The meeting began at 1:10pm

The motion to accept the minutes of the last meeting was passed by Dana Williams, seconded by Lora Thompson and passed unanimously.

The minutes can be seen at: http://www.dartmouth.edu/~hrs/benefits/other/

**SilverScript Pharmacy Benefit Plan Implementation**

Over 1,000 Dartmouth Medicare-eligible retirees and their dependents have moved to SilverScript

Most operational issues have now been resolved

SilverScript will be conducting onsite and telephonic one-on-one sessions with retirees

**Supplemental Benefits**

Brought forward as part of the Union contract, then offered to the whole Dartmouth population.

Dartmouth met with three supplemental benefits vendors – Winston Benefits was selected.

Education sessions have been scheduled and open enrolment will run April 1 to April 19.

**Wellness Update**

Strong engagement for first year of the initiative - successful employee engagement for biometric screening events, field coaching and health assessments

There are roughly 1,200 patients enrolled in Dartmouth Health Connect – Word of mouth is a big draw for the practice.

Iora Health is working to engage the population with more complex health needs

0.3 FTE Psychiatrist hired for the Faculty/Employee Assistance Program

**Future activity:**

- Data analysis & reporting – identify opportunities for future programming based on aggregate data gathered
- Incentives – meeting internally and with partners (Cigna, Iora Health, Aon Hewitt, etc.) to design incentives for 2014
- Evaluation planning
Dartmouth Health Connect – focus on patient mix continues
Advisory Committee – committee structure defined, needs leadership champions

Affordable Care Act Presentation by AON Hewitt

Goals of the Affordable Care Act:

- To increase health access for the uninsured – there are currently 58 million uninsured Americans
- Pay for expanded access through increased taxes and spending cuts
- Bend the healthcare cost downward – the legislation is really focused on reforming markets, not reducing the cost

Is it legal?
The Supreme Court said the “mandate” is a tax and therefore legal and rewrote the ACA slightly.

States Creating Health Care Exchanges
Health care exchanges are in the process of being developed – some states will create exchanges, some won’t, some will create exchanges in partnership with the federal government. Only one-third have agreed to state based public exchange in 2014

The challenge is that the exchanges will look different in different states - there are no guidelines on this in the healthcare law. It will be a marketplace for private companies (not public). Exchanges must be running for 2014

Congressional Budget Office (CBO) projections
CBO projects fewer uninsured due to Medicaid expansion and exchanges:
2023 – 92% insured share of non-elderly population as opposed to 81% before ACA

In some states Medicaid will expand

Cadillac tax – 2018 – need to review impact

Compliance for 2013

- Notify all employees about exchanges (postponed)
- Health FSA $2,500 limit
- New taxes on high income individuals earning over $200K ($250K for joint filers) – in place
  - Increased Medicare tax to 2.35% - hit in January
  - New 3.8% tax on unearned income
- Patient Centered Outcomes Research Institute fee (PCORI)
  - $2 per employee in 2013 – grows every year till 2019
- Additional group market insurance reforms:
  - Coverage of Women’s Preventive Health Services
  - Quality of Care reporting requirements (we are waiting for more guidance)
Compliance for 2014

- No annual dollar limits on essential health benefits – limited guidance on essential health benefits
- Preexisting condition exclusions prohibited
- Max 90-day waiting period for coverage
- Increased cap on rewards for participation in health-contingent wellness program
- Non-discrimination rules for fully insured plans (delayed)
- Cost sharing limits for group health plans tied to HDHP/HSA deductibles and OOP max
  (All plans will require a local out-of-pocket max; there will be a global OOP max, after which there is no co-pay; it will be aligned with the high deductible)
  - Deductible limits only apply to small employers
  - Unclear on application of OOP limits (but Aon Hewitt’s sources indicate that it might apply to all non-grandfathered health plans).

Compliance for 2014 – exchanges, mandates, penalties and fees

- “Applicable large employers” must provide affordable health care coverage to “substantially all” full time employees or risk penalty – the cost must be equal or less than 9.5% of your household income. Dartmouth already has an income-adjusted premium strategy. Most taxes will go to fund the federal exchanges
- Individuals must buy health insurance or pay shared responsibility tax – there will still be uninsured people who would rather pay the penalty, but the costs will ramp up. Some people will also join the public exchanges
- State insurance exchanges begin
- Automatic enrollment (delayed)
- Employer Reporting of health insurance information to government and participants
- Transitional reinsurance fee - $63 per plan participant in 2014, or approximately $510K for Dartmouth based on current enrollment of 8,100. This is the stabilization fee to create a risk pool for state exchanges. The concern is that pre-65 retirees will join and it will become a high-risk pool. The federal government is trying to stabilize the environment and taxing employers to do this: therefore the $500K paid by Dartmouth next year.

Full time employee definition

- Faculty/staff who work 30 hours or more per week over an annual period

Discussion: We are working through understanding what classes of employees who would qualify. Some employers will have to change their entire employee classification strategy. Alice Tanguay: Currently employees are benefits eligible if they work 20 hours a week for 9 months or more.

- Administration issues: tracking part time faculty non-classroom work hours would be difficult
Employer Mandate and Penalties Begin in 2014

Employers are potentially liable for either

**Doomsday Penalty (code section 4980H (a))**

- Employer does not offer Minimum Essential Coverage (MEC) to all FTEs and at least one FTE enrolls in an exchange and receives the Federal subsidy
- Penalty equals $2,000 for each FTE regardless of whether the FTE elected employer-provided health care coverage
- Applies if less than 95% of FTEs are offered coverage

This is not an issue for Dartmouth – main issue is the full-time employee issue.

OR

**Targeted Penalty (code section 4980H (b))**

- Employer offers MEC to FTEs but coverage is either:
  - “Unaffordable” or
  - Does not provide “minimum actuarial value”
- Penalty equals $3,000 per year each FTE who enrolls in an exchange and receives a Federal subsidy
  - Not more than the Doomsday Penalty
  - Also applies to the excluded 5% above

If full-time employee issue is worked out Dartmouth is unlikely to be exposed to either of these penalties. Most employers have some exposure. We want to make sure we are above 95%

CBO’s Latest Projections Show Cost of Exchange Subsidies Rising

Cost to employers who want to get out of providing coverage will rise

Wellness Programs

The ACA provides employers with flexibility for designing Wellness programs. The Act distinguishes between participatory Wellness programs and health contingent wellness programs:

- Participatory – eg. fitness center reimbursement; diagnostic testing without reward based on outcomes
- Health contingent – rewards based on outcomes; meeting targets for exercise

Increases maximum permissible “reward” under a health contingent wellness program

“Rewards” include both a reward or incentive as well as avoiding penalty or surcharge
Reward can have a value of 30% of total premium cost. There is little guidance in the law on participatory programs.

Melissa Miner: Our incentives are participatory and there are no limits to participatory programs; but we have decisions to make re: our future programming, which straddles the definitions. Wellness programs must be compliant with other laws such as the Americans with Disabilities Act, and the laws may contradict each other. So there are still potential risks for employers.

**Health Care Reform Creates Challenges/Opportunities**

- Employers like Dartmouth with modest impact will see costs rise 1-5 per cent
- Employers with low paid workers, long waiting periods, 30-plus hour employees with no or low value coverage could see costs increase 20-40 per cent
- Employers across the spectrum will use 2014 as an opportunity to redefine their health care plan and:
  - move to private insurance exchanges - less uncertainty than public exchange
  - move to public insurance exchanges
  - increase Medicaid enrollment where possible – does not involve a penalty

Chris Kardos: We will continue to monitor the law and work with Dartmouth to ensure compliance.

The presentation concluded – there were no further questions.

**Other Business**

Alice Tanguay opened up the floor to CBC members to raise any further issues.

Cost-sharing analysis

Tricia Spellman will present a cost-sharing analysis at the May CBC meetings.

Caremark

Concerns with the Caremark formulary were raised. There is a very complicated process of appealing for coverage of drugs that are not on the formulary, especially for physicians. Alice Tanguay noted that CVS Caremark reviews the formulary once a year. They may move the tier in which the drug falls quarterly, but it is still a covered drug.

Robert Shumsky asked if the CBC could design a systematic way to see if the formulary is a problem for Dartmouth employees. He noted that the appeal process takes approximately six weeks. Tricia Spellman: We can monitor the number of appeals. Robert Donin suggested that the CBC does either of the following:

i) Outreach to a sample sub-set of employees

ii) Set up a mailbox on the HR website to see if employees have had issues in this area
Other suggestions: Contact pharmacies for aggregate data on Dartmouth employees or create a survey for employees. A request was also made to give the Council two weeks’ notice to gather information for meetings.

Enrollment Patterns
Mike Wagner asked if the CBC has looked at enrollment patterns between Open Access 1 and 2. Alice Tanguay: We looked for significant movement and we found 3% increase in OA1 and 7% increase in OA2. We expected more people to shift because of the premium changes.

Coding
It was suggested that procedures are being coded in a different way than previously; some people feel they are paying more than they expected. Most of the complaints are re: preventive healthcare. Dana Williams noted that there is unlikely to be malicious intent, the codes are just ridiculously complex. A survey was suggested, also a meeting with D-H, and with Cigna, on this topic. The Benefits team can also help employees with coding queries. D-H just implemented electronic medical records – it may have had an impact.

Vision Care
Concerns were raised about Vision Care and Cigna’s limited vision provider network. Cigna’s way of making providers get pre-approved is time-consuming; the requirement that providers have 50% ownership of their premises is also onerous. D-H is saying Cigna Vision card is worthless. The Benefits team is aware of this issue. D-H is a vision provider for medical services, e.g. someone with Glaucoma. But the same person would not be covered there for an eye exam – i.e., D-H is not in the network for all types of services. The Benefits team is working with Cigna to increase their number of vision providers; employees can also use an out of network provider at a higher cost.

Supplemental Benefits
There is some confusion about the new Supplemental Benefits program and whether it is subsidized by Dartmouth and why it is being offered. Alice Tanguay: It provides wrap-around coverage and additional support; could be a dollar allowance for certain services. Dartmouth is not providing additional benefit but because we are a large group the premium is lower. We will request Winston Benefits make the rates more prominent on the website. A suggestion was made that we should add a sentence that Dartmouth is not sponsoring. But has negotiated what we believe to be a reduced rate.

Dartmouth Health Connect
With the increasing enrolment in Dartmouth Health Connect, are the staffing levels changing? Is it meeting needs? Melissa Miner: We have the addition of a health coach and one part time administrator. They feel that not having a traditional practice has enabled them to support more people. MM: There is 88% satisfaction with the practice at present. A suggestion was made to add a question around satisfaction with the practice to the survey – ask for feedback after one year.

Time Taken for Fitness Activities
Can we decide what should be on personal time and what on work time, re Wellness initiatives? There is
language on incentive based activities – that is where the line has been drawn to date. But it is a grey area. The Wellness team will be looking at this.

**Communications**
CBC communications were reviewed and it was decided that the best way to contact staff was by a direct mail from Myron; the least effective was to spread the word via the PAF. Home-mailers are more effective than Hinman.

Next meeting – May 15, 2013 from 2 - 4pm

The meeting adjourned at 4pm