UNIVERSITY of ALASKA

Staff Alliance

UA Staff Health Care Committee

Minutes

November 4, 2010 1:30-3:30
1-800-893-8850, participant PIN **4236369#**
Attachments: **SHCC Roster (p. 3) -** *informational*
September 13, 2010 Minutes (p. 4) - *informational*
Summary of Current Medical Plan Design (p. 7)
Summary of Current Pharmacy Plan Design (p. 8)
PowerPoint on Budget Implications for Health Care
PowerPoint on Potential Plan Design Changes
Excel Summary of Potential Plan Design Changes

Participants: Megan Carlson, Linda Hall, Mike Humphrey, Gwenna Richardson, Maria Russell, Carol Shafford, Lisa Sporleder, Elizabeth Williams

1. **Call to Order**

2. **Brief updates**
   a. Roster and leadership for SHCC
      i. Maria will serve as the other UAF voting member
      ii. Election of chair at next meeting, to allow more time for input at this meeting
   b. Timeline for health care decisions
      i. JHCC reviewing options in November, add SHCC input to those discussions. Decisions about plan design must be made in December to allow time to build contribution amounts and prepare open enrollment materials for spring.

3. **Health Care Framing: Structure of Health Care at UA and Budget Actuals**
   a. Funding Structure, Projections, and Over/Under Recovery
      i. Most of remaining over recovery that has cushioned increases in recent years will be used up in FY11, unlikely to have more than $500K-$600K remaining to apply to FY12
   b. Health Care Actuals FY10 Review
      i. Closed books for FY09 and FY10. Trending at 7% increase for medical and pharmacy claims, 6.37% overall increase from FY09, which compares with Premera and national trends closer to 15%. This is lower than our usual trend, so we estimate conservatively at 10% increase per year.
      ii. University/employee ratio of share for health care costs is currently 83/17. UA leadership would like to bring this to 80/20, but it's an aspect of ongoing union CBA negotiations.

4. **Budget Outlook**
   a. If no changes are made to the current plan and budget structure, the HC expenses will double from $65M by 2017
   b. Health Reform short term mandated benefits will raise our expenses by up to $3.2M due to the removal of lifetime maximums and the broader eligibility for adult dependent children
   c. Combining a general trend of 10% increase, the plan is looking at a $9.7M increase to absorb next year, with almost no over recovery to offset these increases. It's important to find ways to control those costs through higher contributions and changes to the plan benefits in the near term, and bringing down claims long term through awareness and wellness activities

5. **Potential FY12 Plan Design Changes: Summary of Options and Questions (discussion in the next section)**
   a. This complete list of potential changes will not all be implemented. At this point, we are trying to winnow down a broad list of suggestions to a smaller list for further consideration.

b. Questions and issues addressed will be listed here where they arose. Discussion of the pros and cons of these suggestions is addressed in the next section.
c. Excluding Nexium on the plan
    i. Is it possible to get data on the number of people on Nexium who tried other meds in the same drug class
d. Mail order for maintenance (those taken monthly) meds
    i. Data on spoilage, but none on things getting lost in the mail. Is data available?
    ii. Would it be possible to exempt liquid maintenance meds from this requirement, since they're more susceptible to damage?
e. High Deductible Health Plan/Health Reimbursement Account
f. Intent is to make employees more aware of the actual cost of services and meds, rather than just the portion or copay they currently pay. The hope is this will drive behavior. With HRAs, funds can be rolled into future years, so conservative decisions would allow them to build a reserve to offset deductibles in ensuing years.
g. Spousal surcharge
    i. How would the university know if the spouse had benefits available?
    ii. How would it work if they had seasonal coverage?
    iii. How does the surcharge apply when the benefits are available due to retirement coverage (state, military, or otherwise)?
    iv. How does it apply to health care available through the Native Health Centers?
    v. Surcharges would not apply to adult dependents
h. Questions about savings with medical tourism, since current data don't show where the procedures took place in the last plan year. Seems like an additional option to offer our employees that could also save the university money, so it's a no brainer.
i. Plan Design
j. HRA/HSA/FSA Plans and Behavioral Based Plan Design
k. Employee Contributions
    i. Incenting Healthy Behaviors
l. Domestic Medical Tourism
m. Onsite Medical Clinic (likely unfeasible to launch in FY12)

6. Discussion of Plan Design Changes (remainder of meeting)

a. *Note: please see attached spreadsheet for complete summary of input on proposed changes*

Summary of Proposed Potential Plan Design Changes for FY12

Pharmacy Potential Opportunities

Description	Amount Saved	Notes	SHCC Questions	SHCC Comments
Remove Nexium from pharmacy plan	$ 250,000	Multiple OTC alternatives. Nexium costs the plan 307K. To stay on it, member would have to pay out of pocket.	Would it be possible to implement the reference based drug pricing for this med instead of completely excluding it? Mike to find out number of peope on the plan who are on Nexium as a maintenance drugs (at least 2 refills) after having been on others first.	Concerns of medical problems if we take away the drug that works. Don't want to take off the table.
Exclude all Proton Pump Inhibitors from pharmacy plan and implement a $5 copay for OTC PPIs	$ 328,800	Multiple OTC alternatives. To stay on it, member would have to pay out of pocket.	Would it be possible to implement the reference based drug pricing for PPIs instead of completely excluding them?	Concerns of medical problems if we take away the drug that works. Stronger concerns with this option than the one above because it affects a lot more drug options.
Exclude all Non-Sedating Antihistamine (NSA) drugs from pharmacy plan and implement a $5 copay for OTC NSAs	$ 85,500	Multiple OTC alternatives. Fairly common provision on plans.		Similar concerns as above, and saves us less money.
Reduced generic copays for certain maintenance drugs (cholesterol, cardiovascular, diabetes, COPD) to increase compliance	$ 44,900	Retail generic $2, mail order $5. Cost savings projected on medical health utilization from better maintenance of conditions.	Match DM list of conditions (e.g. asthma)? Look at brand where generic is not yet available too?	Great idea to encourage better health and generic use. Definitely support this one, and suggest the additions to left.
Increase differential between preferred brand name and non-preferred brand name from $40 to $60	$ 140,000	Retail tiers would be at $5/$25/$60		Several recent increases. Understand an increase, but the rate is too large-- would support $50 instead.
Referenced based drug pricing (maximum plan reimbursements by therapeutic class)		Base maximum amount on therapeutic class, member pays difference between Drug X and Drug Y within the class. Still a very new system not widely adopted.		A stretch to implement this one at this time. Consider whether it could be applied above to a limited class like Nexium or PPIs.
Mandatory Mail Order for maintenance meds (those taken monthly)	$ 100,400	Refills only covered if filled through mail-order; allow 2 refills before mandatory mail order. Members affected: 2503.	For mail order options, could we exempt liquid medications to avoid weather related issues?	Don't like taking away the choice altogether. Mail order concerns with getting lost in the mail or fixing errors, not just weather-related spoilage.
Non-mandatory Mail Order for maintenance meds: Double retail copay if member does not use mail order starting on third refill	$ 150,400	Retail copays would be at $10/50/80. Members affected: 2503	For mail order options, could we exempt liquid medications to avoid weather related issues?	Don't necessarily love this, but if mail order is implemented, this version is highly preferred.

Summary of Proposed Potential Plan Design Changes for FY12

Medical Potential Opportunities

Description	Amount Saved	Notes	SHCC Questions	SHCC Comments
Eliminate deluxe plan and continue with standard and economy plans	$280K to $360K	.5% savings		Concern with losing orthodontia coverage altogether if deluxe plan doesn't exist.
Eliminate deluxe plan and increase the standard and economy deductibles *Standard $250 increase to $500 *Economy $500 increase to $1,000	$1.8M to $2.1M	3% savings	If we deleted deluxe, could we offer an orthodontia add-on?	Would like to see a middle ground between #2 and #3 that allow three plans and more of an increase for all three. Receptive to an increase, but less than #3. At least one plan should be have a combined OOP & deductible at $2500, which is the FSA limit. Receptive to converting Economy to HDHP.
Increase deductibles and out of pocket maxes for Deluxe and Standard plans, and convert Economy to a high deductible health plan *Deluxe deductible $500, out of pocket $3000 *Standard deductible $750, out of pocket $3500 *High Deductible Health Plan (former economy) deductible $1500, out of pocket $4000 with $250 in seed money	$6M-7M	10% savings		Too big a jump for deductible and OOP. Numbers are the concern, not the intent of moving the deductible and OOP levels.
Introduce new Full Replacement High Deductible Health Plan with HRA account for economy plan	$7M to $8M	11% savings. Savings due to reduced utilization and movement of population to economy plan. Doing away with UA Choice altogether.		Way too drastic a choice.

Summary of Proposed Potential Plan Design Changes for FY12

Employee Contributions Potential Opportunities

Description	Amount Saved	Notes	SHCC Questions	SHCC Comments
Reduce university share (83%) of total cost to plan		Dependent on CBA negotiations; achieved by increasing employee share		Acknowledging that this is CBA-dependent, we did not discuss this option.
8 Tiers for employee contributions (replaces 4 tiers for employee, employee/spouse, employee/child, and family)		Different tier for dependents 1-3 for employee & employee plus spouse: EE, EE +1, EE +2, EE + 3, EE + SP, EE/SP +1, EE/SP +2, EE/SP +3 New way of distributing costs, unlikely to save money but may control the risk.		Supportive of this.
Spousal surcharge for covered working spouses who have another option for health care benefits		Typical amount is $50/month. Shifts risk, don't know uptake so hard to project savings.	Would like more information about reference to ASEA (20%) plan if this is a concern, and answers to questions about other coverage that might trigger the surcharge (seasonal coverage, retirement coverage, native health care coverage, etc.)	Concerns with this one, particularly as it relates to the numerous areas where we need more information.
Tobacco surcharge		Typical amount is $50/month. Offer smoking cessation program. Short term savings unclear.	Could it be easily removed if the tobacco user quite?	Decent idea. Would like more information about how it could be ended if the member quit. Surcharge that could be easily removed would be supported.
Charge Part-Time Employees more for benefits than Full-Time employees	$ 179,000	Part-timers typically cost more to the plan. Members affected: 299.	Need more data on whether **our** PT employees are actually spending more.	Only supportive if the data actually back this up for our employees. Would this be a straight $50 surcharge, or more for dependents?
Exclude high risk activities		Sky diving, bungee jumping, operating motorcycle or plane, scuba diving, hang gliding, rock climbing, parachuting, parasailing		Too undefined, concern about the list of activities expanding in the future
Different university contribution (83%) for dental and vision benefits				Don't want to take away the opportunity to catch medical conditions through this care
Employee contributions tied to completion of wellness activities and outcomes		Reduce contributions if you do an annual physical, complete HRA, participate in IHP. Could also have different deductibles for wellness plan and not-wellness plan. Short term savings unclear, greater impact on wellness participation and behavior change.		Would like more information about what this would look like, but generally receptive.

Summary of Proposed Potential Plan Design Changes for FY12			
Other Potential Opportunities			
Description	**Amount Saved**	**Notes**	**Notes**
Implement medical tourism (cover travel expenses for patient & another person to have certain procedures done in Puget Sound)		For each knee replacement done in Seattle and not Fairbanks UA could save $46K. 43 knee replacements, 29 hip replacements, 26 discectomies in FY10.	Excellent idea, strong support
Pilot onsite medical clinic in Fairbanks or Anchorage		Unlikely to be implemented in FY12 due to startup logistics	Great thing to reduce costs and make health care services more accessible.