MINUTES
EMPLOYEE BENEFITS COMMITTEE
April 11, 2008

Members Present
Darryl McCullough, Chair       Dick Bennett
Debbie Copp                   Brenda Freese
Karan Glickman                Susan Marcus-Mendoza
Nancy Matthews                Milt Olsen
Charla Rae                    Will Wayne

Members Absent
Stacy Anderson                Frances Ayres
Dunn Cumby                    Simin Pulat

Ex Officio Members
Barbara Abercrombie           Julius Hilburn
Nick Kelly

The meeting was called to order by the Chair at 1:32 pm.

I. Approval of Bylaws (Darryl McCullough)

Discussed the changes with the HSC Faculty Senate and the Tulsa Staff Senate, and both approved our bylaws.

• Voting on bylaws stand approved and will appear on our website.

II. RFP Update (Julius Hilburn)

The RFP Evaluation Committee and our consultants from Segal have been in the process of reviewing proposals for medical, dental and flexible spending administration for the past several months. The committee wants to share as much information with the various governance groups but still needs to keep many elements of the proposals confidential for negotiating purposes.

Segal will present the Summary of Analysis of Proposals for Medical, Dental, Prescription Drug, Medicare and Flexible Spending Accounts (FSA) Programs with the EBC (Mitch Bramstaedt and Robert Grinberg)

• Overview of Bidders
  o RFP was sent to organizations that could administer the University’s plan of benefits. Bidders were asked to provide responses and commentary on the following: Medical, Dental, Prescription Drugs, Disease Management, Wellness, FSA, International Coverage, and Medicare.

• Timeline
  o RFP released to selected vendors in early December. Over the next few weeks, Julius and Nick will discuss the information with the various
governance groups. We hope to have a decision made in early May. Implementation date is January 1, 2009.

- Disease Management and Wellness are two very important issues we have been looking into. There is an additional committee looking at these issues.
  - Bidders that received RFP and Provided Proposals
    - Aetna, Blue Cross Blue Shield of Oklahoma (BCBSOK) and United HealthCare (UHC) bid on the Medical and Medicare Programs, whereas Humana bid solely on Medicare programs but did not have a strong proposal. CIGNA received RFP but did not respond back.
    - Aetna, BCBSOK and UHC all provided proposals for FSA program.
    - Aetna, BCBSOK, CIGNA, Delta Dental, Guardian, MetLife, and UHC all were sent RFP’s for dental. CIGNA, Guardian, and UHC did not submit a proposal. MetLife has a poor network, so they have dropped out of the process.
    - After the finalists meeting, the Committee agreed to narrow the field of finalists to Aetna, BCBSOK, Delta Dental and UHC.
  - Evaluation Considerations
    - Negotiations are ongoing.
    - Discussion of pricing should be handled cautiously as we are towards the end of negotiations. All organizations were asked to price a multiple-year arrangement, and we are receiving quotes on this. Each organization has based their pricing on OU’s experience and claim history.
    - There are a number of bids that fall within the University’s projected budget.
    - In regards to network issues, Aetna would create the least disruption, BCBSOK’s network is generally the largest with gaps in the HMO network, and UHC’s network is generally smaller but does not have key gaps in the HMO network.
      - BCBSOK’s PPO network is almost as big as Aetna’s, so there will not be significant disruption. However, there is a significant difference in their HMO network. Currently, their HMO network does not include Norman Regional or St. John’s or St. Francis’ hospitals in Tulsa. There is discussion of how to work around this issue.
    - In regards to customer service, Aetna services OU from its Dallas office, BCBSOK would service OU from its Oklahoma City and Tulsa offices, and UHC would service OU from its San Antonio and Salt Lake City offices but has offered alternatives.
    - BCBSOK and UHC have offered to bid on the same plan design as what we currently have. There will be some differences in the implementation of how the plans are administered. Deductibles, co-pays, co-insurance, out-of-pockets, office visit co-pays, and drug plans match exactly.
    - There is a difference in the Medicare prescription drug plan BCBSOK can offer. They cannot exactly match the current plan. They have lowered the
brand non-preferred formulary co-pay but raised the mail order co-pay a little bit. This is still in negotiation.

- All three organizations are different in their corporate cultures. Aetna is a traditional insurance company. They are also a big, national company in how they service their clients. UHC is very similar to Aetna in that they are big and national, and they can provide a stronger commitment towards managed care. BCBSOK was not an insurance company first; they were a funding organization. They are also regional. They are a subsidiary of a larger company called Health Care Service Corporation.

- On the wellness side, each organization can bring something to the table. They are all different, but we are ok with that because the committee can look more into this issue.

- OSEEGIB Considerations
  - Normally the process of bidding is held up until after OSEEGIB discusses their plan. There has been a suggestion to move up the decision process to June, and OSEEGIB will no longer be a consideration. OSEEGIB does not have a national network option that is affordable, there is no advantage from a pricing standpoint, and they cannot provide a multiple-year guarantee. Dependent coverage may also be more expensive with OSEEGIB. The plan design is not flexible, and their level of wellness is not where the University wants to be at this moment.
  - If we move the decision-making to June, there will be more time for implementation of the new plan.
  - The RFP committee has thought through how competitive OSEEGIB would be with what we are evaluating; we did not see any advantage to waiting for their proposal.

Questions/Comments

Debbie mentioned staff people do not understand why we have continued to go back to OSEEGIB since the rates are higher and the price is not that much better. It would be different if the state were to give us money to help pay for healthcare costs but they are not going to do that. Most people would prefer to have the national network, and if there is a change, they do not want to feel rushed with the new implementation.

Susan brought up she was having some provider issues because her providers are not in the Aetna network. She asked the provider if our three organizations that are bidding on our service is accepted with them, and they said Blue Cross would be the first, followed by Health Choice, then United, then Aetna in regards to taking their coverage. I feel we would have the same issues with United as we have had with Aetna.

Darryl commented Health Choice was competitive in pricing a few years ago. Right now we have good bids on the table. The emphasis of wellness has become a big factor as well.
Debbie also mentioned OSEEGIB is so inflexible, and if we went with one of the three organizations that have offers on the table, we can negotiate our plan. We will have to take whatever OSEEGIB will give us. Their prices have continued to rise over the past few years as well.

Julius said some members of EBC mentioned they wanted to continue to look at the comparison. We want a three-year commitment so we do not have to go back and forth. I think we know enough about OSEEGIB that they are no longer a player.

Susan stated OSEEGIB is not the same provider as they used to be.

Debbie also suggested the longer we have to implement any changes will be best for our employees. The last few years have been very rushed, and employees have been unhappy.

- Next Steps
  - Resolve network disruption issues. Norman Regional and the two hospitals in Tulsa are being worked out.

Debbie asked as the networks are compared, if there is a way to project what the organizations will have in January.

Mitch answered if a provider group is going to drop out, it is almost impossible to include it in this analysis. No organization should be discussing that change as it is under negotiation. No insurance company is going to highlight the fact they know a provider is leaving. On the upside, we are actively building each network so they have the right providers on January 1st, especially those key providers.

  - Complete pricing negotiations.
  - Clarify the remaining plan design issues. The big one is the Medicare issue, but it is in the process of being worked out.
  - Communicate RFP status with OU’s governance groups.
    - Next week, the Faculty Senate and Staff Senate will be met with. HSC Faculty and Staff Senate will also be addressed the following week.
  - RFP Evaluation Committee recommendation in mid-May.
  - Decision timing
    - Final recommendation presented at June Regents’ meeting.

Debbie asked what can be done between now and when the presentations begin to be helpful. What type of feedback would be helpful?

Nick answered there is a provider nomination form for employees to fill out and return to use. There are network issues that are tough to deal with, but we are trying to consider them.
Julius mentioned employees have not been bashful in letting us know what works and what doesn’t. Key concerns will be addressed, and we just need their honest opinion and feedback.

In regards to dental, Aetna and BCBSOK have quoted a price for medical and dental as a package. UHC did not quote a dental option. If you chose UHC, you would need a dental option. Delta Dental has the advantage of a regular PPO network with a decent number of providers, but they also have a premier network which does not allow balanced billing. Even though the member is getting an out-of-network benefit, the doctor cannot allow balanced billing. Balanced billing means the dentist cannot charge more than what is usual and customary for a service.

Lastly, the FSA pricing is all very similar and consistent. Ultimately, whichever medical provider you choose, you will add their FSA plan with it.

Julius mentioned the RFP Evaluation Committee will meet again around the May 9th assuming we can get the negotiations sped up and make sure all the outstanding issues are worked out. The EBC will meet at our regular time of May 15th.

Karen stated employees need to be reminded we are going to the full 100% contribution this year.

Julius answered when we introduced the contribution tiers, that it was phase one. What we were trying to do is introduce the contributions and start making an impact on the dependent rates. Since we introduced it based on a salary-based program, the dependent rates are more competitive compared to other organizations in the lower tiers. For the upper tiers, we estimated where we could make an impact, but we are not close enough to other organizations as we would like to be. It appears that we can implement the plan for 2009 without having a substantial impact on the rates we charge employee currently. If the negotiations go the way we would like, we may not need to increase the employee contribution for medical premiums. We are also discussing whether to look at the dependent rates and trying to get those numbers closer to the market number that is out there.

Dick brought up there are two bills in the legislature regarding mandate coverage for autism and standard testing. Has this been discussed with the vendors?

Julius answered the insurers are aware of those two initiatives, and I don’t know if they qualified their bids as a result of this. Their bids are fixed in the sense they have made a commitment. If there is some change in what is mandated for coverage, they couldn’t pass that along to us.

Julius asked Mitch if the vendors can go back and modify their proposals after we accept them.
Mitch answered generally no. Normally state-mandated benefits are not big dollar items, normally. If there was a big dollar item that was passed, there would be discussion on when they would go into effect.

Julius continued there are some things in the contract which will allow the vendor to go back and re-negotiate in case of a significant event. These are in place in case our enrollment changes significantly. What I’ve seen is that these mandates are around a 1% increase in overall plan expenses.

V. Other Updates

Julius mentioned the Retiree Medical Review Committee has not met since the last time EBC has met, so there is no progress to report. It continues to be an issue that is complex, and the committee is trying to work through different scenarios. Nothing has been decided yet, and nothing should motivate anyone to jump ship. The next meeting is scheduled for May 2nd.

VI. New Business

There being no other business, the meeting was adjourned at 2:41 p.m.