Senate Benefits and Welfare Committee
University of Pittsburgh
Minutes of March 15, 2011 Meeting

9:00-10:30am, A219B Langley Hall (Executive Conference Room)

Attendees: Jim Holland, Sandra Founds, Lara Putnam, Mark Scott, Irene Kane, Emilia Lombardi, Alan Meisel, Linda Rinaman, Elizabeth Richey, Nancy Gilkes, Harvey Wolfe, John Kozar, Michael Pinsky
Guest: Sheryl A. Kashuba, Esq., Senior Director of Health Policy, Assistant Counsel, UPMC Health Plan
***Absent:** Judith Lave, Yong Li, Robert Robertson, Sunny Fulton, Angelina Riccelli, Elsa Strotmeyer*

Topic	Discussion	Action to be Taken
Call to Order	L. Rinaman, chair, called the meeting to order at 9:02 AM	
Committee Business	Minutes from Jan 11, 2011 meeting were approved	
Benefits Office Report (J. Kozar)	Several items: 1. Announced healthy lifestyle experience wellness fair being held this Thursday, March 17, 11-1:15 at the Union. Healthy foods, presentations on nutrition, etc. 2. Retirement planning symposium this Friday in Union Ballroom. Long-range planning event – meant for people ranging from 15 years out from retirement to those closer to retirement. Announced in University newspaper and via mailed postcards. Speaker is Betsy Newman, author of “Retirement as a Career.” Currently 170 people signed up – very large interest. Plan future events for different age groups, e.g., possibly one in June for 40+ group.	
Topic	**Discussion**	**Action to be Taken**
Update on Health Care Reform (Sheryl A. Kabusha, Esq.)	Millions uninsured; increased dramatically from 2008 to 2010, and insurance premiums doubled in past decade to $13,000. Who is to blame? Insurance industry operates on about 3.3% margin, UPMC lower in 2% range; lower than a number of other industries (88th out of 215). E. Lombardi asked source of data; unsure, but S. Kabusha will find out. M. Pinsky pointed out that a lot is hiding in the means; asked to see how UPMC stacks up against other insurers in terms of frugality. H. Wolfe pointed out that no one would buy stock in company with 3.3 margin but insurance companies do very well. U.S. spends more on insurance but ranks in bottom 25% of life expectancy. Other reasons for high costs: economy has forced healthier people to drop coverage, leaving sicker population in pool; insurer’s admin costs up; people using more healthcare; new, more expensive treatments available; unhealthy lifestyles (75% obesity rate anticipated for 2015); population aging; regulatory changes; provider consolidation and increased	

	leverage. At current rate, by 2060 the US would be spending half of its economy on health insurance. Patient Protection and Affordable Care Act signed into law on March 23, 2010. Large focus on private insurance market, but changes for government programs and providers. M. PInsky: Why didn't they allow for collective bargaining on prescription drugs? Huge cost, and unsure of why that wasn't part of bill. A lot of it involves politics. Secretary has power to continue shaping ACA through regulations; thus far has issued about 20 and another 20 expected by end of year. For insurers, this means things happening at unprecedented pace. Formed Office of Health Policy to assist in ACA implementation and policy development. 25 major changes in past year; update on larger ones. Major commercial product changes in 2010: adult dependent coverage to age 26 (Pitt currently voluntarily extended to age 30 under PA Act; will switch to this requirement this July); preventative services at no cost-sharing; no lifetime or annual dollar limits; new complaints and grievances standards; grandfathering rules. N. Gilkes: Raised issue of not being allowed to deny children coverage based on pre-existing condition. Defended adult dependent coverage, based on need for many young people unable to get jobs with coverage. Upcoming changes for 2011: 1. Medical Loss Ratio requires portion of premiums to be spent on clinical services/quality improvement. Member rebates required for non-compliance. If money not spent on medical services, must be given back. UPPMC exceeds standard (spends about 90 cents on the dollar, while requirement is 80). Works to the advantage of UPMC, but many for-profit insurers fall very short of it. 2. If insurer increases premium by more than 10%, it must be reviewed. Problem is that 40% of small group increases have exceeded 10% in past 3 years. Insurers argue this benchmark is too low; will require significant number of increases be reviewed. H. Wolfe: What can we do with this information? If rate increases by 15%, we can't do anything. J. Kozar: It is based on claims costs. S. Kabusha: Primarily offering this as background. University is self-insured plan,	

	so we wouldn't be subject to this review, because all we do is pay claims. J. Kozar: Picking up more individuals who previously had coverage and now are picking up partner coverage. Driving up total cost as we pick up more of population. I. Kane: Does that mean that claims increase drives premium increase? Can we look at claims and know what's driving cost? For example, if we see increase in depression claims, identify that as something driving costs? J. Kozar: Premium costs do reflect claims costs. S. Kabusha: For fully insured companies, don't know what portion of premiums are going to claims and what is going to administration or other costs. Being self-funded, we avoid that ambiguity – know that all money goes toward claims, minus administrative fee. 2012: Accountable Care Organizations. Bundled payment with some incentive or shared savings arrangement. Contrast with HMOs – providers have to report on quality. Focuses on total patient care and wellness. M. Pinsky – European countries have accountable care system, but its quality fluctuates with the economy. In England, saw attitudes of private doctors change because they weren't being paid more for working more, so lines and waits increased. Human nature side of issue that must be included. CLASS Insurance: Similar to 401K, where employer takes money out. Voluntary long-term care opt-in program; individuals pay premiums for 5 years and are then eligible for a daily benefit ($50/day). Must be solvent; serious doubt about feasibility. L. Rinaman pointed out $50 is also not much toward actual LTC costs. J. Kozar: Long-term care available through Pitt. For faculty and staff, there will be an offering during enrollment this year. N. Gilkes: Average home care cost in Pittsburgh is roughly $20-25/hour with minimum of 5 hours. M. Pinsky: In parts of Europe, don't see outside care as different from inside care. Goal is just to get citizens back to productive work. No care for non-citizens, though. Leapfrog group arguing that whole process should be regarded as acute care. Consider people inside hospital as "acute care" - includes hospitalists – and outside hospital as "maintenance." Alternative idea is that all care – inside and outside hospital – are acute care. 2013: Start of Co-Ops: Seen as compromise for those who wanted single-payer	

	program. In 2013 those who are not currently insurers can get together and serve as insurers for small groups. “Member-run non-profit health plan.” Major current challenge is where the expertise would come from, given that no one involved can have been an insurer. In theory would increase competition and drive down price. 2014: Big year for changes. Community rating and guaranteed issue – prohibits pre-existing condition coverage exclusions. Also have community rating. Currently, if parents seek coverage for a sick child, coverage can’t be denied but famiy can be charged a very high premium. In 2014, can no longer adjust rate based on illness. Only factors for rating premiums will be age (maximum 3:1 variation), smoking (maximum 5:1), individual vs. family, a few others. Age variation may drive up premiums for younger people because can’t make fee for older individuals more than three times as high. Individual mandate: Fines for not meeting minimum essential coverage are relatively low. Exist with goal of creating “all in” situation – insurance only works if healthy individuals are also in pool. May be enough to get people to seek coverage. Already done in MA, and number of people who signed up to avoid fine greatly exceeded what costs would suggest. On other hand, very low penalty for those who don’t want to seek coverage. Employer penalties: Employers must consider cost of coverage for their employees. If cost of sponsored coverage is more than 9.5% if employee’s household income, or if coverage pays for less than 60percent of covered expenses, employer is subject to penalty. One issue: how will employers access household income? Also penalty for employers with more than 50 full-time employees do not offer coverage. Same balance issue – cheaper to pay penalties than to offer coverage, though doesn’t necessarily mean employers will make that choice. Health Insurance Exchanges: “Travelocity for health insurance.” Established in state (or feds, if states fail). Still in early stages of development. Unclear what it will look like. To work: must pull in healthy individuals, benefit employees and employers. Possible changes: Currently debate about repealing or replacing. 5 Federal District Court decisions – 3 found it constitutional and 2 unconstitutional. In meantime, states are moving forward with assumption that it will be upheld.	
Other Business	Election Of new B&W Committee Chair by voting members via ballot. Outcome: Irene Kane elected new chair for 2011-2012.	

Adjournment	L. Rinaman adjourned the meeting at 10:20 AM	