




Office of Human Resources
16 Central Street
Bangor, ME 04401-5106

Human Resources: 207-973-3370
Benefits: 207-973-3380
Labor Relations: 207-973-3386
Fax: 207-973-3384
Payroll: 207-973-3320
Fax: 207-973-3349
TTY: 207-973-3262
www.maine.edu

June 13, 2011

To: Richard Pattenau, Chancellor

From:  Tracy Bigney on behalf of Employee Health Plan Task Force

Subject: Report of the Task Force

On behalf of the Employee Health Plan Task Force, I am pleased to transmit the report of our work. We thank you for the opportunity to explore in depth the issues related to the cost trend increase of the employee health plan. We believe that our recommendations, if fully implemented and vigorously supported, will result in decreasing the trend for the plan and increasing the quality of health care and the health of the plan participants.

We would welcome the opportunity to meet with you to discuss our recommendations. Please note that our recommendations include a request that there be an ongoing group charged to monitor the implementation and the health care environment to make recommendations for any necessary modifications.

Cc: EHPTF Members, Observers and Staff
Jeff Wahlstrom

The University of Maine

University of Maine
at Augusta

University of Maine
at Farmington

University of Maine
at Fort Kent

University of Maine
at Machias

University of Maine
at Presque Isle

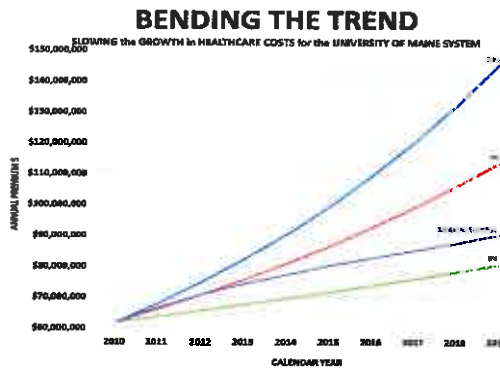
University of
Southern Maine



UNIVERSITY OF MAINE SYSTEM

Report of the

Employee Health Plan Task Force



Submitted to

Chancellor Richard Pattenau

June 6, 2011

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Executive Summary

At the appointment of the Chancellor, a task force, referred to as the Employee Health Plan Task Force (EHPTF), consisting of employees of the University of Maine System, convened in the fall of 2010 for the purpose of recommending actions that will allow UMS to continue to offer a competitive, high-quality, health care benefit while reducing the cost trend for the employee health plan. At the start of the Task Force's work, the most recent trend analysis projected that the cost of the Employee Health Plan would grow at a rate of between 7% (UMS trend for the preceding 5 years) and 10% (national trend) for the ten year period 2010 – 2019.

EHPTF was charged with developing a set of recommendations for reducing the cost trend for the plan to no more than the following amounts for the next 5 years (FY 12-16):

FY12 - 6% FY13 - 5% FY14 - 4% FY15 - 4% FY16 - 3%

The Task Force began its efforts with meetings, including a well-attended summit, to develop a shared understanding of the multiple factors affecting medical costs in the U.S. and their impact upon the UMS Employee Health Plan. As was pointed out by Denise Stephenson of Willis, these include such factors as pharmaceuticals, physician practice, technology, new treatments, group characteristics and age in addition to personal behavior. Many of these are difficult to influence through plan design. From the earliest meetings, and throughout all of its deliberations, there was a shared understanding among the members of the Task Force that meeting the challenge of “bending the trend” in health care costs would require collective cooperation and commitment by all stakeholders.

As the Task Force considered the options and opportunities, we developed a set of Guiding Principles to use in shaping strategies, plan design, and recommendations. With those principles in mind, we met with healthcare experts, providers, hospital administrators, and colleagues from across Maine who are developing innovative approaches to bending their own health care cost trends.

It became immediately obvious to all members of the Task Force that there would be no “silver bullet” or simple solution to bending the trend and achieving the Chancellor's charge. Rather, the Task Force identified several “pathways” to explore, and it is within these pathways that the Task Force is making its recommendations to the Chancellor (in summary form below):

Quality, cost and payment reform

- Negotiate the implementation of Accountable Care Organizations (ACO's) in the Bangor area, the Augusta area, and where there are other opportunities, with the goal of negotiating a fixed expense target combined with high quality and service standards for plan members who live in the region.
- Outside of the ACO regions, follow the essential elements of the State of Maine's “quality and cost tiered networks” for hospitals and primary care providers, adding specialty providers when available.

Plan design changes

- To encourage members and their providers to choose prescription drugs that are clinically appropriate and cost effective, implement step therapy (existing therapies would be grandfathered) and reduce the co-pay for preferred generic drugs.
- Adjust co-pay and deductible amounts to encourage members to seek-out providers and hospitals that meet the quality standards supported by the Maine Health Management Coalition, incent visits to primary care physicians, and discourage inappropriate use of the emergency room.

Health improvement

- Maximize Rise UP as part of a more comprehensive campaign to promote participation in wellness strategies and care management for those with chronic diseases. EHPTF is embracing a goal of 85% participation in Rise UP and related wellness activities (with a year-one target of 78%).
- Incentivize participation in Rise UP through the implementation of a University/employee health premium cost-share of 90%/10% for those who participate in phase I of Rise UP and \$100 per adult incentive to complete phase II. Those who choose not to participate will have a health premium cost-share of 80%/20%. Work with each campus community to develop wellness and health improvement strategies that are appropriate for their campuses, attached to measures, and for which the Presidents are accountable.
- Connect Rise Up programs with members' PCP practices for mutual reinforcement of wellness and appropriate health care.

Communication and education

- Launch an ambitious communications campaign that engages members of EHPTF, union and management teams, and senior administration in helping plan members understand the changes to the plan and how their behaviors and choices directly impact the cost of care.
- Implement strategies, and adjust and revise policies and procedures, to remove as many barriers and to encourage members to engage in wellness and health improvement efforts.

In addition to the recommendations that were made within the four “pathways” is the recommendation that a task force, including at least a core set of the members of EHPTF, be empowered to continue the work presented in these recommendations. The members of EHPTF acknowledge that there is much more work to be done and believe that real success in “bending the trend” will require constant attention and work by a core group of stakeholders.

The Task Force believes that the recommendations made here can result in meeting the charge presented by the Chancellor. We are very aware, however, that the environment surrounding health care includes many unknowns: legislative changes, ACO negotiations, and the reality that even one or two critically ill members can dramatically alter the projections in a self-insured plan. It may be necessary to revisit the recommendations made here if some adjustments are required in order to meet the model assumptions and cost estimates.

The challenges of “bending the trend” are formidable but achievable, but only with a shared commitment by UMS’s leadership, from the presidents, from the faculty and staff, and from their families.

What follows is a more detailed report on the work of the EHPTF and our recommendations.

Introduction

Competitive total compensation is essential in attracting, rewarding, and retaining the highly qualified faculty and staff needed to carry out UMS's mission. At the same time, the rising cost of benefits—particularly health care costs—is contributing to the financial structural gap that must be closed in order to keep education affordable and for UMS to achieve financial sustainability.

UMS's share of the premium costs for the Employee Health Plan in 2010 was approximately \$50 million. Current projections developed by our consulting actuary, Stuart Rubinstein, tell us that, without making substantive changes, the premiums will grow at a trend rate of 8.5% per year. At this rate, we can anticipate that in five years UMS's share of the premium costs will have grown to a total of approximately \$78.5 million. The magnitude of this cost and the rate at which it is growing (a rate that exceeds the growth of other UMS costs and revenue) contributes to a lack of financial sustainability for UMS.

With a strong desire to maintain a competitive health care benefit for employees and their dependents, the Employee Health Plan Task Force (EHPTF) was formed and presented with the following charge:

The Employee Health Plan Task Force will study best practices, emerging trends and changes in the environment affecting the cost of employee health care. The Task Force is charged to make recommendations to the Chancellor by March 31, 2011 for changes to the UMS Employee Health Plan that would result in reducing the cost trend for the plan to no more than the following amounts for the next 5 years (FY 12-16), as measured by the insured premium rate or self-insured premium equivalent. Long-term success will hinge on reducing the cost trend for the health plan to no more than the rate of revenue increase, and this balance should be achieved as soon as possible.

FY12 - 6% FY13 - 5% FY14 - 4% FY15 - 4% FY16 - 3%

Specific tasks assigned to the Task Force included the following:

1. Assist in planning and sponsoring a UMS Health Care Summit.
2. Develop a high level of knowledge and shared understandings of the factors affecting the cost of the employee health care plan.
3. Study alternative ways to reduce the cost trend for the UMS employee health care plan and make recommendations for actions to meet the targets set in the charge.
4. Recommend approaches to employee education and communication relating to health care and health care costs.

EHPTF chose the path of focusing on health improvement, quality health care, and appropriate benefit design as the key mechanism to achieve savings.

Our report begins with some background, includes a description of our work, and concludes with our recommendations to the Chancellor.

Background

Since its inception in 1968, the University of Maine System has offered health insurance to its employees at every location because of a conviction that assisting faculty and staff to maintain good health and protect them from catastrophic costs were important benefits to employees and to the University.

While there were years early in the plan's history when employees did not pay a portion of their health insurance premiums, as health insurance costs began to rise, it became necessary to require employee participation in the cost of coverage for themselves and their dependents. The continued rise in health insurance costs led to the introduction – through collective bargaining – of premium participation by active employees for their own coverage. The share of premium paid by UMS employees has risen several times, and today employees are responsible for approximately 12.25% of the total premium.

UMS employees have the option to select from two health plans—a traditional indemnity plan with a deductible and percentage co-insurance and a managed care plan with a co-payment (a side by side health plan comparison is attached as Exhibit I). UMS currently funds both health plans on a self-insured basis and contracts with a third party administrator (TPA) to process claim payments. For calendar year 2010, UMS's administrative cost, as a percentage of claims, was approximately 7.5% - 8% (which includes the administrative and disease management fees, stop-loss, and Dirigo access payments).

As of January 1, 2011, the number of employees enrolled in the two health plans was 4466. Add to that total the employees' dependents, retiree members and their dependents (under age 65), and the total is approximately 10,000 members participating in the plan. The cost of all claims paid by UMS in calendar year 2010 was \$51.7 million. Add to that the cost of administering the plan, which was \$4.85 million, and the total cost of the health plan for UMS was \$56.6 million.

While UMS has beaten the national trend during the last five years by keeping the average annual rate of premium growth around 7%, current projections tell us that, without making substantive changes, the premiums will grow at a trend rate of 8.5% per year (see Exhibit II). At this rate, we can anticipate that in five years UMS's share of the premium costs will have grown to a total of approximately \$78.5 million. If UMS can successfully bend the trend to meet the Chancellor's charge, it could result in annual savings of more than \$24 million before the end of this decade.

The Task Force's Work

Composition of the Task Force

The successful work of three Retiree Health Plan Task Forces (RHPTF I, II, and III) served as a model for the development of EHPTF (those reports can be viewed at www.maine.edu/system/hr/RHPTF.php). As with RHPTF, the Chancellor appointed the Task Force; it was not an outgrowth of collective bargaining, nor a joint labor management committee. Unions were invited to nominate representatives and send staff observers. Non-represented employees and administrators were also appointed. A facilitator assisted the Task Force in its work. An employee benefits consultant and members from the UMS benefits and labor relations staff were non-voting members of the Task Force. Most of those appointed had served on RHPTF I, II, or III, which had developed a solid understanding of issues related to retiree health care and a successful working relationship. (A full listing of Task Force membership is attached as Exhibit III.)

Joining the Task Force at almost every meeting, and serving as a resource to the facilitator and the UMS benefits staff, was Ted Rooney, RN, MPH. Mr. Rooney is a project leader with the Maine Health Management Coalition (MHMC) and brought both breadth and depth of experience to the Task Force as a trusted partner in our work together. UMS has been a long time member of the MHMC. Along with Elizabeth Mitchell, MHMC's CEO, the MHMC brings expert resources to help EHPTF in its work.

The Task Force met seven times between August 2010 and March 2011 to gain an understanding of the issues and to explore potential strategies. Almost every meeting included presentations by healthcare experts, providers, pharmacists, hospital administrators, and colleagues from across Maine to enhance the Task Force's understanding of the shifting health care landscape, describe innovative approaches that others are exploring, and offer their knowledge regarding the best practices in the field.

In addition, EHPTF hosted a summit on October 8, 2010: "Bending the Trend – slowing the growth in healthcare costs for the University of Maine System." The summit included a full day of presentations designed to provide members of the Task Force with a shared base of understanding and to offer a larger segment of the UMS community with a common set of facts and essential education and information about health care and cost and quality issues. Nearly 100 members of the UMS community, and invited experts, attended the summit.

Exploring the options

Among subjects reviewed in advance of exploring specific options were:

- The impact of the recently enacted Federal health care reform (the Patient Protection and Affordability Act) and determining what impact, if any, it would have upon the Task Force's work, particularly the regulations on "grandfathered plans."
- The factors impacting UMS's wellness program, "Rise Up," plan design and administrative changes, and other wellness programs.
- The work of the State of Maine Employee Health Commission to develop a cost and quality measurement initiative to tier providers and hospitals.
- The potential of engaging in "medical tourism" to lower costs for particular procedures.

- The Mayo Clinic model and Accountable Care Organizations
- Value-based healthcare systems
- Patient Centered Medical Home pilots
- UMS plan utilization and an analysis of opportunities and options
- Consumer and provider incentives to promote shared decision making
- A review of UMS Rx use and the potentials for cost containment through pharmacy management
- Emergency Room utilization and its impact on the UMS plan
- Establishing targets for Health Assessment participation
- Return on investment in worksite health promotion

Linking quality to our strategies

It became clear early on, that the problems of underuse, misuse, and overuse of health care were significant contributors to the rising cost of health care. Most experts estimate that about 30-40% of all health care expenditures are unnecessary. Some of these are unneeded tests and procedures. Others are admissions for someone with diabetes for example, which would not have been needed had appropriate primary care been given. EHPTF came to the conclusion that by focusing on how health care services were organized, delivered and paid for, and how they are connected to health improvement efforts, they could achieve trend reduction while improving quality and minimizing cost shifting.

Accountable Care Organizations

The Task Force became engaged with the concept of Accountable Care Organizations (ACO) through discussions with the State Employee Health Commission, the Maine Health Management Coalition, Eastern Maine Medical Center and other major employers in Maine. The ACO model is emerging as a way to improve health and reduce costs by involving patients and providers and aligning incentives for appropriate care.

The ACO model is described as follows by Dr. Mark McClellan (The Brookings Institution) and Dr. Elliott Fischer (Dartmouth Medical School), writing for the ACO Learning Network:

Accountable care is based on the principles of clear, patient-focused aims (better overall health through higher-quality care and lower costs for patients), provider accountability through transparent performance measures that reflect those aims, and payment reforms that use the measures to align provider support with the aims. Accordingly, ACOs are provider organizations that are directly and meaningfully focused on these aims. They are able to monitor and report their performance in improving health and lowering costs, and are supported by financial and professional incentives that are aligned with achieving better health and lower costs for their patients. In summary, ACOs are:

- Collaborations of primary care professionals and other health service providers, such as other physicians and hospitals;
- Organized around the capacity to improve health outcomes and the quality of care while slowing the growth in overall costs for a population of patients cared for by a well-defined group of primary care professionals; and
- Capable of measuring improvement in performance and receiving payments that increase when such improvements occur.

UMS is involved in preliminary discussions with the hospitals and major primary care practices in the Bangor area to design an ACO for members of the UMS health plan. UMS has also become a partner with the State Employee Health Commission and Maine General Health in discussions for an ACO in the Augusta area.

Our guiding principles

As the Task Force considered potential options, we also worked together to develop a shared set of “Guiding Principles” to guide the development of strategies, plan design, and our recommendations to the Chancellor:

- Reduce the cost trend, where possible, but ensure that quality of care is maintained or enhanced. Our goal is to “bend the trend” AND improve quality.
- Support strategies that maintain access to care, especially for those who live in Maine’s rural communities. We do not want to penalize those who live in rural locations.
- We endorse a “primary care-centric” model for plan design that fosters a satisfying and healing relationship between participants in our plan and their providers.
- Through education, information, and communication, foster consumerism that results in savings AND better outcomes.
- The health plan design should encourage employees and their dependents to maintain healthy lifestyles, take advantage of preventive health care, and reduce health risks.

It is also our expectation that decisions in plan design and strategy development will be based upon data and experience (proven best practices) from those who have had success and that they will continue to remain true to the objectives UMS adopted in 1988 for its benefits program:

- Address their [employees’] health benefit needs in a manner that is cost and tax effective for both employees and the University,
- Protect them from severe financial hardship
- Ensure that benefits are provided on a cost-effective basis
- Improve the long-term overall health of the University community
- Provide . . . a program that continues to attract and retain highly qualified employees.

Recommendations

Following extensive discussion, review, and financial modeling, the Task Force reached unanimity on the following set of recommendations:

Quality, cost and payment reform

The Task Force sees real value in leveraging the work that has been done by the State of Maine Employee Health Commission to implement their quality tiered network, particularly as they prepare to add cost-tiering to the equation for hospitals. The potential impact that UMS can have on improving the quality of healthcare in Maine is tremendous, and it will not only affect our members but will enhance quality for all residents in Maine. While the potential for savings to UMS is less apparent, we are operating with the belief that quality will ultimately translate to savings.

The opportunity for truly significant savings can come from working with Maine's healthcare systems, hospitals, and providers as they develop Accountable Care Organizations (as a response to provisions in the Patient Protection and Affordability Act). Over 5 years, implementation of the ACO, as it is being negotiated now, has the potential of significantly reducing the health care cost trend.

Our recommendations:

- Implement quality and cost tiered network for hospitals and quality tiered network for primary care providers (PCP's)
 - As appropriate to the Guiding Principles developed by EHPTF, continue to leverage the ongoing work of the State of Maine.
 - Statewide, apply "quality networks" as a "wrap around" to the ACO structure (with the understanding that ACO providers would be exempted from the cost-tiering)
- Require employees to select a PCP regardless of the plan in which they participate (however, PCP referrals would not be required in the Indemnity Plan).
- Negotiate the implementation of an ACO in the Bangor area, where approximately 50% of health plan members reside.
 - Potential partners currently include Eastern Maine Medical Center, St. Joseph hospital and its PCP network, and Penobscot Community Health Care, and it is highly desirable to engage all of these partners in a collaborative approach.
 - Work with Maine Health Management Coalition (MHMC), Maine Quality Forum (MQF), and Quality Counts to support negotiation and implementation.
- Implement an ACO in the Augusta area, building upon work done by the State of Maine.
- Participate with other major employers in development of ACO's in other areas of the state including Portland, Lewiston-Auburn and all Eastern Maine Healthcare facilities.

Maine is made-up of a patchwork of different health care providers that serve our members across a broad geographic region. As we develop ACO relationships and implement a quality tiered network, it is essential to the Task Force that we ensure that the plan remains fair and not unduly burdensome to our members, no matter where they live—in Maine, outside of Maine, outside the network, or outside the country. We want to make certain that there are administrative solutions in place to avoid unintended

consequences that might negatively impact members in the plan or prevent them from getting the insurance they need.

Plan design changes

From the start of our work together, we have appreciated that some element of our work would involve changes in the plan design, not as a means of “cost shifting” but as a way to incent healthier behaviors and better choices. We have also learned from our ongoing ACO negotiations that they will also require particular changes to create the right incentives for members to obtain preventive care and work appropriately with their primary care physicians to obtain ALL the health care they need, while reducing unnecessary waste and potential harm. As a result, what we are proposing for plan design changes includes some *increases* in co-pay and deductible amounts and some *decreases* in co-pay and deductible amounts. In some cases, these changes will cost UMS more in the short term but will result in long-term savings.

Our recommendations:

- Implement “step therapy” to help members and their providers choose prescriptions drugs that are clinically appropriate and cost effective. Existing therapies would be grandfathered.
- Reduce co-pay amount from \$10 to \$5 for preferred generics, resulting in 4-tier RX co-pays
- Reduce office visit co-pay to \$10 for primary care providers who meet UMS’s quality criteria (POS only).
- Increase co-pay amount from \$20 to \$25 for specialist provider office visits for providers that do not meet the UMS quality standards (POS only).
- Add \$100 deductible for admission to a hospital that does not meet the UMS quality standards (POS and Indemnity Plans).
- Increase co-pay for emergency room visit from \$25 to \$100 (POS and Indemnity Plans).

See Exhibit IV for a “plan design grid” that summarizes the changes that are being recommended here.

The members of the Task Force continue to be concerned about the potential that some health plan members, primarily because of their geographic location, could be penalized for using the emergency room when they really have no other viable choice. At the same time, we also see the importance of not incenting or enabling poor quality, so considerable deliberation needs to go into determining the administrative details.

Health improvement

One of the essential elements of bending the trend is the necessity of improving the health and wellness of the plan’s members. Real, meaningful change will come when UMS employees and their dependents make the behavioral changes required to live healthier lives. With that said, we acknowledge that the single most ambitious aspect of our recommendations is that we set a goal of 85% participation in Rise UP (first year target of 78%) and in our wellness and care management strategies. In 2010, 29% of plan participants completed health risk assessments under the RiseUP program. So the challenge before us is huge, but the pay-off can be enormous.

- Continue Rise UP wellness program with health risk assessment, health premium incentive, local health coaches, disease management, care management and case management
- Incentivize participation in Rise UP through the implementation of a University/employee health premium cost-share of 90%/10% for those who participate in phase I of Rise UP and an additional incentive of \$100 per adult (employee, spouse, or domestic partner) to complete phase II. Those who choose not to participate in phase I will have a health premium cost-share of 80%/20%. Note that 90%/10% and 80%/20% are aggregate averages—the actual premium split might vary, depending upon the coverage selected.
- Work with each campus community to develop a team to work on wellness and health improvement strategies that are appropriate for their campuses, attached to measures, and for which the Presidents are accountable. As each campus community develops its plans, they should ground their plans in proven best practices and also consider the following:
 - Strategies that encourage or incentivize employee and family fitness by broadening opportunities and options and making it more attractive, more convenient, and less costly to use University fitness facilities.
 - Smoke free campuses (with a commitment to enforcement) that are linked to smoking cessation programs.
 - Strategies in dining facility and vending machine operations to reduce unhealthy options and encourage healthy food choices.
 - Strategies to engage and support those who are associated with the campus but don't have a physical presence on the campus (Cooperative Extension employees, for example)

In implementing the recommendations above, the Task Force urges those engaged in developing campus strategies to focus their attention on learning what has worked elsewhere and to learn from and share with each other. We also want to emphasize that we heard again and again that the most dramatic stumbling block to getting members to participate in Health Assessments is their concern about the confidentiality of the information they provide in those assessments. UMS must gain the trust of the health plan members in this regard.

Finally, it is important to note here that some of EHPTF's most spirited discussions surrounded the desire to increase access to University fitness facilities by employees and their families. While it was acknowledged that every campus has different facilities, and different business models for those facilities, consideration needs to be given to offering employees and their families free use of fitness facilities (and fitness programming). The goal should be to reduce barriers to fitness and wellness activities, and the cost of using the facilities is one of those barriers.

Communication and education

The members of EHPTF have had the advantage of time together, several months of presentations, and extensive reading about how choices we each make impact the quality and the cost of our care. We also understand how the choices we make can also impact the cost of the plan for all participants. The challenge is getting the rest of the plan's members to have a similar understanding.

Our recommendations:

- Success in getting 85% of employees and their adult dependents to participate in wellness activities will require multiple strategies and commitments that are linked to the Rise UP program.

- To gain an understanding as to what works and what doesn't, it will be necessary to invest time in learning why members are not participating now and gain an understanding as to what strategies are proven to work.
- Presidents, senior administrators, and supervisors will need to demonstrate a commitment to achieving the goal and be active in developing campus strategies that support and encourage participation.
- In order for employees and their dependents to understand and appreciate how their behaviors and choices impact the plan, an ambitious educational campaign needs to be launched to show them the real costs of their healthcare, encourage members to seek out quality providers, and promote participation in wellness activities.
- Explore how to use the annual enrollment period (and hiring) to provide education and to incent healthy decisions and behaviors.
- Develop an ongoing educational and marketing campaign that includes face-to-face meetings with members of EHPTF, union and management teams making presentations, testimonials from employees, and ongoing marketing in all communications materials.
- Concerns about the confidentiality of medical information cannot be underestimated, and every communication needs to stress the level of confidentiality provided and the protections that are in place. Members of EHPTF made it clear that they need to have full confidence that there is a "fire wall" that ensures that neither UMS nor insurance providers/administrators can gain access to confidential medical information.

Members of EHPTF have each expressed a willingness to actively participate in communication and education strategies that will support implementation of the Task Force's recommendations.

Ongoing stakeholder involvement

The members of EHPTF acknowledge that our charge was to deliver a series of recommendations that met the Chancellor's charge. However, while we have confidence that we have met the charge, we also acknowledge that there will be a tremendous amount of work required in order to implement the recommendations and monitor the results. We believe that real success in "bending the trend" will require constant attention and work by a core group of stakeholders.

Our recommendations:

- Develop a charge for an ongoing task force (or similar) that has responsibility for supporting implementation of the recommendations.
- To reduce the amount of time required to get the members of the task force "up to speed," build the membership around a core group of EHPTF members.
- Consider having a first order of business for the task force that focuses its work on developing the communication strategies described in this document.
- Charge the task force with responsibility for monitoring the plan and recommending adjustments and changes in order to ensure that financial and healthcare targets are met.

The recommendations included in this report have the unanimous support of the Task Force. However, these recommendations come with the acknowledgement that the Employee Health Plan is a mandatory subject of collective bargaining. The Task Force was not authorized to engage in negotiations, and its recommendations are considered advisory to the Chancellor and to the bargaining process.

Projections

If these recommendations are accepted and implemented, the Task Force projects that UMS will successfully achieve the cost trend targets set forth in the charge. We acknowledge, however, that achieving success will be highly dependent upon some key variables:

- An ACO in the Bangor area that reduces the health cost trend to 3% for that portion of the population
- Achieving at least 78% and later 85% or more participation of adults in the plan in health assessments and in commitment to their own health improvement
- Adoption of the recommendations by UMS and through collective bargaining
- Vocal, committed, persistent support by the Chancellor, Presidents, Board of Trustees and other leaders
- Vocal, committed and persistent support by the unions representing UMS employees
- Financial and staff resources to carry out the work involved in successful implementation of the recommendations
- Continued work by the Task Force or successor body to monitor and adapt the work to the changing environment
- Effective communication and education of employees and dependents about the importance of this work to their own health and to the financial health of UMS

We feel that it is also important to note that EHPTF's projections have not anticipated what the additional cost might be to UMS to provide and support the implementation of the wellness strategies described in these recommendations.

Conclusion

Throughout our meetings and deliberations all members of the Task Force have approached this work with a shared understanding of the challenges, a mutual commitment to a sustainable health care plan, and collective cooperation to arrive at recommendations that all parties could support. Rather than viewing this as someone else's problem to solve, all participants in this process have accepted this as a mutual challenge that requires everyone to work together towards mutual solutions. Despite occasional deeply felt differences in viewpoint, the climate has always been civil and process-focused. The opportunity to hear and gain an appreciation for the perspectives of others has been, for each of the members, a positive experience.

While the Task Force believes that the recommendations made here can result in meeting the charge presented to EHPTF by the Chancellor, we are very aware that the environment surrounding health care includes many unknowns. Legislative changes on the state and federal level can certainly have an impact, but we are also aware that an essential element in achieving the charge will be UMS's success in partnering with health care providers to develop Accountable Care Organizations that can provide our members with the quality health care they need at a negotiated price. Those negotiations are underway but are far from complete. It is also worth noting that with a self-insured plan of approximately 10,000 members, it only takes one or two critically ill members to substantially impact the cost of the plan and alter future projections.

In some ways, changing the plan design is the easy part of this work. The hard part will be in changing the behavior of the plan's members and developing wellness strategies that engage 85% or more of UMS medical plan members and their families. Without the buy-in of the plan's members, we will be unable to have a positive, sustained impact upon our cost trend.

The message is clear here: without a shared commitment from UMS's leadership, from the presidents, from the faculty and staff, and from their families, "bending the trend," retaining our health care benefits, and achieving financial sustainability for UMS will be impossible. Task Force members believe that the UMS community can rise to this challenge with the support of the Board of Trustees, Chancellor, Presidents, unions and with our continued work.



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**University of Maine System
 COMP-CARE Comprehensive Group Health Plan/HMO Choice Point of Service Plan
 Benefit Comparison – Effective January 1, 2011**

	COMP-CARE Comprehensive Group Health Plan	HMO Choice – Point of Service Coverage Highest Level of Benefits	Self-referred Level of Benefits
Important Information	<p>Benefits are based on our maximum allowance for covered services. Our maximum allowance is the most we will pay for a particular service.</p> <p>When covered services are received from a participating provider:</p> <ul style="list-style-type: none"> • Claims are filed by the provider in most instances. • You are only responsible for the deductible and coinsurance. • Participating providers cannot bill you for balances that exceed Anthem Blue Cross and Blue Shield's maximum allowance. 	<p>Benefits are based on our maximum allowance for covered services. Our maximum allowance is the most we will pay for a particular service.</p> <p>Coverage described in this column applies when covered services are provided or authorized by your Primary Care Physician, unless otherwise stated.</p> <p>You are responsible for any copayments and coinsurance that apply.</p>	<p>Benefits are based on our maximum allowance for covered services. Our maximum allowance is the most we will pay for a particular service.</p> <p>Coverage described in this column applies when you self-refer to providers or professionals. (The Primary Care Physician does NOT provide or authorize services.)</p> <p>You may be responsible for filing claims and paying balance bills in addition to the deductible, copayments, and coinsurance. You may also need to pay the provider or professional up front.</p>
Inpatient Admission Review	<p>For scheduled inpatient admissions, except for planned cesarean sections, you or someone you designate must call 1-800-392-1016 for a preadmission review. If you do NOT call for review before admission, benefits can be reduced by 50% up to \$500.</p> <p>For emergency admissions, you or someone you designate should call within 48 hours after admission.</p> <p>For maternity admissions, you or someone you designate must call if the hospital stay is longer than 48 hours for a normal vaginal delivery or longer than 96 hours for a cesarean section.</p>	<p>Scheduled inpatient admissions, except for planned cesarean sections, require preadmission authorization by the Primary Care Physician.</p> <p>For emergency admissions, you should call your Primary Care Physician within 48 hours after admission</p>	<p>For scheduled inpatient admissions, except for planned cesarean sections, you or someone you designate must call 1-800-392-1016 for preadmission review. If you self-refer and do NOT call for review before admission, benefits can be reduced by up to \$500. The \$500 penalty does not apply to emergency admissions.</p> <p>For emergency admissions, you or someone you designate should call within 48 hours after admission.</p> <p>For maternity admissions, you or someone you designate must call if the hospital stay is longer than 48 hours for a normal vaginal delivery or longer than 96 hours for a cesarean section.</p>
Calendar Year Deductible	\$300 per member/\$600 per family	None	\$250 per member /\$500 per family
Coinsurance	Unless otherwise specified: Anthem Blue Cross and Blue Shield pays 80% You pay 20%	None (except for infertility)	Unless otherwise specified: Anthem Blue Cross and Blue Shield pays 80% You pay 20%
Calendar Year Out-of-pocket Limit (Deductible + Coinsurance) <i>A separate out-of-pocket limit applies to prescription drugs.</i>	\$1,100 per member \$2,200 per family	None	\$2,500 per member \$5,000 per family
Lifetime Maximum Benefits			
General	None	None	None

	COMP-CARE Comprehensive Group Health Plan		HMO Choice – Point of Service Coverage	
			Highest Level of Benefits	Self-referred Level of Benefits
Hospital Services (Inpatient & Outpatient)	80%		100%	80%
Preadmission Testing	100% (deductible does not apply)		100%	80%
Second Surgical Opinion	100% (deductible does not apply)		100%	80%
Emergency Room Care	80%		100% after a \$25 copayment For emergency services, you should seek immediate medical care. If you are admitted to the hospital from the emergency room, the copayment is waived.	
Professional Services				
Inpatient & Outpatient	80%		100%	80%
Physician Office Visits: Sick Care Adult Routine/Preventive	80% 100% (deductible does not apply) Includes: Up to one exam per calendar year ages 18+ Screening mammograms Screening Prostate Specific Antigen test and rectal exam		100% after a \$20 copayment 100%	80% Not covered
Well Baby Care	100% (deductible does not apply) (8 exams age 0 through age 1, 2 exams age 1 through age 3)		100%	Not covered
Well Child Care	100% (deductible does not apply) (1 exam per calendar year age 3 through 19)		100%	Not covered
Maternity Care: Pre & Postnatal	80%		100% after a \$20 copayment for the first visit	80%
Delivery	80%		100%	80%
Routine Gynecological Exam <i>One Exam and Pap Test per calendar year</i>	100% (deductible does not apply)		100% (No PCP referral required)	100% Not covered if you self-refer to a non-participating professional
Family Planning Services				
Physical Exam, Laboratory Tests, Information & Counseling	80%		100% after a \$20 copayment	80%
Insertion/Removal of IUD	80%		100% after a \$20 copayment	80%
Insertion/Removal of Norplant	80%		100% after a \$20 copayment	80%
Diaphragm	80%		100% after a \$20 copayment	80%
Vasectomy	80%		100%	80%
Elective Tubal Ligation	80%		100%	80%
Reverse Sterilization	80%		100%	80%
Abortion	80%		100%	100% (no PCP referral required)
Infertility Services	Not Covered		50% <i>See Summary Plan Description for limitations</i>	Not covered
Diagnostic Services				
High Tech Diagnostic Radiology (including but not limited to, CT Scans, MRI/MRAs, Nuclear Cardiology, PET Scans. These services require prior authorization	80%		100% 100%	80% 80%
Physical & Occupational Therapy	80%		100% after a \$20 copayment	80%
Speech Therapy	80%		100% after a \$20 copayment	80%

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			Highest Level of Benefits	Self-referred Level of Benefits
Cardiac Therapy	80%		100% after a \$20 copayment	80%
Chiropractic Care	80%		100% after a \$20 copayment No referral required for up to 36 visits in a calendar year to a network professional	100% after a \$20 copayment for first 36 visits in a calendar year to a network professional 80% for visits to a non-network professional or over 36 visits in a calendar year No referral required for up to 36 visits in a calendar year to a network professional
Routine Eye Exam	Not covered		100%	100% (no PCP referral required) Not covered if you self-refer to a non-participating professional)
			One routine eye exam every calendar year up to age 18. One routine eye exam every 2 calendar years thereafter.	
Allergy Testing/Injections	80%		100% after a \$25 copayment per testing visit 100% after a \$20 copayment per injection	80%
Private Duty Nursing	80%		100% <i>Preapproval required</i>	80% <i>Preapproval required</i>
Skilled Nursing Facility	80% Up to 730 days when transferred from hospital; up to 100 days otherwise.		100%	80%
			100 days per calendar year	
Home Health Care	80% (Up to 100 visits per calendar year)		100% <i>Preapproval required</i>	80% <i>Preapproval required</i>
Hospice	100% (deductible does not apply)		100%	80%
Christian Science Sanatorium	80%		Not covered	Not covered
Jaw Joint Disorder Services (TMJ)	80%		Not covered	Not covered
Durable Medical Equipment (Prosthetics to replace limbs are not subject to the deductible)	80%		100%	80%
Smoking Cessation Smoking Cessation Program	80%		100%	80%
Medications prescribed by a physician	Prescription drug copayment applies		Prescription drug copayment applies	Prescription drug copayment applies
Physician follow-up visits/counseling	80%		100% after a \$20 copayment	80%

COMP-CARE Comprehensive Group Health Plan		HMO Choice - Point of Service Coverage	
		Highest Level of Benefits	Self-referred Level of Benefits
<p>Managed by Anthem Behavioral Health and all services require preauthorization. Failure to comply with the requirements outlined in your Certificate of Coverage may result in a penalty up to \$500.</p>	<p>For inpatient services you must call Anthem Behavioral Health (1-800-755-0851) for preauthorization of all scheduled inpatient admissions. For emergency admissions, you or someone you designate should call within 48 hours of admission.</p> <p>For outpatient services you must call Anthem Behavioral Health (1-800-755-0851) for preauthorization of mental health and substance abuse services to be directed to an appropriate provider.</p>	<p>Primary Care Physician authorization is not required. Limits and maximums apply to services received at the highest and self-referred levels of benefits combined.</p>	
		<p>This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health (1-800-755-0851) for all inpatient and outpatient mental health and substance abuse services, and receives those services from the provider that the mental health care manager indicates.</p>	<p>This coverage level applies when the member does not contact Anthem Behavioral Health (1-800-755-0851) for preauthorization of mental health and substance abuse services or chooses to receive services from a provider other than the provider the mental health care manager indicates. (The member may have to pay balance bills in addition to deductible and coinsurance amounts.)</p>
<p>Mental Health and Substance Abuse Services</p>			
Inpatient	80%	100%	80% after deductible
Day Treatment	80%	100%	80% after deductible
Outpatient	80%	100%	80% after deductible
Hospital Emergency Room	80%	\$25 copayment, then 100%	\$25 copayment, then 100%
Office Visits	80%	\$20 copayment, then 100%	80% after deductible
Home Health Care Services	80%	100%	80% after deductible

Prescription Drug Coverage (3 Tier Benefit)

Retail Pharmacy

<p>Prescription Drug Coverage</p> <p>Note: Primary Care Physician authorization is not required.</p> <p>All eligible University of Maine System Employees; Retirees; Former Employees on Long Term Disability; and COBRA beneficiaries</p>	<p>Generic Drugs: You pay a: \$10 copayment for up to a 30-day supply, \$20 copayment for up to a 60-day supply, \$30 copayment for up to a 90-day supply.</p>	<p>Brand Name Drugs:* You pay a: \$25 copayment for up to a 30-day supply, \$50 copayment for up to a 60-day supply, \$75 copayment for up to a 90-day supply.</p>	<p>Optional Brand Name Drugs: * You pay a: \$40 copayment for up to a 30-day supply, \$80 copayment for up to a 60-day supply, \$120 copayment for up to a 90-day supply.</p>
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Mail Service Pharmacy

Generic Drugs: You pay a \$20 copayment for up to a 90-day supply.

Brand Name Drugs*: You pay a \$50 copayment for up to a 90-day supply.

Optional Brand Name Drugs*: You pay a \$80 copayment for up to a 90-day supply.

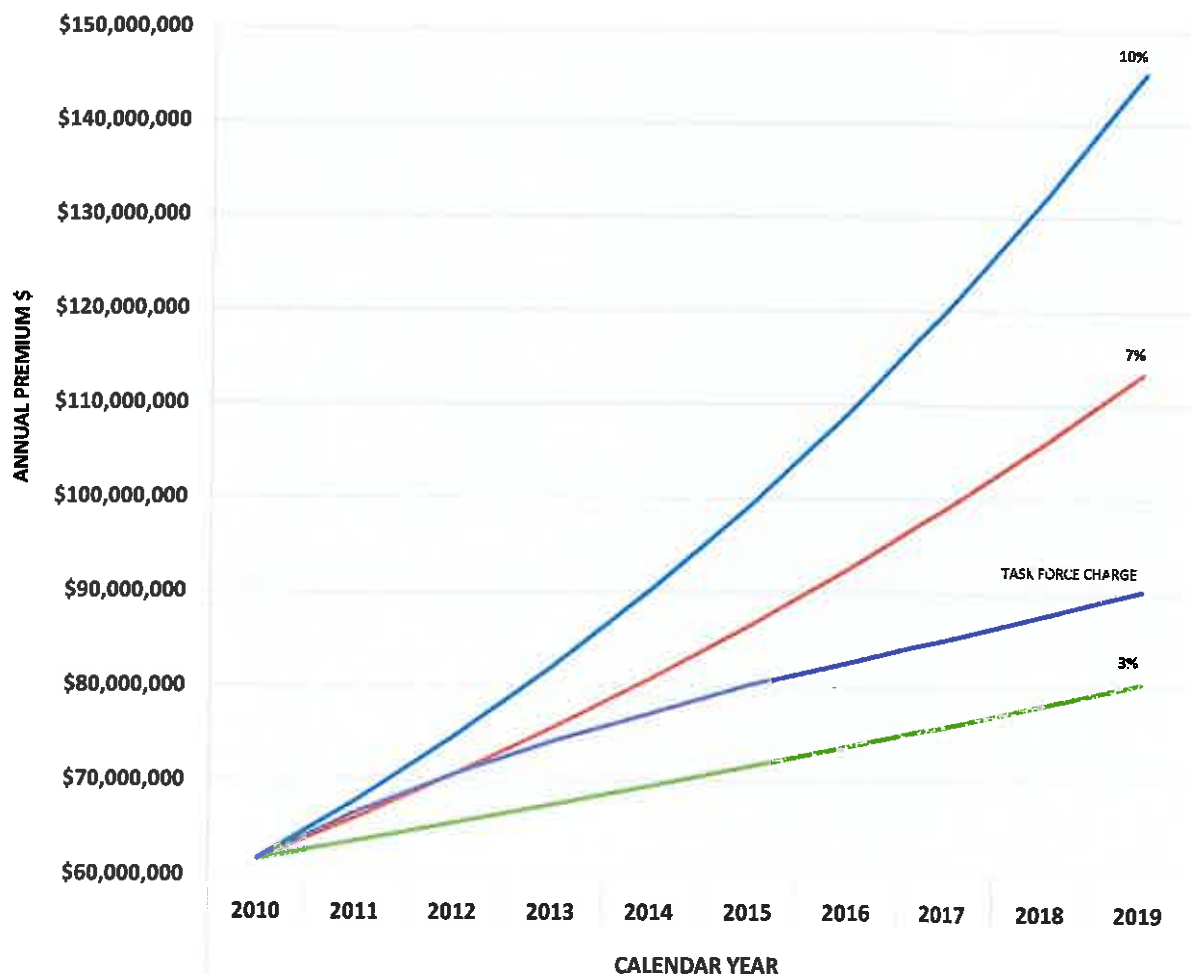
Certain Maine retail pharmacies can fill your prescription at the same copayments that apply to the mail service pharmacy level of benefits. Please ask your pharmacy if they offer this special arrangement or call our Customer Service Department at the phone number on your ID card for a list of retail pharmacies that offer the mail service pharmacy level of benefits.

Out of Pocket Maximum: Once the member has paid \$1,300 in copayments during the calendar year, prescriptions are covered at 100% for the rest of the calendar year for that member. Once the family has paid \$1,950 in copayments during the calendar year, prescriptions are paid at 100% for the rest of the calendar year for the whole family.

This Benefit Comparison is not a contract; it is an outline of your coverage. Your Summary Plan Description/Certificate of Coverage and Benefit Overview fully describe the benefits and exclusions. In the event of a conflict, the terms of the Summary Plan Description/Certificate of Coverage and Benefit Overview prevail. You may contact your Campus Benefits Office to obtain a copy of the Summary Plan Description/Certificate of Coverage and Benefit Overview.

BENDING THE TREND

SLOWING the GROWTH in HEALTHCARE COSTS for the UNIVERSITY OF MAINE SYSTEM



EMPLOYEE HEALTH PLAN TASK FORCE
MEMBERSHIP DIRECTORY

Nina Adams (Staff, Support)
Administrative Assistant II
University of Maine System
16 Central Street
Bangor, ME 04401
207-973-3370
nina.adams@maine.edu

Jerry Ashlock (Observer)
AFT-MAINE
P.O. Box 1007
Augusta, ME 04332
207-621-2854
aft.maine@gmail.com

Tracy Bigney
Chief Human Resources Officer
University of Maine System
16 Central Street
Bangor, ME 04401
207-973-3234
bigney@maine.edu

Michael Burke
PATFA President
University of Maine at Farmington
125 Lincoln Street
Farmington, ME 04938
207-778-7205
mdburke@maine.edu

Mark Coffey
University of Maine Police
Public Safety Building
Orono, ME 04469
207-581-4040
mcoffey@maine.edu

Tracy Elliott
Director, Finance & Controller
University of Maine System
16 Central Street
Bangor, ME 04401
207-973-3252
tracye@maine.edu

Tim Farwell
Police Sergeant
University of Southern Maine Police
Upton Hall
Portland, ME 04104
207-780-5211
timothy.farwell@maine.edu

Ross Ferrell (Observer)
AFUM
Maine Education Association
1349 Broadway
Bangor, ME 04401
207-942-2907x2307
rferrell@nea.org

Frank Gerry (Staff, Labor Relations)
Director of Labor Relations
University of Maine System
16 Central Street
Bangor, ME 04401
207-973-3375
fgerry@maine.edu

Neil Greenberg
UMPSA
University of Maine
Aubert Hall 360
Orono, ME 04469
207-581-2759
neiljg@maine.edu

Carl Guignard, Teamsters (Observer)
Secretary Treasurer
Teamsters Union Local No. 340
144 Thadeus Street
South Portland, ME 04116-2290
207-767-2106
carl@teamsterslocal340.org

Arthur Hill
PATFA
University of Maine at Machias
Science Building
Machias, ME 04654
207-255-1287
ahill@maine.edu

Betty Hilton, USM
Chief Steward
Service and Maintenance
University of Southern Maine
Anderson 104
Portland, ME 04104
207-780-5226
bhilton@usm.maine.edu

EMPLOYEE HEALTH PLAN TASK FORCE
MEMBERSHIP DIRECTORY

Tom Hopkins (Staff, Benefits)
Director, Compensation and Benefits
University of Maine System
16 Central Street
Bangor, ME 04401
207-973-3388
thopkins@maine.edu

Jennifer Moreau
Housing and Communication Director
University of Maine
Hilltop 103
Orono, ME 04469
207-581-4585
jmoreau@maine.edu

Cynthia Huggins
President
University of Maine at Machias
Powers Hall
9 O'Brien Avenue
Machias, ME 04654
207-255-1224
chuggins@maine.edu

Ron Mosley
AFUM President
Professor of Business Studies
University of Maine at Machias
Kimball Hall
Machias, ME 04654
207-255-1265
rmosley@maine.edu

Constance Laughlin
University of Maine
5778-University Bookstore
Orono, ME 04469
207-581-1700
connie@maine.edu

Polly Moutevelis-Burgess
Director, EAP
University of Maine
126 College Avenue
Orono, ME 04469
207-581-4014
pburgess@maine.edu

Christopher Leclair
Chief Steward
Service and Maintenance
University of Maine
Service Building/Paint Shop
Orono, ME 04469
207-581-2662
tracyleclair@msn.com

Tim Pinkham
ACSUM
University of Maine at Augusta
Bookstore
Augusta, ME 04330
207-621-3124
tpinkham@maine.edu

Ryan Low
VP Administration
University of Maine at Farmington
Merrill Hall - 1st Floor
Farmington, ME 04938
207-778-7271
ryan.low@maine.edu

Tony Richard (Staff, Benefits)
Director of Employee Benefits
University of Maine System
16 Central Street
Bangor, ME 04401
207-973-3379
tonyjr@maine.edu

Jim McClymer
Associate Professor of Physics
University of Maine
Bennett Hall 206
Orono, ME 04469
207-581-1034
mcclymer@maine.edu

Judith Ryan
Vice President for Human Resources
University of Southern Maine
School Street, 128
Gorham, ME 04038
207-228-8304
judyryan@maine.edu

EMPLOYEE HEALTH PLAN TASK FORCE
MEMBERSHIP DIRECTORY

Denise Stephenson (Health Consultant)
Vice President
Willis of Massachusetts
Employee Benefits
Three Copley Place, Suite 300
Boston, MA 02116
617-351-7418
denise.stephenson@willis.com

Tim Wooten (Observer)
UMPSA, ACSUM
Maine Education Association
1349 Broadway
Bangor, ME 04401
207-942-2907 x2306
twooten@nea.org

Sheri Stevens
Vice President for Administration
University of Maine at Augusta
Farmhouse
Augusta ME 04330
207-621-3110
sheri@maine.edu

Dorice Timko
Program Aide I
UM Cooperative Extension
Washington County
Machias, ME 04654
207-255-3345
dorice.timko@maine.edu

Jeff Wahlstrom, Facilitator
Starboard Leadership Consulting
84 Harlow Street
Bangor, ME 04401
207-992-4407
cjw@starboardleadership.com

Steven Weinberger
Assistant VP, Human Resources
University of Maine
Corbett Hall 230A
Orono, ME 04469
207-581-1580
sweinberger@maine.edu

Miriam White (Staff, Budget)
Director, Budget & Financial Analysis
University of Maine System
16 Central Street
Bangor, ME 04401
(207)973-3364
mwhite@maine.edu

Medical Plan Design to Support ACO Development

GOAL : Lower copays to incent prevention and quality care; raise copays to discourage inappropriate plan use

Plan Design Provision	ACO Provider and/or Blue Ribbon QUALITY Provider	POS In Network CURRENT	POS In Network PROPOSED
Inpatient Hospital Deductible	3, 4 or 5	\$0 copay	\$0 copay
Inpatient Hospital Deductible	None, 1 or 2	\$0 copay	\$100 per admission
Wellness Visits		\$0 copay	\$0 copay
Primary Care Provider	3, 4 or 5	\$20 copay	\$10 copay
Primary Care Provider	None, 1 or 2	\$20 copay	\$20 copay
Specialist Provider	3, 4 or 5	\$20 copay	\$20 copay
Specialist Provider	None, 1 or 2	\$20 copay	\$25 copay
Urgent Care Facility		\$25 copay	\$25 copay
Emergency Room Visit		\$25 copay	\$100 copay