BENEFITS ADVISORY COMMITTEE
MARCH 28, 2013

[In these minutes: Accountable Care Organizations (ACO), Boynton Health Service Influenza Vaccinations, Tobacco-Free Campus, 2012 FrontierMEDEX Report, Chair's Comments/Updates]

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

PRESENT: Tina Falkner (chair), Pam Enrici, William Roberts, Dale Swanson, Jody Ebert, Sara Parcells, Jennifer Schultz, Sandi Sherman, Nancy Fulton, Susann Jackson, Joseph Jameson, Carl Anderson, Amos Deinard, Roger Feldman, Judith Garrard, Richard McGehee, Fred Morrison, Theodor Litman, Rodney Loper, Dann Chapman

REGRETS: Tatyana Shamliyan, Karen Lovro

ABSENT: Jacqlyn Price, Kathryn Brown, Aaron Friedman, Keith Dunder

OTHERS ATTENDING: Karen Chapin, MaryBeth Galley (Medica), Betty Gilchrist, Ryan Gourde, Kathy Pouliot, Judy Reger (Medica), Laurie Warner

GUESTS: Medica representatives: John Naylor, senior vice president, Commercial Markets, and Angela Eberhardt, senior director, Alternative Contracting

I). Tina Falkner called the meeting to order and welcomed all those present.

II). Ms. Falkner welcomed today's guests from Medica, John Naylor, senior vice president – Commercial Markets and Angela Eberhardt, senior director - Alternative Contracting, who were invited to provide information on Accountable Care Organizations (ACO). Mr. Naylor distributed a PowerPoint handout to members to supplement their presentation. He began by providing the committee with background information about ACOs. ACOs, stated Mr. Naylor, are an effort to help employers fix health care costs while still giving employees choices.

Medica, stated Mr. Naylor, has been working over the past two years to partner with health care systems to build out its ACO offerings, which have been very successful thus far. Based on Medica's experience to date, approximately 40% of employees, given the choice of choosing an open access plan or a single care system (ACO), are choosing the ACO.

Medica's four ACOs are:

1. Fairview Health Advantage
2. Park Nicollet

3. Ridgeview Connect
4. Inspiration Health by HealthEast

In deciding which health care systems to choose as its ACO partners, Medica took into account a number of different factors including, but not limited to which providers were providing quality, efficient care, and which providers were leading-edge in terms of innovation. Medica is in discussions with other care systems across Minnesota in order to expand its current offerings.

How does the ACO concept differ from what the Buyers Health Care Action Group (BHCAG) put together back in the 1990s, asked Professor Schultz? Ms. Eberhardt explained that people choose their ACO, and it is a completely different experience for people. Whereas BHCAG focused on managing overall spend and quality, ACOs are a concerted effort to improve the health of a defined population.

In response to a question from Professor Deinard about offering ACO options for coordinate campus employees, Mr. Naylor stated that Medica is in discussions with care systems in Greater Minnesota. He added that because Medica just recently rolled out its ACO offerings that it wanted to make sure that everything is working well before it expands too quickly. There is a lot of complexity related to the care delivery model of an ACO, e.g., Medica has integrated its systems with the health care systems. There is a lot of behind the scenes work involved in setting up an ACO.

What are the implications for the Fairview Health Advantage ACO if there were to be a Fairview-Sanford Health merger, asked Professor Garrard? Mr. Naylor stated that he is not privy to any of the discussions between Fairview and Sanford Health, but he would envision Medica's contract with Fairview to remain valid through its duration. Ms. Eberhardt added that Sanford Health is within the Medica service area, and Medica has informed them about what they are doing in terms of total cost of care, ACOs, healthcare homes, and Sanford Health is supportive and interested.

Professor Garrard asked what happens if an ACO member is out of state and needs immediate health care. Mr. Naylor explained that the ACO travel benefits would kick in or urgent care and emergency benefits would apply.

Professor Morrison asked about the length of Medica's contracts with its ACOs. Ms. Eberhardt stated that they vary, and range between three to five years in length. Mr. Naylor stated that the three to five year contracts in these changing times are actually quite long. He speculated that there will be more health plan and care system consolidations in the marketplace as people try to figure out how to be successful in this post-health care reform world. Ms. Eberhardt added that Medica also has very specific merger and acquisition language in its contracts, which was recently reviewed by their legal team.

A fair number of UPlan members cover their dependent children who are either attending college out of state or who happen to live out of state, noted Professor Morrison. Are

parents who cover their dependent children who live out of state able to participate in an ACO? Ms. Eberhardt stated that as long as the dependent child is a Minnesota resident, their out of state care would fall under the ACO travel benefit. Mr. Naylor stated that Medica is committed to continuing to offer Medica Choice National, the open access plan with a nationwide network. In the future, stated Mr. Naylor, he predicts that each family member will be able to choose their own plan rather than having the entire family have the same plan.

In response to a question about physician associates (PA), Mr. Naylor explained that for the Fairview Health Advantage ACO product, UMP specialists are in network but their primary care physicians are not. UMP specialists and primary care physicians have different practice/clinical models. The care systems are always willing to entertain ACO solution discussions for large organizations such as the University.

How are clinicians being paid in the hospitals? Is their pay being capitated? According to Ms. Eberhardt, payment is not capitated. Physicians continue to be paid under their fee for service contracts, which have the same length of term as the ACO contract. There now is more opportunity under the ACO model for providers to earn different rewards based on how they manage their entire patient population.

Responding to a question about how referrals work in the ACO environment, Ms. Eberhardt explained that each ACO designs its own core network (a robust network of primary and specialty care physicians), and, for ancillary services, e.g., skilled nursing facilities, transportation, the ACO has access to Medica's entire service area of providers. In an ACO model, employees and their family members would select the same ACO for the plan year. As long as the patient stays within the defined ACO network, he/she does not need a referral. Only if the patient goes out of network, would he/she need a referral.

Professor McGehee asked the representatives from Medica to explain the difference between quality and outcomes, and how are the ACOs held accountable for quality and outcomes. Beyond looking at whether a patient had a quality experience, stated Ms. Eberhardt, Medica goes one step further and looks at the outcome of the patient's experience in terms of was the outcome a healthy result so it did not have a recurrence. Medica is closing the gaps in the care models to ensure better outcomes, and not just a quality experience. Mr. Naylor stated that the reason the care systems are willing to entertain these aggressive contracts, is that for the first time they have accountability for a patient's entire care.

Professor McGehee asked about the consequences to the ACO for poor outcomes. Does Medica stop paying them? Ms. Eberhardt stated that ACOs are held financially accountable. While Medica never stops paying its ACOs, the ACO shares in both the losses and gains. Performance bonuses, added Mr. Naylor, can translate into millions of dollars for ACOs.

Mr. Anderson commented that it is his understanding there will be less savings to share back with the ACO if they overspend on some patients. In other words, there is less

savings to redistribute based on an attribution model. Yes, stated Ms. Eberhardt, this is correct.

What happens to patients who have chronic diseases or diseases that are difficult to diagnose, asked Ms. Ebert? Will they be turned away because they will cost the care system too much money? Mr. Naylor stated that Medica, from a population health management standpoint, stratifies the population a health care system is accountable for. Under the old model, health care systems only saw the sick who sought out care (an episodic focus on care of the sick). However, under the new model, population health management, there is a focus on continuum of care with an emphasis on improving the health and wellbeing across a patient's lifetime. To accomplish this, Medica is working with the care systems like never before by supplementing the ACO's resources, which vary significantly, to ensure continuum of care for all patients. Ms. Eberhardt went on to explain about the ACO's "on-boarding" process, which entails reaching out to new patients and asking them a series of questions in order to learn about their health care needs versus waiting until that person gets sick and decides to come in to the clinic. Mr. Naylor added that the use of electronic medical records facilitates each care system's ability to manage patient care.

Ms. Enrici asked how the care systems are being incentivized to improve patient health and wellbeing. Mr. Naylor stated that there are two components, the first being a financial component and the second being a reputation component. Each health care system wants patients from "cradle to grave," and each care system wants to be the provider of choice for the community it serves and known for providing high-quality, cost-effective delivery of care.

Professor Garrard asked about the Fairview Health Advantage ACO contract with UMP specialists but not UMP primary care physicians. Mr. Naylor explained that Medica has a contract with all of Fairview, but not UMP, which is a different organization that is not a part of the Fairview network. With that said, Fairview has included the UMP specialists but not its primary care physicians in its ACO network. He added this is how the product is set up now, but that does not mean it cannot change at some point. Fairview believes their primary care physicians have a certain clinical model and practice that they believe is more efficient than the UMP primary care physician model. Therefore, because Fairview is ultimately accountable for costs, they decided not to include the UMP primary care physicians in their ACO network. However, Mr. Naylor indicated, the University may have some ability to work with Fairview to see what flexibility there might be with regard to UMP providers.

In response to comments about unevenness in experiences from clinic to clinic, Mr. Chapman reminded the committee that the ACO model is a consolidation of services and a means of providing a variety of improvements/innovations in the care systems, which are taking place at an uneven rate across the health care provider community. While some clinics are already functioning in a team manner, a majority of care systems have not yet gotten to this point. The ACO model, using financial and contractual

mechanisms, is driving care systems to take greater responsibility/accountability for their patients.

Who oversees the ACOs in terms of their performance, asked Professor McGehee? Mr. Naylor stated that each ACO oversees their own performance and are doing their own analytics. Medica, however, sets the benchmarks for its ACOs, e.g., cost and quality goals, and provides additional analytical support to the ACO.

Professor McGehee asked whether these products would be put on the health care exchanges once they are set up. Mr. Naylor stated that he is unaware of any care system putting their product on the exchange this year, but, going forward, they absolutely could if they chose to do so. Medica is planning to put some of their products and networks, but not all of them on the exchanges. These products are options within My Plan by Medica, a defined-contribution benefits program. Medica is also looking at customizable ACO solutions outside of My Plan by Medica for the University of Minnesota. He reminded members that the ACO concept is unique and new, and that no one else in the market, regionally or even nationally, is offering a product like this at this time. The exchanges, added Mr. Chapman, are primarily a place to access individual policies. He noted that Medica is not driving the "ACO boat," but rather it is the federal government, the State of Minnesota, etc. The big care systems have been thinking about this concept for quite some time because they believe this is the direction that health care needs to go in the marketplace. Medica provides a good partner for the care systems to deliver this kind of care. The University has also been thinking about the future of health care delivery for quite some time, and, during the last round of RFPs was looking to identify a partner who was advanced in making inroads and who would be able to incorporate the new movements in the marketplace like an ACO in the UPlan.

How would the ACO option play out for retirees, asked Professor Garrard? Ms. Chapin stated that the ACO option would only impact early retirees who are in the UPlan, but would not apply to the age 65 and older retirees unless the retiree medical plans began offering ACO options.

In response to a question about the University offering an ACO option, Mr. Naylor stated that the University and Medica have discussed creating an ACO plan for the University. Regarding non-metro ACO options, because outstate care systems are further behind in this process, those care systems would be added as they became available. The initial plan would probably include some non-metro ACO care systems with some possibility of adding additional care systems in over time.

Mr. Naylor stated that ACOs are transforming health care in Minnesota. The feedback Medica has been receiving about its ACOs has been very positive. The goal of the ACOs is to keep its patients healthy, and give them a positive experience. Ms. Eberhardt turned members' attention to a couple of slides that highlight unique services the four ACOs are offering in an effort to improve patient health and experiences.

Are mental health services covered under the ACO plans, asked Ms. Parcells? Yes, stated Ms. Eberhardt, mental health services are covered.

How many Medica members have elected one of the ACO options since the offering was rolled out on January 1, 2013, asked Mr. Swanson, and are the employers that are offering ACO options primarily fully insured or self funded? Mr. Naylor stated that Medica has almost 25,000 members in its My Plan by Medica book of business and of those people roughly 5,000 – 6,000 members have elected one of the ACO options. Regarding the question about fully insured versus self funded, noted Mr. Naylor, most employers offering an ACO option are fully-insured, but there are a number of self-funded employers that are starting to talk about offering this option as of January 1, 2014.

Assuming the UPlan offers an ACO option at some point, will members who elect to participate in it really see a difference in their care, asked Mr. Roberts? Yes, most definitely, stated Ms. Eberhardt, who then took a few minutes to share her experience since joining an ACO. People will notice an increase in attention to their health by the care system that will be working to engage them in improving their health. Mr. Naylor added that the care systems are using the ACO model as a long-term strategy for being the care system of choice for its members. The ACOs will be making a concerted effort to appeal to health care consumers.

When did Medica rollout the ACO option, asked Professor Loper? Mr. Naylor stated that Fairview Health Advantage was rolled out July 1, 2012 and the other three (Park Nicollet, Ridgeview Connect, and Inspiration Health by HealthEast) were rolled out on January 1, 2013.

Ms. Falkner thanked Mr. Naylor and Ms. Eberhardt for a good discussion and information about ACOs.

III). Ms. Falkner welcomed today's guests from Boynton Health Service (BHS) Ferd Schlapper, director and chief health officer, and Dave Golden, director, Public Health and Communications, who were invited to provide the committee with information on flu shots and the tobacco-free campus campaign that is currently underway. Handouts to supplement their presentation were distributed to members.

Regarding influenza immunizations, Mr. Golden reported that BHS administered over 17,000 influenza vaccines on the Twin Cities campus this year, the highest number of flu shots administered since the program began. Despite concerns about the effectiveness of the flu shot, the vaccine is still the best tool available for preventing the flu. The Centers for Disease Control and Prevention and the World Health Organization recommend vaccination against influenza as the number one way to prevent the spread of influenza in a population.

Ms. Sherman asked Mr. Golden to talk about whether seniors should still be encouraged to get the vaccine every year given that as people age their antibody response goes down. As people age, stated Mr. Golden, their immune response for all vaccines becomes more

of a challenge. There are various schools of thought on whether the elderly should be vaccinated every year or not, but what might be a better strategy would be to vaccinate everyone around them in order to prevent/slow down the spread of the virus.

The number of deaths associated with the influenza virus in the past few years has been considered light. So far this year there have been 180 influenza deaths, and more are anticipated. This year is considered a moderate to severe year in terms of influenza deaths.

Since the University's vaccine program was launched, BHS has developed a high level of capacity for influenza administration. The support of the BAC and the University has allowed BHS to develop a strong infrastructure for being able to do mass dispensing. In addition, mass dispensing the vaccine saves the University money.

Professor Garrard suggested giving students, faculty and staff the ability to put this information in their medical records, e.g., link to Epic. Mr. Golden agreed that in an ideal world it would be great to have this capability. BHS is looking into different options for getting this information into people's records, but there would be a significant amount of effort to put these connections in place.

Moving on, Mr. Schlapper provided the committee with a tobacco-free campus initiative update and began by providing some background information. Salient highlights from his update included:

- President Kaler remains supportive of the effort to garner support for implementation of a tobacco-free policy and requested that another survey be conducted to gauge the current level of support. The last survey was conducted in 2009.
- Survey data indicate that non-smokers and smokers alike are supportive of a tobacco-free campus policy.
- Over 1,110 college and universities across the country have gone either smoke-free or tobacco-free and that includes 49 schools in Minnesota.
- Second hand smoke has health impacts. Second hand smoke exposes people to a Class A carcinogen, and there is no safe level of exposure. Over 80% of students, faculty and staff say they are exposed on a weekly basis to second hand smoke on campus and these same people report that the University of Minnesota campus is the number one place in their lives where they are exposed to second hand smoke.
- Twenty two percent of faculty and staff, and 16% of students have health conditions that are made worse by second hand smoke, e.g., asthma.
- A number of smokers also support a tobacco-free campus policy because they are trying to quit smoking. While the cessation and nicotine replacement therapy programs are important to offer, they are not the most effective deterrent to smoking. The most effective deterrents are price point, changing the cultural norm/social acceptability around smoking, and convenience or lack thereof.
- Twenty two percent of University smokers reported having started smoking since they came to the University. Big tobacco companies are targeting this population, particularly 18 – 24 year olds.

Members' questions/comments:

- What percentage of University smokers support a tobacco-free campus policy? According to Mr. Golden approximately 16% of University smokers favor a tobacco-free campus policy.
- Please provide data in raw numbers versus a percentage for the question that asks faculty, staff and students (smokers and non-smokers) if they support the implementation of a policy that would prohibit tobacco use on all University property.
- How does the most recent survey data compare to the 2009 survey in terms of the number of smokers? Mr. Golden stated that the most recent survey indicates that the number of smokers has declined since 2009. He added that the demographics of the students who reported smoking on a daily basis changed dramatically, and continues to decline. Interestingly, graduate students used to be the group with the lowest number of reported smokers, but now it is undergraduates, with just 3% of undergraduates reporting smoking on a daily basis.
- When was the most recent tobacco survey conducted? December 2012, stated Mr. Golden.
- Please talk about implementation of a tobacco-free policy. Will a tobacco-free policy be able to be enforced? Mr. Schlapper stated that the legal ruling is that universities have jurisdiction over the public thoroughfares that run through their campuses. Based on 10 years of research and best practices when it comes to implementing a tobacco-free or smoke-free policy, education, signage and clear and consistent messaging about smoke-free zones make the community expectations around not smoking stronger and, as a result, it is more likely that people will not smoke. The research shows that the most effective implementations are rolled out over a 12 – 18 month period, and, generally speaking, have a 95% compliance rate. The compliance rate rises to 99% when anyone smoking is reminded that tobacco use is not permitted. Then, for the remaining 1% who refuse to comply, some form of disciplinary action would need to be taken.
- Is the Minnesota State Fair going smoke-free this year? Yes, stated Mr. Golden, the State Fair will be smoke-free this year; however, no final decision has been made about whether they will have a designated smoking area(s). In addition, beginning this year, the designated smoking area outside of Gate 6 at Target Field will no longer allow people to exist and re-enter after smoking. Fans will be required to cross the street to smoke.
- The terms smoke-free and tobacco-free have been used interchangeably throughout this discussion. Does putting a smoke-free policy in place drive people to use other tobacco products? In Mr. Schlapper's opinion, a smoke-free policy likely increases the number of people who use chewing tobacco. From a health standpoint, this is why a tobacco-free policy is being proposed for the University. Besides lost productivity, another big cost associated with tobacco use is the cost of clean up. (Taking four 10-minute smoking breaks in a day translates into a person working 11 months out of the year versus 12 months.)

- Will smoke-free cigarette substitutes (e-cigarette) be allowed if a tobacco-free policy is put in place? E-cigarettes would not be permitted, stated Mr. Schlapper. One of the reasons behind the 12 – 18 month implementation period is to continue working with smokers to try to get them to quit.
- Please comment on the campus boundaries, e.g., smoking in a vehicle in a University-owed ramp, and also how riders of the LRT would be impacted if the University were to go tobacco-free. Mr. Schlapper stated that the LRT and its stations are smoke-free. If the University does not go tobacco-free, as it stands right now, someone could get off the LRT and smoke on campus. Regarding smoking in a car, the ruling is that there is no smoking on campus even if a person is in his/her own vehicle. The perimeter of the campus will be clearly defined and publicized. Based on the boundaries that have been discussed, the maximum distance that anyone would have to walk to get off campus would be about 3.5 blocks. Inconvenience is part of the effectiveness of the policy by making it less convenient for people to go out and kill themselves. For students, research indicates that 11% of them will die prematurely for tobacco-related use.
- What are the next steps in terms of convincing the administration that the University should go tobacco-free? Mr. Schlapper stated that work will continue on getting formal support from various groups on campus. The tobacco-free policy proposal will be brought to the University Senate in May in an effort to get the endorsement of the Senate. There is also interest in seeing an implementation plan so this is being drafted. In addition, discussions continue with University leadership about creating a healthy campus environment, which would include a tobacco-free campus.

At the conclusion of the discussion, Professor Morrison asked Mr. Schlapper and Mr. Golden whether they would like the BAC to take action on this matter. Members unanimously voted to reaffirm their support of a tobacco-free policy at the University of Minnesota. Ms. Falkner agreed to craft a brief letter on behalf of the committee and send it to President Kaler.

Mr. Schlapper and Mr. Golden thanked the committee for their support.

IV). Next, Ms. Chapin distributed the 2012 FrontierMEDEX utilization report for members to review. She then took a few minutes and highlighted the following:

- 187 people contacted FrontierMEDEX in 2012 as compared to 163 the year before.
- There were 6 hospitalizations in 2012 as compared to 7 the prior year.
- There were 23 overseas cases and 5 overseas hospitalizations.
- U.S. cases increased from 121 in 2011 to 149 in 2012.
- There were 4 cases in Canada with one hospitalization.

To conclude, Ms. Chapin stated that this is a helpful program for the University, and one that is greatly appreciated by employees, particularly parents whose dependent children are traveling abroad.

V). Ms. Falkner concluded with the following remarks and announcements:

1. The discussions between Fairview and Sanford Health will be interesting to follow.
2. A sizeable number of comments/feedback on the health and wellness plans were received.
3. A call for feedback on the pharmacy programs was recently sent out.
4. RFPs for dental, retiree medical and life insurance are wrapping up this week.

VI). Before adjourning, members were given copies of the most recent newsletter and summary of benefit booklets for the medical and dental plans.

Ms. Falkner announced that the April 4 BAC meeting is cancelled, and that the next BAC meeting will be on April 18.

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

Renee Dempsey
University Senate