College Benefits Council Meeting Minutes
April 30, 2014
10:00 am - 12:00 pm
Parkhurst 303

Members present: Rich Howarth (Chair), Ginny Hazen, Tricia Cornelius, Bob Hawley, Allan Gulledge, Ronald Green, Harold Frost and Andrea Tarnowski
Members absent: Patti Bacon, Richard Sansing, Ethan Lewis, Carrie Colla, Gwen Williams, Kate Soule and Katrina Davis
Also present: Rick Mills, Michael Wagner, Lynn Baker, Tricia Spellman, Courtney Rotchford and Melissa Miner, Alice Tanguay
Minutes: Krystal Knowlton

1. Review and Approval of Meeting Minutes from March 2014

There was a motion to approve the March 2014 minutes. The motion was approved.

2. Workgroup Updates

Updates were given regarding the progress each workgroup has made

- Plan Design
  - A brief overview of the current plan design including deductible and coinsurance levels.
  - Actuarial value of each plan: the percentage of the total actual cost for covered benefits that the plan will cover essentially, how much the plan is worth. Currently, OAP1 has an actuarial value of 87%, OAP2 has a value of 83% and the HDHP has a value of 75%.
  - The workgroup has been discussing multiple options for plan design changes in 2015:
    - Keep 3 plans or collapse into 2
    - Equal premium increase across all plans or try to encourage enrollment into higher cost sharing plans by having a premium differential (higher increase in OAP1 versus the other 1 or 2 plans)
    - Continue current cost sharing (deductible and coinsurance levels) or tweak – could potentially add coinsurance to the HDHP
    - Lab, X-ray and DME costs – cover at 100% in any plan or make subject to deductible and coinsurance
    - Vision hardware benefit – add $50 benefit in OAP2
    - Expand the employer $250 contribution to the FSA to also include the HSA to encourage enrollment in the HDHP
  - The most important aspect of any plan changes made is that it can be effectively communicated by the Dartmouth community – need to be able to justify any change in benefit and explain how it impacts the college overall.
  - Providing choice of 3 medical plans only makes sense if the plans are different enough from one another that it allows the employee to make a choice based on their needs. There is concern that a significant increase in OAP1 premiums will force lower income employees to elect the higher cost sharing plans.
    - Also a concern that employees may delay or avoid care if they cannot afford it
The group feels they need additional information before making a recommendation; need to be able to discuss within the community why the changes are being made and that justification is not yet understood within the group.

- Could shift towards a highly managed care network – this plan design would bring costs down by closely managing the care of each employee and would add a component of gate keeping which generally prevents misuse of insurance.
  - There is an issue of limited providers in the upper valley which makes it more difficult to closely manage care – employees would also need to engage with care coordinators over the phone
  - Could incentivize employees to use lower cost settings for basic services such as MRI’s

- Another suggestion is that Dartmouth does not decrease the value of the medical plans and just pays the excise tax in 2018. Could design the OAP1 plan with the lowest deductible and copays possible while staying just under the ceiling amount for the tax – would keep the plan rich but would likely have extremely high premiums.
- Could look into a plan design with a donut hole – a certain amount of coverage is paid for first, then employee would enter the deductible period and then reaches full coverage after the deductible is met.

- Group feels the best way to go is to make short term decisions for 2015 and continue conversation about the impact of the excise tax to decide on long term changes. Decisions should be made by June to calculate premiums and program system for open enrollment.

- Medical Management & Employee Education
  - Workgroup subject matter revolves around the commitment to healthcare dialogue that needs to happen outside of open enrollment.
  - Healthcare conversations to begin in Mid-June and continue through the fall to discuss what is going on in healthcare nationally and what impact these changes have on Dartmouth's plan design for 2015 and beyond.
  - Group is working to find space on campus to host forums and encourage employees to learn more.
    - Screening guidelines for preventive care a suggested topic
  - In 2015 this workgroup will continue and will focus on educating employees on the Nurseline, other resources available other than the emergency room, website navigation, and why is Cigna calling me?

- Behavioral Health
  - Workgroup is still brainstorming and looking into survey data that might be available to give insight about the population, access to care issues, and how to create a comprehensive model around behavioral health.
  - Three models are currently under review by the group – the best option may not be one of these, but a combination of the models considered best practice.
  - Dartmouth needs to remain conscious that it is not the job of the college to manage care but to help employees find solutions to the access to care issues in the community.
  - The current medical plan design allows 12 lifetime visits to an out of network provider at the in network cost – this has helped employees around the access to care issue in the short term, but once an employee is established with a provider they often don’t want to transition to an in network provider.
At this point an employee would need to be added to a waiting list to see an in-network provider or would spend the money out of pocket to continue care with their out of network provider.

- Dartmouth has worked with Cigna to add providers to the network but many local providers are not happy with the contracted reimbursement or reporting to insurance companies.

- Next steps for this workgroup include:
  - Engaging in conversation with CIGNA’s National Behavioral Health expert
  - Completing additional research on what organizations in the area are doing to increase access to care for their employees
  - Each member of the workgroup is following up with a contact outside of Dartmouth to find out additional information
  - Considering a special benefit with CIGNA or with local providers for children’s mental health in the area, as this is another large gap in care
  - Looking into conflict management and the need for supervisor training across campus

- For fall 2014 the workgroup needs to be prepared to make a recommendation for change, which could involve plan design changes for 1/1/15 or changes implemented mid-year 2015.

3. Dartmouth Health Connect Update

- There was a need for Dartmouth to think creatively about managing costs as a self-funded health plan and using a new model of primary care, Dartmouth Health Connect was the answer.
  - Holistic approach to healthcare
  - No billing between DHC and Cigna; no copayments for employees and a focus on preventive care
- While enrollment in DHC has slowed down, by early fall the capacity of 1600 should be reached.
- The goal was to enroll 13% complex patients; although the model usually has a much higher rate of complex patients which has been proven to lower costs, investing money in preventive care up front may also bring costs down by keeping employees healthier.
  - DHC looking to test the model with a healthier population
- The Measure Up/Pressure Down program has focused on those patients with high blood pressure – currently, 83% of those identified as hypertension patients are below 140/90
  - These are among the best rates seen in the country – goal to reach a minimum of 90%
- There is no normal patient visit schedule. Patients have individual treatment plans depending upon how much care is needed; can even triage incidents over the phone.
  - Clinical staff at DHC have a meeting each morning to discuss patients who are in need of care; patients discussed have a high worry score given by the clinical team and likely need follow up; way to keep high risk patients in mind
- Further evaluation is taking place to compare DHC patients to non DHC patients.
- Next steps for Dartmouth Health Connect:
  - Continue enrollment up to 1,600 patients, with additional effort to recruit patients who could benefit the most from care
  - Increase focus on downstream care coordination, establishing protocols for specific specialties and targeted relationships with high-value specialists
  - Deploy a new set of population health management and care coordination tools
• Within the next 9 to 10 months there should be enough data to determine whether to open up enrollment beyond 1,600 patients.

4. Revisit Pharmacy Savings Options

• Spend on specialty drugs in 2013 was 3.1 million dollars – represents only 1.3% of prescriptions.
• There are options to change pharmacy plan design to decrease costs but they will impact how employees access medication.
• Recommendation for 2015 plan design changes will need to be made by June.
• Pharmacy saving options will be reviewed at the next CBC meeting.

5. Next Steps

• Workgroup meetings will continue
• Next CBC meeting will be planned for late May or early June
• All recommendations for plan changes for 1/1/15 need to be made by June

The meeting was adjourned at 12:05pm.