UNIVERSITY of ALASKA

Staff Alliance

UA Staff Health Care Committee

Draft Agenda

September 22, 2011 9:00-10:30
Video Conference Locations
UAA – Adm 201 UAS Juneau – TBD UAF - TBD
Audio Bridge: **1-800-893-8850, participant PIN 4236369**
Attachments: Draft Minutes from August
Tobacco Surcharge draft documents

1. **Call to Order, Roll Call, and Approval of the Agenda**

Name	Representative Group	*E-mail*
Craig Mead, **Chair****	UAA Classified Council	cimead@uaa.alaska.edu
Linda Hall	Statewide Administration Assembly	linda.hall@alaska.edu
Lisa Sporleder*	JHCC Voting Member Statewide Administration Assembly	lisa.sporleder@alaska.edu
Melodee Monson*	JHCC Voting Member UAA APT Council	melodee@uaa.alaska.edu
Russ Pressley	UAA APT Council (alternate)	afrhp1@uaa.alaska.edu
Carol Shafford	UAF Staff Council	cashafford@alaska.edu
Maria Russell	UAF Staff Council	mtrussell@alaska.edu
Catherine Williams	UAF Staff Council (alternate)	cewilliams2@alaska.edu
Richard Machida	UAF Staff Council (alternate)	rm@alaska.edu
Elizabeth Williams	UAS Staff Council	eawilliams2@uas.alaska.edu
Gwenna Richardson	UAS Staff Council	gjrichardson@uas.alaska.edu
HR Representative,*ex officio*	UA Human Resources	

* Joint Health Care Committee (JHCC) Voting Member **JHCC Alternate

2. **Brief Status Updates**
   a. Committee Business—*Craig Mead*
      i. Approval of Minutes from August
      ii. Transition for HR Benefits representative on the SHCC
   b. JHCC September meeting—*Lisa Sporleder, Melodee Monson, Craig Mead*

4. **Tobacco Surcharge Update—**
   a. FAQ and Certification drafts for committee review and input

5. **Discussion of Potential Plan Design Changes for FY13**
    a. Agenda packet includes communication to employees about plan changes for FY12. These files and more are available here: http://www.alaska.edu/benefits/health-plan-changes/.
    b. Does the committee support considering any changes to the health care plan in the fiscal year that begins in July 2013? If so, what should be on or off the table?

6. **Revisit HRA/HSAs after data is available on the number of employees on each plan**
    a. We were presented with enrollment numbers last month. What is our next step to move forward?

7. **Topics for next meeting**
    a. Thursday, Oct. 27th 9:00-10:30

UNIVERSITY of ALASKA

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UA Staff Health Care Committee

Draft Minutes

August 25, 2011 9:00-10:30

Attendees: Megan Carlson, Lisa Sporleder, Linda Hall, Kat Williams, Melodee Monson, Mike Humphrey, Beth Behner, Todd Leveridge (Lockton), Craig Mead, Elizabeth Williams, Russ Pressley, Kim Fackler, Juella Sparks

1. **Call to Order, Roll Call, and Approval of the Agenda and Minutes from June & July**

2. **Brief Status Updates on JHCC**
   a. JHCC: Charter Committee had not met. Unclear what the status of the 2nd voting member of non-represented staff would be. Charter committee to meet prior to 9/21 meeting.
   b. Heard reports on Pharmacy utilization. Some prescriptions may see cost saving opportunities this fiscal year, due to new generics that are expected to be available.

3. **Tobacco Surcharge Update**
   a. Discussed draft affidavit form and FAQ. There was general agreement with JHCC that FAQ needed more clarity regarding the requirement of non-smokers to complete and turn in affidavit during open enrollment.

4. **4th quarter utilization information presented by Todd Leveridge (Lockton)**
   a. Large Claims accounting for much of cost increases seen on the plan. Some large claims categories could suggest conditions from lifestyle. University should continue emphasis on prevention and wellness.
   b. Emergency room claims data suggests that plan members are going to the ER for appropriate services.
   c. Slight increase in length of stay for inpatient services, still before Premera Norm.

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UA Staff Health Care Committee

2011-2012 Membership List

Name	Representative Group	*E-mail*
Craig Mead, **Chair****	UAA Classified Council	cimead@uaa.alaska.edu
Linda Hall	Statewide Administration Assembly	linda.hall@alaska.edu
Lisa Sporleder*	JHCC Voting Member Statewide Administration Assembly	lisa.sporleder@alaska.edu
Melodee Monson*	JHCC Voting Member UAA APT Council	melodee@uaa.alaska.edu
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Elizabeth Williams	UAS Staff Council	eawilliams2@uas.alaska.edu
Gwenna Richardson	UAS Staff Council	gjrichardson@uas.alaska.edu
Mike Humphrey, *ex officio*	UA Human Resources	mike.humphrey@alaska.edu

* Joint Health Care Committee (JHCC) Voting Member **JHCC Alternate

Last Updated: August 15, 2011

Office of Human Resources
907-450-8200 (phone)
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UNIVERSITY
ALASKA
Many Traditions One Alaska

DATE: January 21, 2011

TO: Patrick K. Gamble, UA President
FROM: Beth E. Behner, Chief Human Resources Officer

SUBJECT: Recommended Changes to UA's Health Care Plan for FYI2

The University's System HR office has worked extensively with the University's Joint Health Care Committee (JHCC) and the Staff Health Care Committee (SHCC) over the course of the last year to review possible changes to the University's health care plan. In August, 2010, the University hired a new consultant, Lockton, whose representatives have been invaluable in helping us analyze and consider a range of options. Presentations of our analysis of the University's growing health care costs and possible ways to address it have been shared with the health care committees, UA's Human Resources Council, UA's Business Council, Governance groups throughout the system, UA's executives and UA's Board of Regents, with input received and considered from each meeting. For FYI 0, UA's actual health care costs were $65M. The bottom line is that if plan changes do not occur, the University's health care costs are projected to increase by $6.5M for FYll and another $7.2M for FYI2. By FYI7, a status quo health care plan would cost UA $72.5M more than it currently does, which means UA would experience a doubling of its health care costs over seven years. Documents and briefing summaries concerning plan costs and plan design options are maintained on UA's SWHR Benefits website, for easy access by employees concerning information gathered and the status of issues under consideration. The review process by UA's health care committees has now concluded.

Under the terms of the collective bargaining agreements (CBAs) between the University and its represented benefits-eligible employees, the JHCC makes recommendations based on a consensus approach or a formal vote if consensus is not possible. Although representatives of the Staff Health Care Committee are not in a union, the University operates in a collaborative fashion with them to review health care plan issues and consider the staff committee's recommendations. At the conclusion of the input and consideration process, recommendations from both committees were forwarded to me as the University's Chief Human Resources Officer (CHRO). The language in the CBAs calls upon the University to accept the JHCC's recommendations unless the CI·IRO determines that the best interests of the University and the health care plan would not be served in accepting the recommendation(s). In this memo, I have described whether my recommendation on behalf ofUA's administration is aligned with the JHCC and the SHCC recommendations or if it differs, as well as the rationale for reaching any decision which differs from the recommendation or input from the JHCC and the SHCC.

The University health care committees have been infom1ed that because of the significant level of plan design changes under discussion, I planned to consult with you before final decisions are made. In this memo I am presenting for your consideration, 3 health care plan changes and pharmacy changes to be implemented in FY12, for a total projected cost savings to the health care plan of$7,815,500. Some plan changes for FY12 have associated features that will be implemented or continued during FY13. Beginning on page eight of the memo, I have addressed other plan changes that I am not recommending at this time, or that are recommended for further review or for future implementation.

Please let me know if you endorse these recommendations. I will then proceed accordingly to communicate the decisions to UA's health care committees and begin working toward implementation.

Medical Plan Change Recommendations for FY12

I. Eliminate costly features of the current deluxe plan. Maintain three health care plans (Low, Medium and High), from which employees may choose. Increase deductible and out-of- pocket maximum levels for all plans. Because of the significant savings to the University from implementing these changes, the total amount of employee recovery needed will not change from FYI! to FYI2. Therefore, UA will not seek an increase in total employee contributions, although the University will consult with its health care committees prior to establishing employee charges for the health plan tiers. The University does not plan to make any additional deductible or out-of- pocket maximum levels for UA health care plans through FY13, although other health care or pharmacy plan changes may be determined necessary.

Explanation: See attached chart of proposed tiers, with modified deductible and out of pocket (OOP) maximum levels.

Input by the Joint Health Care Committee and Staff Health Care Committee: The JHCC did not have enough votes to reach a formal recommendation for any of the specific plan scenarios formally considered. However, union representatives on JHCC were generally not in favor of the plan changes I have recommended. They expressed concerns that too many costs would be shifted to employees through the proposed increases to deductibles and out-of-pocket maximums. The SHCC's preferred scenario was one which made less significant changes to the deductible and out of pocket maximum levels, for a projected savings level of $3.9M.

Rationale for CHRO's Recommendation: The current deluxe plan does not steer plan members to network doctors and hospitals by requiring a higher coinsurance on non-network providers. This results in much higher plan costs since non-network providers charge the plan more for their services.

Deductibles and out of pocket maximums need to be increased across the board as they have not kept pace with years of medical inflation. For example, the $100 individual deductible contained in the university's deluxe plan has been in effect at least since the early 1970s. Higher deductibles and out-of-pocket maximums for all three plans will increase consumerism because members will spend money out of pocket first and will not qualify as quickly for 100% coverage by the health care plan.

As a part of the recommendation for the plan changes listed on the attached spreadsheet, the University would implement a health savings account (HSA) or a health reimbursement account (HRA) in combination with a qualifying high deductible plan for the Low Tier in FY13. This would be a further step in incenting plan members to make careful use of the health care plan. With the implementation of an account based plan, the University would provide "seed money," to cover some first dollar costs. The deductibles and out-of-pocket maximum amounts for the Low Tier would be increased by the amount determined appropriate for the seed money. The university's contribution to employees of the seed money will remain in members' accounts (HSAs or HRAs) until such time as the money is used on a first dollar basis to satisfy their deductibles, coinsurance and co-pays. Members may carry unused HSA or HRA funds over from year to year while employed. Only with an HSA would an employee be able to retain account funds after leaving UA employment. The Low Tier plan proposed for FY12 will qualify for and be easily transitioned to the implementation of a HSA or HRA account-based health care plan.

My decision to make the present recommendation for the described changes in the absence of full support or consensus by UA's health care committees is based on the following reasons:

A. This plan change will more immediately shift behavior and increase careful utilization by health care plan users.

B. This plan change allows stability through the intention to have the major health care plan features (deductibles and out of pocket maximums) in place for at least two years. If we made more modest plan changes now, we would likely have to increase deductibles and out-of-pocket maximums again in FY13.

C. This plan change permits us not to have to increase the total amount of employee contributions for health care in FY12. A less significant change in the plan's deductibles and out-of-pocket maximums would have required the University to increase all employee charges for FY12. This would have resulted in less take-home pay for all employees, whether or not they have used any medical or pharmacy services. The recommended plan bases increased costs to employees on the level of their actual plan use, rather than applying increased costs to all employees.

D. This plan change creates a Low Tier plan that is ready to be accompanied by an HSA or HRA for FY13. This will enable the university and its health care committees to educate employees on the features of account based plans, which some employees will find very attractive.

E. This plan will prepare the university for future health care reform changes that go into effect in 2014 and 2018. On the latter date, the "Cadillac tax" will go into effect (a tax of 40% for benefit values over the set limits of $10,200 for a single employee and $27,500 for a family.)

Estimated savings to the health plan budget-- $6,500,000

2. Institute a Tobacco Surcharge for employees if they or their covered spouse/dependents use any tobacco products. A charge of $50 per month would be deducted from the employee's pay.

Explanation: Upon enrollment in the health care plan, employees would be presumed to be tobacco users subject to the charge unless they submit a signed form stating that they and their dependents do not use tobacco.

Input by the Joint Health Care Committee and Staff Health Care Committee: Both the JHCC and the SHCC viewed this proposal favorably.

Rationale for CHRO's Recommendation: A monthly charge of $50 is an amount sufficient to incent people to reconsider their use of tobacco. Tobacco users cost the plan substantially more than non-users because of the adverse health effects of tobacco use over time. Depending upon where you live in the U.S., a habit of one pack per day can cost up to $1,800 in increased health care per year. In announcing this new surcharge, the university will inform current tobacco users that they may avoid this surcharge by participating in a smoking cessation program, which will be offered on a no-cost basis by the university. Following the implementation of the surcharge in July, 2011, members who use tobacco will only qualify for removal of the surcharge if they and their

dependents have been tobacco free for 12 months or have satisfactorily entered a tobacco cessation program and not resumed tobacco use.

Estimated savings to the health plan budget-- $504,000

3. Conduct a dependent audit.

Explanation: Until this current fiscal year, the university did not require documentation from new employees to verify the eligibility of spouses or dependents whom the employee wished to enroll in UA's health care plan.

In July 2010, UA changed its health care plan, instituting a program to check dependents' eligibility documents, e.g. birth certificates and marriage certificates. This review process is currently done by the MAU HR offices. Checking occurs for new hires only, or when current employees request to add a spouse/dependent. A dependent audit, conducted by an external vendor who is a specialist in this type of verification, will be employed to ascertain the eligibility of every dependent listed on UA's health care plan.

Input by the Joint Health Care Committee and Staff Health Care Committee: Both the JHCC and the SHCC viewed this proposal favorably.

Rationale for CHH.O's Recommendation: The cost of covering ineligible dependents on our plan is an expense that must be avoided. As health care costs have increased, it is to be expected that some employees would attempt to list individuals on the plan even though they are not eligible under the terms of UA's plan.

Reviewing eligibility of adult children of dependents is another task that will be done as a part of the dependent audit. The university has carefully scrutinized eligibility when covered children reach the age when they are no longer eligible for health care coverage. Under the terms of the current plan, enrolled children will not be eligible for health care at age 19 unless they provide proof of enrollment as full-time students. Children of UA employees currently are no longer eligible for coverage whatsoever once they reach the age of 24. However, on July I, 2011, federal law will require the coverage of employees' dependents until they reach the age of 26. Those children currently not covered by UA's plan due to age or lack of full-time student enrollment status will be entitled to return to coverage until they are 26 years old. A dependent audit will help the university with the extensive process of reviewing eligibility of the new category of dependents who have never been on our plan or who have left it and are requesting to be returned to coverage under the federally mandated plan changes.

Estimated savings to the health plan budget -- $500,000, over and above the cost of the audit's cost of between $65,000 and $75,000. In the contract with the vendor, there is a vendor guarantee that if UA does not have a 4% drop of ineligible dependents, they will reduce their fee proportionately for every tenth of a percentage point below 4%. Thus, if UA were to only achieve a 3% ineligible drop rate, a 25% reduction in the fee would occur and UA would receive back approximately $17,000 in fees.

Pharmacy Plan Change Recommendations for FY12:

I. Move certain prescription products to the Tier III copay from Tier II, and require preauthorization before prescriptions for these drugs can be filled.

Explanation: Nexium, Dexilant, Proton Pump Inhibitors and Non-Sedating Antihistamine (NSA) drugs are available in chemically equivalent over the counter form.

Input by the Joint Health Care Committee and Staff Health Care Committee: Both committees considered whether to remove these drugs from the plan altogether, which would have caused members to either have to use OTC products or pay the full costs for the prescription drugs. While it would save more money for the plan not to cover these medications at all, there are some patients who cannot use the OTC products. The JHCC recommended removing them from plan coverage, while the SHCC voted to move these prescriptions to Tier III.

Rationale for CHRO's Recommendation: Moving these drugs to Tier III and requiring preauthorization requires members to use generic products unless the patient receives approval for the brand name drug based on a doctor's certification. Even if that occurs, a higher price will be paid by the user as the drugs will be in Tier III.

Estimated savings to the health plan budget-- $23,700 just to move Nexium from Tier II to Tier III. We have not requested the savings for other drugs from Caremark.

2. Eliminate generic retail and mail-order co-pays for certain generic maintenance drugs, i.e. those used for treatment of patients with chronic problems due to cholesterol, cardiovascular disease, diabetes, chronic obstructive pulmonary disease (COPD) and asthma.

Explanation: Patients with these chronic diseases cost the health plan a substantial amount of money on the medical side. The eligibility for free generic drugs is contingent on the patient's participation in the disease management program.

Input by the Joint Health Care Committee and Staff Health Care Committee: Both the JHCC and the SHCC viewed this proposal favorably.

Rationale for CHRO's Recommendation: Providing maintenance drugs at no cost to the member to incent continued and consistent use is good for the patients and saves medical costs from complications and exacerbated conditions.

Estimated increase to the health plan budget-- $2,600.

3. Increase differential between preferred brand name and non-preferred brand name drugs by increasing the copay from $40 to $50.

   Explanation: Under this recommendation, retail copay costs for prescriptions would then be $5 for Tier I (generic), $25 for Tier II (preferred brand) and $50 for Tier III (non-preferred brand), with mail-order being two times the retail copay. The goal is to shift use to lower cost generics or preferred brand name drugs, which are less expensive for the plan.

   Input by the Joint Health Care Committee and Staff Health Care Committee: Both the JHCC and the SHCC viewed this proposal favorably.

   Rationale for CHRO's Recommendation: This change saves the plan money while not presenting a significant disadvantage to pharmacy users, most of whom can successfully substitute generic or preferred brand prescriptions for non-preferred brand prescriptions.

   Estimated savings to the health plan budget -- $140,000

4. Incent mail order filling of prescriptions for maintenance medications

   Explanation: Plan would be modified to increase copays for retail prescriptions to double the rate of the regular retail co-pay if the plan member does not use mail order starting on the third refill. The exclusion to this plan provision would be for medications that could freeze during shipment.

Input by the Joint Health Care Committee and Staff Health Care Committee: Both the JHCC and the SHCC viewed this proposal favorably.

Rationale for CI-IRO's Decisions: Mail order is much less expensive for the University, but many members do not use it because they believe it is more convenient to go to local pharmacies. Higher financial costs will change members' behavior.

Estimated savings to the health plan budget -- $150,400

In summary, recommend that these changes be put into place as a package of health care and pharmacy plan changes for FY12. Communications to employees will begin immediately. The primary plan change, of creating new Low, Medium and High Plans, will be available for employees' selection during open enrollment, which begins in mid-April. Other components of the plan changes, which do not affect employees' plan selections, would be rolled out sooner. For example, the Dependent Audit will be initiated immediately, and smoking cessation offerings would begin as soon as they can be arranged.

The health care committees also considered many other suggestions designed to achieve cost savings to UA's health care plan. The remainder of this memo provides information concerning those issues, the feedback received from the committees and the current status of Statewide Human Resources' recommendations on each.

Medical Plan Changes Under Consideration for FY13 **or** After

I. Institute a Spousal Surcharge. This would deduct a certain dollar amount, e.g. $50 monthly, from the pay of any benefits-eligible employee who has enrolled his/her spouse in UA's health care plan. The surcharge would only apply if the spouse is eligible and has access health care benefits through their own employer.

Explanation: The university wants to be an employer of choice without being an insurer of choice. UA should not have a plan that is so reasonably priced for dependent coverage that spouses decline the coverage offered by their own employer and choose to be covered by the UA plan. The university's charging structure to date has not provided a disincentive for members to enroll their spouses under UA's plan rather than their own.

Input by the Joint Health Care Committee and Staff Health Care Committee: Both JHCC and the SHCC were opposed to this change at this time. SHCC wanted to UA to see if

the plan changes in FY12 will reduce the number of spouses enrolled on the plan and if not, a spousal surcharge could be added in FYI3.

CHRO's Recommendation and Rationale: A spousal surcharge was not recommended for FY12 as the significant increases in family deductibles will tend to operate as a deterrent to enrolling spouses if they have equivalent coverage elsewhere. However, this type of surcharge will remain under evaluation as we review how many spouses are enrolled on UA's plan. Data on other coverage will be gathered by the vendors conducting the dependent audit, which will help us further evaluate this type of surcharge.

2. Create new tiers for dependent charges, so that covered members will pay more for larger families than is currently the case.

Explanation: Currently, the University has 4 dependent charging tiers: Employee only, Employee plus spouse, Employee plus child(ren) and Employee plus family. While the current structure does address the increased costs of adding dependents, if we added more tiers, it would allow better control of the increased cost to the plan when large families are covered.

Input by the Joint Health Care Committee and Staff Health Care Committee: Both the JHCC and the SHCC recommended more research on the methodology for setting employee rates and further analysis of types of claims dependents are having. If the research supports a change, it could be implemented in FY13.

CHRO's Recommendation and Rationale: Continue to evaluate this as Lockton gathers more information and analysis regarding the costs to the plan caused by dependent usage.

3. Charge part-time employees an increased employee charge for health care coverage.

Explanation: Currently, part-time employees are eligible for health eare if they are in a benefits-eligible position and work over 20 hours per week. Many employers do not offer health care coverage to employees at this low a level of hours worked, or the employers may charge the part-time employee a higher cost for coverage than full-time employees pay. Some employees work part time due to their own preference, or in order to obtain health care benefits. If there is no business need to hire part-time employees, the university incurs greater costs when it hires 2 part-time employees with two benefits packages rather than 1 full-time employee with one benefit package.

Input by the Joint Health Care Committee and Staff Health Care Committee:
Both the JHCC and SHCC recommended more research into the claims costs for part-time employees. If the research supports a change, it could be implemented in FYI3.

CHRO's Recommendation and Rationale: CHRO recommends reviewing this issue further. Currently, the university employs about 300 part-time, benefits eligible employees, but it is not known how many of these employees are part time due to the university's needs and how many have requested to be part time. The university contributes the same amount for health care for part time, so the benefits costs are higher relative to the salary costs than is the case for a full-time employee. However, it is not known whether part-time employees cost more in terms of health care plan utilization. Rather than a part-time surcharge for benefits, the university may want to limit health care coverage to those employees working 30 or more hours per week. Effective January 1, 2014, Federal law will require employers to provide health care coverage to employees on a full-time basis if they work a minimum of 30 hours per week. Increasing the hours needed for health care eligibility would require a modification to University Regulation 04.06.149, "Benefits for Extended Full Time and Part-Time Temporary Employees," as well as changes to health care plan documents.

4. Exclude high risk activities from coverage under UA's health care plan.

Explanation: Activities such as sky diving, bungee jumping, operating a motorcycle or plane, scuba diving, hang gliding, rock climbing, parachuting and parasailing could be excluded from coverage.

Input by the Joint Health Care Committee and Staff Health Care Committee: The JHCC and the SHCC questioned how this could be administered and what activities should be included as "high risk."

CHRO's Recommendation and Rationale: Review this issue later, after additional information is gathered. Eliminating high risk activities would mean that employees would bear the entire costs of medical care if accidents occurred while engaging in such activities. Such exclusion would be highly controversial and unwelcome to employees who are active and adventurous.

5. Tie employee charges to completion ofwellness/fitness activities and outcomes.

Explanation: This approach would base employee deductions on documented statistics and measures of involvement in activities that promote health and wellness and therefore are predicted to reduce the individual's risk to UA's health care plan. Through lower employee charges, an incentive would exist to encourage employees to obtain an annual physical, complete an annual health risk assessment, obtain and monitor biometrics and BMI, as well as to participate in defined activities to improve fitness, good nutrition, a healthy weight and positive lifestyle choices.

Input by the Joint Health Care Committee and Staff Health Care Committee: JHCC and SHCC need to be involved in the development of wellness activities that would lead to the lower employee charge.

CHRO's Recommendation and Rationale: There is widespread support for tying employee charges to documented wellness activities, so that employees who are trying to avert their own health complications and chronic conditions are charged less than those who are not making such an investment of their time and effort. Using measured activities and outcomes as a basis for employee charges is more effective than rewarding activities without subsequently reviewing whether or not they have resulted in a reduction of risk factors. Lockton has the ability to analyze the utilization ofUA's plan, which will help us in structuring an incentive structure likely to yield positive plan results. However, more time is needed to work with Lockton, UA health care committees and employee groups to consider the type of incentive structure to devise that will be well received by employees and make a difference to plan use. A differential charging structure based on a number of participation levels would require Banner system changes, as modifications in the employee charge structure must be programmed into the payroll system.

6. Implement a Surgical Travel health care plan feature.

Explanation: Research into the costs for particular medical procedures performed in Alaska compared with the costs for the same procedures performed in the Northwest shows that there is a substantially higher medical cost for some medical procedures obtained in Alaska. The university's medical plan could offer members who need certain kinds of surgeries additional financial support to help defray travel and related costs if they decide to have the surgery in designated treatment centers in the Northwest.

Input by the Joint Health Care Committee and Staff Health Care Committee: Both the JHCC and the SHCC viewed this proposal favorably.

CHRO's Recommendation and Rationale: This idea should receive further review as to the level of support that would serve patients' interests and needs, while still representing a significant cost saving to the university. This should be considered only for those members/covered dependents who prefer to travel to obtain surgeries. A pilot project with eligibility limited to certain surgical procedures would be a sensible way to test this option.

7. Establish an onsite medical clinic in Fairbanks or Anchorage.

Explanation: A medical clinic, staffed with UA-employed MDs or physician assistants and staff, could be located on or close to UAF or UAA to serve university employees and their dependents. This would present a major investment, due to the need for a facility and staff for such a clinic. However, universities and other organizations that have opened their own clinics are better able to control medical costs, while offering services conveniently close to the workplace.

Input by the Joint Health Care Committee and Staff Health Care Committee: Both the JHCC and the SHCC viewed this proposal favorably.

CHRO's Recommendation and Rationale: This is an idea for consideration in the future with the likely pilot project being UAA's physician assistant program.

8. Eliminate the current award of $100 per year for each covered employee and spouse who completes a personal wellness profile (PWP or health risk assessment).

Explanation: The university has provided this amount every year for participating employees and spouses since 2004, when a provision was first negotiated into CBA articles regarding this payment. Completion of a personal wellness profile (PWP) provides the individual with feedback on their state of health as well as making recommendations for steps that can be taken to improve their health risk levels, addressing issues such as the level of physical fitness, mental health, diet, alcohol consumption and stress. However, the biometrics reported in the health risk assessments are all self reported and there is no linkage between the PWP contents with any referral to medical providers, disease management services or the employee assistance program.

Input by the Joint Health Care Committee and Staff Health Care Committee: The JHCC and the SHCC were both in favor of eliminating the $100 award for the simple task of

completing the PWP, believing that such an incentive could more beneficially be used to reward activities that have a greater impact on employee behavior.

CHRO's Recommendation and Rationale: CHRO agrees with this assessment and is in favor of biometrics being measured and entered into a data base that can be forwarded for review by UA's disease management program to assure appropriate follow up and attempted intervention. However, the provision for the $100 award to employees and spouses is currently referenced in collective bargaining agreements, and hence must be changed through negotiations or via a memorandum of understanding with the unions.

9. Require employee participants to complete 5 out of 6 sessions when they enroll in the university's Individual Health Plan (IHP) coaching program, or pay a penalty.

Explanation: Currently, about 20% of participants drop out of the IHP program after enrolling. They take up space that others could utilize, which results in an inefficient use of WIN for Alaska's staff and increased costs to UA.

Input by the Joint Health Care Committee and Staff Health Care Committee: The JHCC and SHCC recommended that rather than a penalty for non-completion, we consider a reward or incentive for successful completion of all 6 IHP sessions.

CHRO's Recommendation and Rationale: CHRO agrees with the committees' recommendation and will continue to review this issue, recognizing that the value of the IHP offering itself is very valuable to each individual who is able to participate in the sessions.

10. Require employees to participate in obtaining and logging biometric information upon enrollment into IHP sessions, as well as at the end.

Explanation: Currently, IHP enrollees may choose to have biometric screening, but it is voluntary. Further, even if the biometric numbers are logged into the employee's own wellness page, the information is not entered into a database so that aggregate statistics can be reviewed or personal information forwarded to UA's disease management program for follow up. The recommendation would change this, making it mandatory to have biometric information gathered and shared in a confidential manner with UA's disease management providers.

Input by the Joint Health Care Committee and Staff Health Care Committee: The JHCC and the SHCC members recognized the value of requiring biometrics for appropriate individual follow up/intervention.

CHRO's Recommendation and Rationale: CHRO supports mandatory gathering, logging and reporting of!HP participants' biometric information to UA's disease management vendor.

A review by Lockton of the aggregate biometric information of!HP participants could also allow UA to more reliably determine whether the IHP program is providing the university an appropriate return on investment. II-!Ps are personalized coaching services that can directly help individuals to make health and lifestyle changes, but they are expensive to deliver because of the one on one sessions offered. Individuals who are realizing the benefit of the personalized coaching should be willing to participate in the review of its effectiven