BENEFITS ADVISORY COMMITTEE
MINUTES OF MEETING
FEBRUARY 15, 2007

[In these minutes: UPlan Metrics, Long Term Care, Medica CT, PET, MRI Consultation Process, Star Tribune Article - *Equal health insurance pricing isnÕt fair,* UPlan Medical Coverage Waiting Period]

[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), Linda Aaker, William Roberts, Karen Wolterstorff, Jody Ebert, Jennifer Imsande, Rhonda Jennen, Jerremy Mlenar, Sandi Sherman, Don Cavalier, Joseph Jameson, Carla Volkman-Lien, George Green, Amos Deinard, Richard McGehee, Fred Morrison, Peh Ng, Theodor Litman, Rodney Loper, Dann Chapman

REGRETS: Tina Falkner, Michael Marotteck

ABSENT: Carl Anderson, Carol Carrier, Frank Cerra, Keith Dunder

OTHERS ATTENDING: Linda Blake, Ted Butler, Karen Chapin, Joyce Carlson, Nancy Fulton, Murray Harber, Shirley Kuehn, Kathy Pouliot, Kelly Schrotberger, Curt Swenson

I). Gavin Watt called the meeting to order.

II). Gavin Watt noted that Professor McGehee brought to his attention that the committee does not need to elect a new BAC chair today after all. Professor McGehee uncovered that the BAC voted in December 2005 to elect Gavin Watt as BAC chair for the period July 1, 2006 – June 30, 2008. At this same meeting, the committee also voted to elect Professor McGehee as vice chair for the same two-year period. Since that time it was discovered that the vice chair position should have only been elected for a one year term. With this said, Mr. Watt opened the floor for a nomination(s) for a BAC vice chair to serve through June 30, 2008. A motion to nominate Professor McGehee was put forward. The committee voted to unanimously elect Professor McGehee as BAC vice chair for the term July 1, 2007 – June 30, 2008.

Mr. Watt noted that in the fall of 2007, the committee will vote to elect a chair for the period July 1, 2008 – June 30, 2010 and a vice chair for the period July 1, 2008 – June 30, 2009.

III). Ted Butler distributed a handout, 2006 UPlan Dashboard Metrics Summary. Before walking the committee through the handout, Mr. Butler noted that these metrics were established to track the UPlanÕs performance overtime.

Three sets of metrics are used for reporting on the UPlan medical program:

1. Overall financial metrics.
2. Pharmacy program metrics.
3. Medical utilization metrics.

The financial metrics are metrics for the medical program including the pharmacy benefit. Mr. Butler shared the financial data for paid claims through 4th quarter 2006. Highlights from this data included:

- There was a fairly significant increase (13.2%) from 2005 to 2006.
- For this same period, pharmacy claims increased by 8.3%.
- Through 4th quarter 2006, the UPlan medical program had actual expenses of $147,836,459. Budgeted expenses for this period were $144,507,832.
- Budgeted per employee expenses for 2006 were $8,444 and actual expenses for 2006 were $8,656.

In terms of pharmacy metrics, there is not as much of a difference between incurred claims and paid claims because pharmacy claims are paid much faster than medical claims. Pharmacy metrics for 2006:

- Utilization has been fairly stable from fourth quarter 2004 to fourth quarter 2006; however, there was a slight uptick in pharmacy claims in fourth quarter 2006.
- Members paid about $1 less out-of-pocket for prescriptions from fourth quarter 2005 to fourth quarter 2006.
- During 2006, 74.1% of prescriptions were filled for a co-pay of $10 or less.
- Retail 2006, the average total ingredient cost for a generic drug was $29 and the average total ingredient cost for a brand drug was $148. While the UPlan only has a co-pay difference of $10 between generic and brand drugs, the actual cost difference is substantially more.

Mr. Butler noted that medical utilization claims have a longer processing time than pharmacy claims so medical utilization reporting is not as timely. Significant findings related to UPlan medical utilization, which include services incurred through second quarter 2006 include:

- Total eligible charges submitted by providers are discounted by about 40%. Plans negotiate contract discounts with providers. Additionally, members pay about 5%, which represents their cost share. The UPlan pays the remaining amount of total eligible charges.
- In fourth quarter 2004 and fourth quarter 2005, there were peaks in the number of outpatient visits by UPlan members. It will be interesting to see if this ÔtrendÕ will continue in 2006.
- There has been a significant increase in emergency room utilization from 2004 through early 2006. This is a concern because emergency room visits are very expensive.

Moving on, Mr. Butler distributed additional pharmacy exhibits:

- Top 30 Therapeutic Categories: YTD 2006
- Top 30 Drug Products: YTD 2006

- Therapeutic Category Listing-Descriptions and Common Drugs

In terms of the top 30 therapeutic categories for 2006, there has not been much change since the last time the committee reviewed this list. Antidepressants, specialty drugs and cholesterol lowering drugs make up the top 3 therapeutic drug categories by spend.

A common theme running through the top 30 drug products is that 3 of the top 6 products are some form of Lipitor. Lipitor is the UniversityÕs number one drug in terms of total cost and total volume.

A member heard anecdotally that a physician was willing to write out a higher milligram prescription and instructed his/her patient to cut it in half in order to save the health plan money. This cost saving strategy should be communicated to UPlan members suggested a member. Karen Chapin and Gavin Watt both noted that RxAmerica and Boynton are piloting a program to investigate whether this is a viable approach for reducing plan costs. Mr. Chapman voiced a word of caution with respect to rolling out a program like this. He stated that there are concerns because some pills do not split well, and, therefore, doses do not come out evenly. In addition, pharmacists have diminished potency concerns. This has to do with the fact that when seals are broken on certain pills, some become less potent overtime.

IV). Karen Chapin distributed handouts having to do with Long Term Care:

1. Long-Term Care PowerPoint presentation.
2. Informational meeting schedule and instructions for accessing the webinar presentations.
3. CNA/John Hancock comparison chart.
4. U & Your Benefits newsletter.

She then provided the committee with an abbreviated version of the presentation that John Hancock will be giving to employees. Ms. Chapin highlighted the following:

- The plan becomes effective on April 1, 2007. Open enrollment is from February 19 – March 16, 2007.
- Long-Term Care is a time period when people need personal care or supervision. LTC covers people in all age brackets.
- LTC insurance and long-term disability insurance are two different kinds of insurance. Long-term disability insurance provides income replacement whereas LTC insurance provides payment for services received in a LTC facility or a home setting.
- LTC insurance will pay for:
    - Nursing home care, which includes on-site/inpatient hospice care.
    - Alternate care facility such as assisted living.
    - Community based professional care, e.g. home health care, adult day care.
    - Informal care, e.g. a family member is trained to take care of the person needing care.
    - Stay at home care, which covers changes that are made to the patientÕs home to allow him/her to stay at home.

- John Hancock is a well-known leader in the LTC marketplace.
- CNA participants will have 3 options:
    - Transfer to John Hancock. The person transferring to John Hancock will pay premiums based on oneÕs current age. Premiums previously paid to CNA have been used to identify a reserve amount, which will be used to discount oneÕs premium with John Hancock. A majority of individuals that transfer to John Hancock will have lower premiums.
    - Remain with CNA. These individuals will still be able to pay their premiums through payroll deductions.
    - Leave current coverage with CNA and add new John Hancock coverage. In this case, the discount feature and reserve transfer feature do not apply.
- LTC coverage through John Hancock will now be available to retirees that meet the UniversityÕs age and service requirements.
- The John Hancock LTC plan offers 5 daily maximum benefits (DMB) - $120, $150, $200, $250, $300. The $80 benefit will only be available to current participants. The DMB was increased to better reflect the cost of LTC.
- The plan will have 3 lifetime maximum benefits choices - 3 years, 5 years and 10 years.
- The plan has two approaches to handling inflation:
    - Future Purchase Option (FPO) – This option is built into the program, and gives participants the automatic ability to increase oneÕs coverage once every three years. The increase will be at least 5% per year, and participants will not be required to take every increase in order to be eligible for FPO increases.
    - Automatic Benefit Increase (ABI) – This option is much more costly than the FPO, but it provides 5% automatic increase in the program per year. Premiums are up to four times higher based on oneÕs age. This policy should qualify as a Minnesota Partnership Policy.
- Additional plan features under the John Hancock program include:
    - Bed reservation benefit for up to 60 days per year. With CNA, participants only have the ability to do this for 14 days/year.
    - Restoration of benefits – If a participant returns to work for two or more years after being on LTC, their entire benefit is restored.
    - International benefit coverage – This coverage is less than the U.S. daily maximum and there is a 6-year maximum benefit.
    - Full return of premium at death up to age 65 and a reduced amount after that time.
- All eligible, non-insured employees can enroll via the web or an enrollment form with proof of good health.
- All employees enrolled with CNA do not have to provide proof of good health. These employees need to complete an enrollment form because a signature is required.
- Retirees, spouses or parents on the current CNA plan will have guaranteed issue for their current coverage, however, if additional coverage is requested, these individuals will have to provide proof of good health.

- All other eligible family members will need proof of good health and can apply even if the employee does not.
- LTC premiums are:
    - Based on the date John Hancock coverage starts, but do not increase with age.
    - Active employees pay premiums for themselves and/or their spouse or same-sex domestic partner (SSDP) through payroll deductions.
    - All other family members pay premiums through ACH or direct bill.
- Forty-three percent of people needing LTC are working adults.
- There is a 2 in 5 chance of needing LTC, but many people do not purchase it.
- Average LTC costs:
    - Nursing home - $71,140/year.
    - Assisted living - $26,300/year.
    - Home health care - $31,200/year.

  These are average costs, and depend on what services are received.
- In 2000, total national LTC costs were $134 billion. Medicaid paid forty-four percent of this $134 billion, and Medicare paid 14%.
- There is a new Minnesota LTC program, Minnesota Long Term Care Partnership. Only about 4 states have implemented this type of program, which serves to enable people who purchase certain private long-term care insurance policies to have more of their assets disregarded if they need to apply for Medicaid. For additional information on this program, visit the website developed by the Minnesota Department of Human Services to explain the program at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_137036 This program is intended to increase the value of having a conventional LTC policy.
- Reasons to consider purchasing LTC include:
    - Protection of financial assets.
    - Minimize chance of becoming a burden to your family.
    - More choice in where you receive LTC and type of care.
    - Maintain affordability of LTC services.
    - In conjunction with the Minnesota LTC Partnership program, LTC policyholders have added estate dollar protection if Medicaid help becomes necessary.

V). Karen Chapin distributed handouts related to MedicaÕs recent announcement that its providers will be required to consult with an outside party (over the phone or via the Internet) when they order an outpatient high-tech CT scan, PET scan or MRI.

The reason Medica has implemented this policy, first and foremost, is because 10 – 20 percent of high-tech scans are unnecessary or simply the wrong test. Additional reasons for implementing this policy are to avoid exposing patients to needless radiation and to control costs. This new requirement is not a prior authorization, so the request to do the scan will not be refused by Medica. The doctorÕs office and Medica will discuss the need for the procedure and the doctor and patient will make the final decision on the test.

In addition, this new policy does not apply to emergency situations or inpatient care situations.

VI). A member brought to the committeeÕs attention a recent Star Tribune article; *Equal health insurance pricing isnÕt fair.* Copies of the article were distributed to members for their information. This article points out that in terms of health insurance, healthy people pay the same amount in premiums as the unhealthy. This member went on to note that there are more and more companies either imposing or considering imposing penalties by charging employees more for higher risk based on given sets of behaviors.

Dann Chapman commented that he had seen the article and planned to bring it to the next BAC meeting, hopefully, after he had had a chance to get more information concerning the Purdue study that was mentioned in the article. He added that the article does not talk about health conditions per se, but healthy versus unhealthy behaviors. There are certain people that intentionally allow themselves to be at a higher risk for health problems.

This article reminded Mr. Chapman of the numerous discussions the BAC has had concerning the concept of insurance. These discussions for the most part did not take into account the logical distinction between a health risk, which cannot be controlled and behavior risk, which can be controlled. With this said, the University has taken steps through its Wellness Program by rewarding healthy behaviors. It behooves the University to keep its wellness efforts as positive as possible, and to reward healthy behaviors. There is no question anymore that certain behaviors are contributing significantly to the cost of healthcare in the U.S. noted Mr. Chapman.

VII). Gavin Watt noted that awhile ago the BAC made a recommendation to the AWG to consider modifying the waiting period related to when health benefits start for new employees. The University adopted (policy change was bargained) this recommendation. Mr. Watt asked Ms. Pouliot to provide the committee with an update and background information regarding this policy change. Ms. Pouliot highlighted the following:

- The UPlan waiting period change took place on January 1, 2004. Prior to the 2004 plan year, the waiting period was the first day of the pay period following 28 days of employment.
- Currently, the UPlan waiting period stipulates that basic medical, dental and life insurance coverage is effective on the first day of the month following thirty calendar days of employment.
- With the change to the waiting period, the University began to offer Waiting Period Medical Coverage, which provides the option to obtain medical coverage for the waiting period from the first day of employment until active coverage begins. Since January 1, 2004, 83 new employees have elected this coverage. Generally new employees with fall semester appointments are the individuals who most frequently elect this coverage.
- Big 10 benchmark data indicates that a majority of institutions offer immediate eligibility. Others offer coverage the first day of the month following the date of hire.

- Data shows also that a majority of the top 10 public institutions have immediate eligibility and the remaining have eligibility on the first day of the month following the date of hire.
- Ms. Pouliot distributed a handout, an impact analysis of waiting period options for UPlan medical coverage. Ted Butler walked members through the chart.

Professor Morrison provided history on how the most recent decision to change the medical plan coverage effective date came about. He noted that the committee centered its discussions around whether the University was really providing necessary coverage.

After some discussion, Gavin Watt noted that this item would be brought to the AWG. Based on todayÕs discussion, he reported having the sense that the committee was in favor of changing the waiting period to either 30 days after date of hire or the first of the month following date of hire. He made it clear, however, that any changes to this benefit are subject to bargaining.

VIII). Gavin Watt reported that the committeeÕs next meeting is scheduled for March 1, 2007 in the Boardroom of Coffman Memorial Union. Hearing no further business, Mr. Watt adjourned the meeting.

Renee Dempsey
University Senate