to remember that the U.S. is spending, on average, $8,000 per person per year while other industrialized countries are spending $5,000 per person per year or less. Even if a percentage distribution issue is uncovered, it needs to be translated into real dollars. Recognizing percents are a useful measurement tool, the underlying dollars need to be examined to understand the true impact. Dr. Schondelmeyer illustrated this using a prescription drug example.

When comparing the U.S. to other countries in terms of health care costs, asked a member, are the figures that are spent on real health care as opposed to administration analyzed separately? Yes, stated Dr. Shondelmeyer. The cost of administrative health care expenditures is higher in the U.S. than most other countries irrespective of whether the care is fee-for-service or managed care. Depending on the approach, the U.S. spends anywhere from 6% - 20+% on administrative costs. Most insurance companies administrative expenditures are 10% - 15%. Medicare, on the other hand, has administrative costs around 5% - 6%, and other countries around the world have administrative costs in the 3% - 10% range. Mr. Chapman added that the administrative costs for the UPlan are at roughly 7½% . Mr. Watt encouraged members who are interested in this topic to read the January 2007 McKinsey & Company report on this subject: *Accounting for the Cost of Health Care in the United States* -

http://www.mckinsey.com/mgi/rp/healthcare/accounting_cost_healthcare.asp (IS THIS THE RIGHT REPORT, GAVIN? PLEASE ADVISE.)

Mr. Chapman reported recently attending a Senate Committee on Finance and Planning (SCFP) meeting where members asked about medical trend, and why it continues to increase. In Mr. Chapman's opinion, this is because people are paying for services instead of outcomes. There is an incentive for health care providers to deliver more services and more expensive services rather than providing the best possible care to get the best possible outcomes for patients. Dr. Schondelmeyer agreed and stated that both how much people pay and the payment structure for health care is not set up to provide the right incentives.

A member asked whether there is a correlation between the increased cost of health care and life expectancy. No, stated Dr. Schondelmeyer, U.S. life expectancy is not the highest of all countries. Certainly new drugs and devices have served to extend life expectancy. Society, however, needs to look at the cost of balancing new treatments with outcomes. Another member added that while life expectancy is an important measurement, quality of life is also extremely important.

To put pharmaceutical expenses into perspective, Dr. Schondelmeyer turned members' attention to a chart, which illustrated that by 2015 drugs are expected to be 3½% - 4% of the total U.S. economy, and 20% of all health care costs. These percentages translate into ¾ of a trillion dollars or $788 billion, which is the cost of each of the two bank bailouts. He went on to explain about drug use since 1950. In 1950, the average person had 2.4 prescriptions whereas now that number has risen to 13.7 prescriptions. While about 10% - 15% of the population does not use any drugs, there are others who use far more than the 13.7 prescriptions per person average. The average elderly person (12% of the population), for example, averages 35 – 36 prescriptions per person per year. Clearly, as a society, the U.S. is not using drugs wisely, and this has been driven, in part, by marketing, inappropriate prescribing habits, etc. With this said, the challenge is to encourage appropriate drug use. One approach the University is using to deal with this problem is the Medication Therapy Management (MTM) program.

With respect to drug prices, Dr. Schondelmeyer pointed out that the average price isn't really the issue, but rather brand drugs versus generic drugs. The average brand name drug in 2007 cost approximately $120 and the average generic cost roughly $35. About 25% - 30% of all prescriptions are for brand name drugs. Today, the cost to the University for an average brand name prescription is $200 or more.

A member asked how many brand name drugs are clearly better than the generic. Arguably, none, stated Dr. Schondelmeyer. Some drug companies claim that there is a difference in the narrow therapeutic index drugs (drugs where the toxic level and therapeutic level are real close). However, keep in mind that drugs are not just biological, pharmacological entities, but they also have social impacts. For some patients, drugs have a very strong social attachment. Some drug reactions are more socially and psychologically driven than pharmacologically driven. Having said this,

some people attribute experiences to drugs that may not have been caused by the drug at all. Social/psychological factors may lead to perceptions of differences between brand and generic drugs.

Given the placebo effect associated with anti-depressants, is there similar research that covers other medications, asked a member? Dr. Schondelmeyer encouraged members who are interested in this research to look at the Consumer Reports Best Buy Drug Project website http://www.consumerreports.org/health/best-buy-drugs/index.htm where these reports can be accessed free of charge. These reports look at the safety, effectiveness as well as drug costs and recommends best-buy drugs in certain categories. For the UPlan, if it were able to increase its use of best-buy drugs in categories that are currently not using best-buy drugs, the plan could save 5% - 20% of its total drug budget. Having said this, however, it is not easy to make these changes because it requires patients and physicians to change their behaviors. The University, stated Dr. Schondelmeyer, will continue to work on encouraging patients and physicians to be aware of and move toward using best-buy drugs. Doing this could result in better outcomes for plan participants and a reduction in drug expenditures.

Dr. Schondelmeyer and the committee spent the remainder of the meeting engaged in a lively discussion concerning trends in health care economics, particularly pharmaceutical trends, and the need for controlling these spiraling costs by, for example, putting pressure on pharmaceutical companies, continuing to increase generic drug usage, etc.

Mr. Watt thanked Dr. Schondelmeyer for his enlightening presentation.

VI). Mr. Watt reminded members that the next meeting is March 4th. He also noted that the second March meeting will be on March 25 rather than March 18 due to spring break week. At the March 4th meeting, Professor Jean Abraham will present the results of the Fitness Rewards survey that was conducted. Ms. Chapin added that Jill Thielen will also share positive indicator data from the Wellness Program.

Mr. Watt thanked Becky Hippert and Renee Dempsey, Senate staff, for setting up a new system for tracking UPlan comments. In addition, he thanked members who agreed to collect and organize UPlan comments – Joe Jameson, Jennifer Imsande, Michael O'Reilly, Dick McGehee, Sara Parcels, Bill Roberts and Ted Litman. Plan reviews will begin taking place in April.

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

Renee Dempsey
University Senate