UNIVERSITY OF KENTUCKY

SENATE COUNCIL

Regular Session

November 12, 2001
3:00 p.m.

W.T. Young Library
First Floor Auditorium
Lexington, Kentucky

Professor William Fortune, Chair

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("She who must be obeyed")

VOTES TAKEN
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MR. FORTUNE: Welcome to the Senate Meeting of November 12.

This is a rather special meeting because the Report of the Health Benefits Committee is going to be released and discussed today for the first time.

We have a couple of minor, very minor items of business to take up. So let me go through those.

First, the minutes of October 8th have been distributed. Are there any additions or corrections to those minutes? (No response.)

If not, the minutes will stand **APPROVED** as distributed.

By way of Chair's announcements, we approved a change in the Dentistry Calendar because of their College Research Day. Senate Council did that. We also approved -- and this is actually a change in the Senate Rules -- to approve a change in the Pre-College Curriculum as it appears in the Senate Rule. There was an emergency situation. We basically -- We needed to do that in order that the bulletin would be correct. And so we went ahead and did that. And, really, all we're doing is conforming to the State policy on that.

As far as waivers of rules are concerned on September 17th, and I forgot to announce these last time, there were four waivers of the I-Grade Rule. These were all situations in which for various reasons the students asked for -- the students and the faculty members involved asked that the I-Grade Rule be waived to allow a grade to be recorded after the normal time for doing that. And on October 29th, at the request of the School Accountancy, we removed a course from the purge list. It had been purged because it had not been taught in a number of years. And we removed it from the purge list in order to make it available to be offered in the spring semester.

By way of other announcements, John Tacoro [phonetic] called us this morning. And the Self-Study Report is up on the web and it's www.uky.edu -- of course -- /selfstudy. And there are two hard copies on reserve at the Library. And I think John's here, isn't he?

John, you need comments on that pretty quickly, don't you?

MR. TACORO: Right. By Wednesday.

MR. FORTUNE: Okay. This is

pretty quick.

MR. TACORO: Bill, let me make some comments, if I may.

MR. FORTUNE: Yes.

MR. TACORO: The president sent out a memo about this November the 2nd. And we also tried to get a note in the Kernel about it. But the Kernel didn't see fit to publish it. So that's why you have the short notice.

MR. FORTUNE: Okay. Well, it's on the web and there are two hard copies in the Library. So for those of you that want to have some input on this, you need to take a look at that and get your comments to John as quickly as possible.

Let me say this about the Board of Trustees Election. As you know, we changed the rules governing that. And there are four folks who have been nominated. Now, all these people have agreed -- Ten people have signed their nomination papers and they have agreed to serve and the ballot will be out soon. And the four people are: David Jones, Michael Kennedy, Judy Lesnow [phonetic] and me. And obviously, for that reason, I'm having nothing to do with this election. It's totally under the control of Brad Canon. And he is the one that will be taking the ballots and counting them and so on, and if there is a second ballot, sending that out.

MR. CANON: I'm open to bribes.

MR. FORTUNE: The only other thing by way of general announcement is that we really are going to have a special program at the Senate Meeting on December 3rd. We're going to honor our longstanding and ever-young Parliamentarian Gifford Blyton. And it really will be a festive occasion. And we're going to marry this to the dinner they're having on the preceding Saturday night. His old debaters are having a dinner for him and seeking to endow the Gifford Blyton Chair at Oral Communication.

And our Monday, December 3rd Senate Meeting will be followed by our Christmas Reception which will be in the Young Gallery out here in the hall and it really should be a fine occasion. We're inviting a lot of folks and we'll have a couple of minor items of business but then we'll proceed into the recognition of Gifford.

There is one action item and that is -- I think there's only one action item. Yes. This is a

request by the College of Engineering to change the rule governing the admission to civil engineering. And circulated with your -- with the minutes was the original proposal.

There have been minor editorial suggestions which the Senate Council has approved. And that's that pink sheet. And so it comes to you. And I don't think this is a situation where I have to waive the ten-day rule because these are merely editorial changes. And so it stands before you as an action item. It comes on the recommendation of the Senate Council and, therefore, it needs no second. So I'll ask at this time if there are any questions. I think we have some folks from Civil Engineering here that perhaps can answer questions about it if there are any questions or discussion of this item. (No response.)

Okay. If not then, all in favor signify by saying aye.

("AYE" VOICE COUNT: ALL)

MR. FORTUNE: Opposed say nay.

("NAY" VOICE COUNT: NONE)

MR. FORTUNE: Then the **MOTION** passes.

Okay. The second item, and what we're really here for today, is the presentation of the Health Benefits Committee Report. And I believe you all have copies of it. And I think you also have an evaluation for -- place that you can make comments. You should have picked that up outside. If not, we'll get a copy to you.

I'm going to introduce Tom Samuel to you, who chaired this committee. And in introducing him, I would -- The only thing that I would say on his behalf is that he put up with an awful lot from all of us. This was a remarkable process. It was a totally open process. We had lots of folks who attended the meetings throughout the year. We heard from everybody under the sun about this. We know more about health benefits, at least I do, than I ever wanted to know. And I think the end product is a good product and I am particularly proud of the process. I think it says a lot of this institution, that President Todd formed the Committee that he formed and allowed us to proceed as he allowed us to do.

And, with that, I will introduce to you Dr. Tom Samuel who will chair this Committee -- excuse me -- who will take over the rest of the meeting.

MR. SAMUEL: I'm not going to

give it to Bill. But, anyway...

MR. FORTUNE: Tom's going to take you through this.

Now, when there are questions or comments from the floor, and we are going to be inviting that, I'm going to stand up here with him so that I can call on you and we can get your names for the court reporter.

MR. SAMUEL: Thank you, Bill.

Let me first introduce the Committee. We have most of the Committee members here today and I do want to make sure that they have recognition. I do appreciate Bill's comment but -- comments about the Chairmanship but this has mostly been a Committee activity. It has not been a Chairman activity and it's been a very open process. We spent in excess of 50 hours of meetings, direct meeting time between July and October. And then we had a retreat, at which we actually put the report together based upon information that we've obtained from various and sundry experts around the University as well as the nation as a whole.

The plan is that -- We presented the plan or the preliminary draft this morning to the President's staff. We're presenting it this afternoon to you as the Faculty Senate. We will have four forums on campus where we will take additional comments. We also will have two electronic forums where we'll have people from Eastern and Western Kentucky participate.

We then will have a meeting next Wednesday just to show we're real serious about this and that next Wednesday, the day before Thanksgiving, we hopefully will wrap this report up and be able to actually get the report to the President, because it's going to take several months of planning in order to implement whatever changes ultimately the President chooses.

So we're going to have not only what this Task Force recommends -- and certainly we need to remember ours are only recommendations -- it's up to the Administration to decide what actually does happen. But this has been a very open process. We have a ways to go. We're very proud of where we got to. And I think we can say we have a unanimous support with one exception, one caveat, which we will talk about when we get to it.

Let me introduce the Committee members. You know Bill Fortune. Sheila Brothers, who is from the Department of Endocrinology in the College of

Medicine. Karen Mayo, who is with the Lexington Community College. Bill Reesor, who is with Physical Plant. Bill Stober, who is Emeritus Faculty Member; and Debbie Davis, who is with the Sponsored Projects; Lee Meyer, who is with the College of Agriculture; and David Hoke, who is with the Wellness Program.

There are three members that are not here. Ann Smith is here but she is not going to sit with us. So, therefore, she's not here. But Ann's at U.K. Hospital and brought with us the perspective of the Medical Center, as did myself and others, as well. Roberta Young, who is with the Custodial Services and Physical Plant Division, was a member of the Committee; and Bob Stroup, who is an Emeritus Faculty Member, also is on the Committee.

It was a very active, involved Committee. We were in fact able to, I think, listen to everybody and everything that anybody had to say. And I think we listened until -- In fact, they were exhausted if we weren't.

Now, what I want to do -- And I'd talked with the court reporter earlier; we were talking about Julia Costich, she was the Staff to the Committee. I said, "Make sure you use whatever term possible to enhance her status." So we called her Executive Staff. She's the only Staff but she's also the Executive Staff to the Committee. And she did much of the work.

I just got back from Romania from a two-week hiatus last Saturday and Julia and Bill and others have been doing the work in the interim. So it's been a very fine Committee in terms of interactive capability, but also people taking responsibility and going forward.

Ms. Costich, if you would please let me know where I...

MS. COSTICH: Wave my magic wand here.

MR. SAMUEL: Okay. And the reason I'm standing is, I need to read this at the same time and I can't do it from sitting down there. And I do encourage the Committee, we'll take any question that you have. And the Committee is encouraged to participate in answering questions at the same time.

This is a preliminary recommendation and if we could get recommendation, one up, so I know what it is.

MS. COSTICH: Okay. This is

an overview but I think you can see it fairly well.
MR. SAMUEL: Everybody got that? That's it.
Thank you very much.
(TECHNICAL COMMENTS OFF THE RECORD)
MR. SAMUEL: I got it. Okay. Core Recommendations. We've divided these into Core Recommendations and other recommendations. And we'll let you know when we've passed the Core so that you can see that we are in other recommendations.
The University should increase its support for the health benefit of Fiscal Year 2003 -- that is next fiscal year -- by $9.6 million. That's a lot of money in this tight-budget time. We have worked with the President's staff throughout the period of meetings of the Committee. This would be $5 million of net general fund money plus the 4.6 million that comes from fee-supported as well as grant-supported positions within the University. And then we will go through how we would recommend spending that 9.6 million dollars but certainly it's to improve the benefit structure. But the majority is actually to increase the contribution.
Our basic thrust is that next year is not likely to be a substantial increase in salary to the University employees. There should be no increase in employee contribution to health insurance, that and the -- when we're looking at approximately a 15 percent increase in health costs for next year.
For 2003 no employee contribution increase for any UK family composition tier; employee contribution to UKHMO employee-children and family tiers should decrease. Part of the problem is that the University of Kentucky, if we look at our 20 benchmarks, they fund on the average 89.1 percent of family coverage. The University of Kentucky funds 32 percent. The next lowest to the University of Kentucky is at about 75 percent of the cost of family coverage. That seems somehow disproportionate in terms of our ability to, in fact, be competitive in recruiting on a national basis, as well as to retain faculty here.
I know personally. I came from Tennessee 15 years ago. I thought I had an increase in salary but I really didn't because I had to pick up the cost of family coverage which I did not have to pick up at Tennessee. They paid 80 percent. That's true of many people that we try to recruit here at the University of Kentucky.

Second recommendation: The University should set a goal of funding 90 percent of individual, couple, employee-child, and family coverage under a designated health plan within five years. Obviously, we cannot achieve all that next year. In fact, we're deficient about $12 million even if the University is able to fund the 9.6 million that we have recommended in this particular proposal. So that there's still a ways to go. We do not think that should happen all at one time. Obviously, it has to be over a period of time during a period when health insurance or cost of health care is going up by 15 to 20 percent per year. We're back to excessive inflation in terms of health care cost but we do think the University still needs to catch up.

In addition to the normal funding for health benefits, we're recommending one percentage point of funds available for raises should be devoted to achieving this goal of 90 percent funding. There is not another source of money. The Committee discussed this at length. The idea that we're going to find someplace else to get 12 point-some-odd-million of recurring dollars is just not realistic.

Therefore, the Committee felt that this was important enough in terms of our competitive position that all we could do was to recommend that at least a portion -- and we recommended one percent per year -- of any salary increase that might be available, be devoted to achieving this goal of a 90 percent funding of these tiers of insurance for couples, for employee and children, and for families. But under no circumstance should the employee-only funding fall below 90 percent.

In other words, this really -- I guess if we put these in proper order, we're really saying this is A, and A is B; that the first thing is that we should not fall below our current level of about 90 percent funding of individual coverage.

After FY 2003, achievement of the 90 percent goal will require University contribution to the cost of dependent coverage that is higher than the contribution for employee-only coverage. What this means is -- and I guess we want to be very clear to the entire University community -- it means that families, employees with dependents, would receive more insurance premium than individuals on their own.

So that, in fact, what we're recommending is a reallocation of resources to make us

competitive in terms of being able to cover families and to, in fact, match where we are relative to our benchmarks. Now, I guess we need to also make it clear that some of our benchmarks are at 100 percent of cost; there is no cost to the employee. We are not recommending that. But that is the case.

The University should monitor benchmark health benefits to maintain parity during and after achievement of the 90 percent goal. The point is that in the Wall Street Journal this morning there was an article talking about employees are going to have to shoulder a greater burden in terms of health care cost in the future. If our benchmarks, in fact, change their level of funding, then we believe, as a Benefits Committee, that the University should, in fact, consider that in terms of what level of funding they choose to apply to the health benefits.

And this is the Rationale. You have that in front of you you can read. How did the Committee get there? I think I've probably covered that along the way.

MS. COSTICH: Actually, you might want to talk about the second--

MR. SAMUEL: Here?

MS. COSTICH: Yes.

MR. SAMUEL: Inadequate funding has also caused many employees to drop coverage of their dependents making the remaining group older and less healthy. This is a key factor when we want to know where are we in terms of the level of funding, what's the effect of the level of funding.

One effect is that we have lots of individuals that are insured at the University that may have dependents at home without insurance. You could say, well, that's certainly their choice. But if it's their choice because they do not have the wherewithal to cover those dependents that's a problem, given the system in the United States that the employer, in fact, will provide -- at least make available health insurance so that the employee can purchase that.

Well, one of the things that happens is, many healthy individuals are not choosing to be insured. In fact, we could probably speculate with some certainty that if you had a dependent, even if you were in a difficult financial position that you knew was going to require health care coverage during the coming year, you probably would buy the insurance. You probably would find a way to fund that.

On the other hand, if you speculated that, well, my children have not needed coverage or not needed excessive care over the last few years that I could not cover out of pocket, you might choose to forego health insurance. That means we have many healthy people that have been excluded from the program or at least they're not participating in the program. That means many of us -- Most of you are not as old as I am. But some of us that are old are consuming a lot more health care than we did when we were younger. If we all get to be old in the program, we'll find out just how expensive health care can be. So this is an attempt to also increase the level of participation by healthy individuals.

Third recommendation. The University should offer a lower benefit option at an employee premium rate at least 20 percent lower than UKHMO -- this is in 2002-2003 -- to provide more affordable dependent coverage before the 90 percent contribution level is achieved. You start by the end of the sentence. We do not propose this low option should continue after 90 percent funding is achieved because it will be a lesser benefit. We also want to make that clear. It's not like we could get the same level of benefit for less money. Hopefully, if we could do that, the University would already we doing so.

What it means is that this would provide a way for people that have dependents that need health insurance that currently do not have it available, that this would provide them a better way, a less-expensive way to have that coverage.

If we could go through some of the points on this.

We have set out, against the better advice of some of the actuaries, some of the considerations that the Committee would like to have considered in producing this particular product. I guess the Committee has no illusions that this is going to be easy, nor do we even think -- do we even guarantee -- or would actuaries guarantee to us, rather, that they could structure such a product. We hope they can. We think it's important that they do so. But there will be limitations in this plan.

We felt, as a Committee, there were certain things we considered along the way that should be considered by the University and by those that provide the product in structuring that benefit. And these are some of those.

Certainly, you could have more stringent managed care strategy such as the gatekeeper and make it a very strict gatekeeper in terms of access to care. It doesn't mean you don't have it but you've got to go through the right steps to get there.

Allow out-of-network utilization at high out-of-pocket cost as much as 50 percent copay if you want to go outside the network.

Impose annual or lifetime benefit limits. Possibly exclude some benefits that are now covered such as transplant or other coverage if that's appropriate, considered appropriate by the actuaries and by the University. Limit the impact on cost of care for children. We felt that we wanted -- One of our purposes here is to have more dependents included in the plan. Therefore, there should be less impact on children than what there might be on adults.

Impose copay for adult outpatient except for annual preventative services, again trying to find a way to make the plan as acceptable as possible in terms of trying to improve health. This offering would disappear once the 90 percent goal had been achieved. We do not recommend, as a Committee, that the University should continue a low option beyond the point that the 90 percent goal is achieved.

Recommendation 4. Identify alternative benefit designs that better meet the needs of the Medicare-eligible retirees.

Last year, as those of us in this room that consume pharmaceuticals know, the copay for pharmaceuticals increased relatively dramatically. For Medicare-eligible retirees, that was the primary benefit that they received because Medicare covers most of the cost of services, not all, but most of the costs. And I think it's somewhere around 60 to 65 percent of the use of this plan by Medicare-eligible retirees was for consumption of pharmaceuticals. That was a disproportionate increase in cost to them beyond what it was to the rest of us, because we consume all our health care under the plan, whereas retirees primarily consume pharmaceuticals.

We feel that designing a plan that would fit the needs of the Medicare-retiree population is more appropriate than to include them necessarily in the plan that is utilized by the remainder of the University population. The key, though, would be to continue the policy of a contribution for retirees at the level of an employee-only coverage in the

"standard" plan of the University, that is, currently the UKHMO. So they would not receive a reduction in funding. They just simply -- We would arrange that benefit package in a different fashion.

Explore ways to lower retirees' exposure to high cost out-of-pocket. Prescription drugs would be the key issue. But also retain protection against catastrophic financial loss. Retain coverage for medically necessary and preventive services. Explore effect of actuarial rating Medicare-eligible retirees separately from active employees. And then support appointment of a retiree to the University's Employee Benefits Committee.

And the last recommendation is: Support surviving spouse coverage at the same percentage rate as family coverage for an active employee. Currently, while the retiree and spouse are both alive, the retiree has his or her premium paid by the University. And they also pay, then, out of their own pocket the cost of the spouse.

Our recommendation would be at the time that the surviving spouse is left without the University employee retiree that we decide, as the University community, to fund 90 percent of that premium. Now, prior to that, there would have been no funding for this premium. And the rationale for that is that at the very time that many surviving spouses are at least capable to pay for health insurance, they're being required to use a larger portion of their total available resources to consume health care. And we had several instances of this where people wrote us letters from the retiree community.

The retiree benefits survey that we did indicated that this was a severe problem for surviving spouses. We feel this is a very low-cost option. It's a group that is not likely to grow significantly beyond what the retiree group would be. And, yet, it's a significant benefit to those that need it. Surviving spouses are often, as I said, least capable of dealing with the increased cost.

5. Correction of UKPPO plan design. Now, I'm not -- I'll be glad to go through each one of these individually, in case some of you have questions. There are several of these that the Committee felt were inappropriate in that we had a number of people that raised the concerns along the way. We don't know the actuarial implications, the cost of each one of these, of trying to "correct" these. Some of them had

to do with our concern that employees didn't really know or weren't fully informed, at least, prior to signing up for the coverage that these limitations would exist or these conditions would exist.

Let me just go through a couple of them. And, like I said, we'll be glad to respond to any individual ones. 100 percent coverage for screening mammograms after a $20 copay. Again, that is a coverage under UKHMO and it makes sense to us that that would be the case here.

Coverage of laboratory services with an outpatient visit at same level whether the service is performed by a laboratory classified hospital-based or outpatient. Currently, the benefits are considerably different if you go to a physician that happens to use a hospital-based laboratory than if you go to a physician that uses an outpatient-based laboratory. Now, we're not sure why that's true. But, in fact, that's the way the plan works now.

So if you, as an individual, and have UKPPO, not HMO but UKPPO, and you go to the Kentucky Clinic, you in fact will have your laboratory services provided by a hospital-based laboratory. That means your payment will have to be higher than if you went somewhere else where your physician, in fact, received those services for you from an outpatient pharmacy. It just seems to be without rationale but, in fact, there it is. We're told that there's a significant cost to this particular benefit, to changing it. But we did make the recommendation it should be considered by the Administration.

CHA Health network (this is for the Regional Service Areas outside of Lexington), for Humana network (for UKPPO) should be encouraged to expand to new counties and add to the network in counties already serviced by that so that as many major hospitals as possible are included.

Many hospitals choose not to be part of a PPO or part of an HMO, particularly outside of the Lexington Service Area, particularly outside of Lexington, Louisville and Northern Kentucky, I guess. So that some employees simply by the fact of where they happen to live end up having to choose hospitals that are different from their local community. Or if they choose to stay in their own community, they may have to pay a higher cost. We are recommending that CHA and Humana make every effort to try to include these hospitals in their network. At the same time, we

recognize how difficult that may be.

Specific standards should be set for network adequacy and it should be assessed carefully. We feel the University should establish these standards, that there should be regular reporting to the Employee Benefits Committee and to the University community, in general. How well are we doing in terms of achieving this standard that we want to have in terms of availability of the network so that you have access to care?

Preferred participation pharmacies issues need to provide other employees with equal prescription drug benefits. If you go to Eastern Kentucky there's not a Kroger on every corner, which those of us who live in the Lexington area are used to. Every Kroger pharmacy is a participating pharmacy. Consequently, we do not have to pay the $5 additional copay with each pharmaceutical -- each prescription that we have filled.

On the other hand, if you live in more rural areas, your local pharmacy may be a Walgreen or a locally-owned pharmacy. Consequently, you're going to pay a higher copay for your pharmaceuticals simply because of where you live. And we feel that every effort should be made to expand the range of pharmacies that participate in the plan.

Recommendation: Settle UKHMO issues. There were a number of issues with respect to UKHMO none of which, in the opinion of the Committee, came down to a severe concern about price. In fact, if we look at the price of UKHMO and compare it to national standards or state standards, we find that it's a very competitive product.

We also know that for a price you could get concierge-type service, health care service. As a matter of fact, it's offered by a number of insurers for an extra $150 a month on your insurance premium. You, in fact, can get immediate access at any time you want to any service you want. Most of us are probably not ready to pay an additional $150 a month.

On the other hand, what is the standard? Which services should be provided by the UKHMO? We feel that those standards need to be set and articulated in such a way that they could be measured and people could report on a regular basis as to how effectively those standards are being met.

In fairness to the UKHMO, they came before the Committee three times, I believe, and each

time pointed out that they were actively recruiting physicians; that it's not as though there's a supply of physicians out there they refuse to employ. It's difficult. It's hard work.

The point is: What is the deficiency? And we can't really measure that now because the standard wasn't established previously. What we're saying is, let's set the standard. Let's have that measured on an ongoing basis. And then let's have that reported back not only to the Employee Benefits Community or a Committee but also to the University community in general.

Monitor primary care and specialty clinics for timeliness of patient care, both time to get an appointment and waiting room time. Report problems and correction plans quarterly to the Employee Benefits Committee. This gets down to the -- Each one of these, they may be on different subjects but the primary issue here was let the University community know how well you're doing in terms of achieving the goal, the standard that was established when the plan was initially set up.

Annual quality of care self-assessment utilizing NCQA standards, HEDIS standards of: What is the quality of care that's being provided? Currently, UKHMO is not eligible to apply for accreditation. But we would suggest that they should, in fact, pursue standards that are equivalent to accredited HMOs in the nation.

Perform annual UKHMO membership satisfaction surveys by the Benefits Office and then reporting that to the Benefits Committee. UKHMO should assure that all departments communicate primary care physicians--

MS. COSTICH: Who are leaving.

MR. SAMUEL: --yes -- to their patients in a timely manner.

What was it?

MS. COSTICH: The departure. There should probably be a "the" between "communicate" and "departure."

MR. SAMUEL: Okay. At any rate, the point is to keep everybody informed, where are we in terms of primary and specialty care.

Now, those are the Core Recommendations. Now, let me go through some Additional Recommendations that the Committee made that are not Core. They're still important to the Committee but they're not what

we consider critical and upfront and the kinds of things that we need to pursue directly.

Off-campus employees. Employees who do not have UKHMO as an option where they work or live pay more of their health care benefits in both premiums and out-of-pocket. We have employees, the University has employees in each and every county of the State. So we have employees, sometimes only seven, eight, nine employees. But the point is, we have a statewide responsibility in terms of the kind of care that we need to be providing them.

Employees outside the UKHMO Lexington Service Area should be allowed to enroll in UKHMO Regional Areas or UKPPO if it is offered in the county where they work. Currently, they're only eligible to take that coverage in a county where they live. Well, let's say you live in Indiana and work in Jefferson County. That means you have no choice in terms of taking a plan. And, yet, you may consume all your health care in Louisville. All we're saying is, let it be a choice. And this is a choice that's already available, I believe, to State employees. This is not something that's radical. Allow the employee a choice of either taking the coverage where they live or where they work.

Until UKHMO is available statewide, consider increasing the University contribution to their coverage so employees share the premium for the least expensive options, that is, not have employees because they happen to live in a county where the hospital will not participate in managed care plan, where in fact the physicians may choose not to participate. Let's see if we could find a way to assist those employees so that their out-of-pocket expense is not disproportionate to those of us who live in Lexington or Louisville or Northern Kentucky.

9. To address the widespread call for an increased employee choice and access to additional health care providers, the University should explore the option of offering a high option plan with a more comprehensive statewide network than is currently available.

Certainly, this is something that high-income employees might choose, as well, in that -- All of us know that, in fact, file long-form taxes, that if we pay our health insurance cost for premiums, those are 100 percent -- escape 100 percent tax, whereas, if we do it out of pocket through a copay, then we have to

accumulate those expenses to equal something like seven percent of our gross income. And that's very difficult to do unless you have some kind of catastrophic event. This would permit high-income individuals to, in fact, tax shelter most if not all of their health care expenses. It also would offer an option to people that might want a richer benefit in terms of their insurance.

10. Plan design suggestions: Restructure prescription drug benefit design with the following goals. Certainly you cannot deny when we're looking at 19 to 20 to 25 increases in prescription drug cost each year, we're going to have to do something to try to control that cost if, in fact, all of us are going to be able to afford health care through the University system. But are there other cost containment measures other than increasing the copay at the time that you pick up the prescription that would accomplish this?

For example, this morning reported in the Lexington Herald-Leader, as well as throughout the country, cholesterol drugs are having less effect than what you would expect. Why is that? Because of the price of drugs. A lot of people are either not buying the drug or they're splitting the tablet and taking half of the prescription, what's prescribed, half of the prescribed amount, and they're not getting the full effect of the cholesterol-lowering effect of the drugs. That's true not just for cholesterol but for a whole lot of drugs. So somebody has less capability through copay.

Let's see if we can't find another way to bring about cost containment. I don't know what those are but there are other people that get paid big bucks out there that might be able to find a way to do that.

Copayment schedules that more accurately reflect the cost and benefits of specific drugs. There's also a problem that some drugs are not included on the formulary. I use myself where they may be included but at a higher copay. Last year I took Claritin and my copay was $20. This year it went to 40 and I decided I didn't need Claritin anymore. And that's a designer product. I mean, it's, you know -- So I have to take Sudafed more often. It's not exactly the worst thing.

But it's a not a cholesterol-lowering drug. It's not my blood pressure drug. It's not all

those other things that old people -- you know, my drops for my eyes to make sure that I don't get glaucoma, et cetera, those things that you have to have. But for some people they're not using those medications either. That is a problem because the beneficial effect of the medication is not reaching those people.

UKHMO primary care physician office visit copayment for adult visit other than annual preventive care visit. Currently for UKHMO participants, specialty care now is at $10 copay. Our recommendation would be that there'd be a copay also for primary care physicians as a way to recognize the use of the service, as well as to assist in paying for the cost of the service.

Cover treatment medication for children diagnosed with attention deficit disorders. This was a significant event for many children that suddenly we were not paying for the cost of the Ritalin and other medication used to control hyperactivity.

Recommendation 11: The University should provide financial support for the College of Pharmacy proposal -- which is on our website and I believe we have handed out here; is that correct--

MS. COSTICH: It should be part of the handout.

MR. SAMUEL: --as a rate proportion to UKHMO's utilization of Kentucky Clinic pharmacy services. We were very impressed with the reports from the College of Pharmacy as a way to control the cost of drugs and to give options to employees. We believe that the University should step forward and find a way for this to be funded. Our recommendation could only go to the extent that there's premiums that are being paid. So we did not say that the UKHMO ought to pick up 100 percent of the cost when the benefit in fact goes, I believe, 85 percent -- 80 or 85 percent to other plans, other prescription utilizers in the Kentucky Clinic other than UKHMO.

Recommendation 12. The University should support the proposal of the Wellness Program -- and it's also attached -- in the areas of preventive service analysis, wellness initiatives and improved member education.

I emphasize "improved member education." There are a number of reports that would indicate only about 50 percent of Americans are medically literate, that is, able to participate fully with their physician

in their own treatment. We feel that, as a University, we have an obligation to make sure that the participants in our plans, in fact, are medically literate and able to participate with the physician in their care. We feel that would have a very beneficial effect not only in terms of medical outcome but also in terms of controlling cost.

Healthy lifestyles, obviously, are important. Everybody ought to be running all the time and doing all those good things and we shouldn't be eating icecream, et cetera. We all know that. And to the extent that David can get us to do it, it's great. He's going to have trouble with some of us getting 100 percent participation.

The task force supports appointment of a Wellness Director ex officio to the Employee Benefits Committee. We feel the Employee Benefits Committee, while it, in fact, addresses all benefits, as Jack Supley [phonetic] as Chairman knows, I can say as somebody who has sat on the Benefits Committee, a whole lot of time is taken up with health insurance. Other things seem to have a way of taking care of themselves. We feel that it's important that the Wellness Program be represented on the Benefits Committee.

13. Customer service and management capacity should be enhanced.

This is primarily for the University Benefits Office. For years we feel it has been underfunded. Those of you in this room, most of you are probably aware, we have what's called a self-funded plan, that is, the University puts up the money. If it costs more, the University has to put up more money. If it costs less, the University gets to keep the savings.

There have been three instances in the past few years where the University had to put up additional money. We feel that if the Benefits Office was better funded, it could more actively participate in the process of designing plans and monitoring the activities throughout the year so that all of us in this room would get a better benefit than what we have now.

Proactive monitoring of UKHMO service capacity. Again, Employee Benefits Committee monitoring that, doing surveys and reporting to the Employee Benefits Committee, as well as to the University Committee as a whole -- community as a whole.

Better customer information about how to contract health plans.

Consistency, timeliness, and accuracy of response to member inquiries. That was a frequent problem that the Benefits Office did not respond either consistently, accurately or in a timely fashion. And some of that has to do -- Most of that has to do with the level of staff.

Complete and up-to-date website materials. For example, I went into the website at one point and much to the chagrin of T. Lynn Williamson all I could find was last year's rates when I wanted this year's rates. Now, it had to do with some perverted way that I got there. Nobody can still quite understand how I did that. But they admitted once they did it, they also got the wrong rates. If you went the right way, it was correct. But, anyway, most of my life has been perverted. So we're fine.

(Crowd laughs)

MR. SAMUEL: Everybody expected that to happen. Now, what can I say.

Timely and accurate plan documentation, identification cards, other personal materials. More comprehensive information for new retirees. Better employee orientation. Employee orientation is one of those things that, having been a part of that at one time in my life at the University of Kentucky, we can put everything in employee orientation to the point that we put nothing in employee orientation. And we may already be there. Exactly how to do this, I'm not sure. The Committee was not sure.

But I think that we feel it is extremely important that people have better information about what is it their benefits really are. Most of us in this room know that we only really care at the point we consume care. So the point is how to get us to know that before we actually show up to consume the health services.

Eligibility. The University should allow same-sex domestic partners to be covered under University health benefits plan if they meet criteria similar to those used by other universities for such coverage. This is -- We feel this is important in terms of Top-20 status. Our benchmark institutions, in fact, have same-sex domestic partner coverage. And, yet, the University has been through a very grueling process in order to finally have that approved, as have other universities. But we feel this is important,

something that needs to be included in terms of our recommendation.

Then after 90 percent contribution level is achieved, it's our recommendation that part-time employees with 20 or more hours have a proportional premium paid for health insurance coverage. The Committee did discuss this at some length. Our concern here is that the University could very easily become a place where people that really need health insurance decide they want to work 20 hours. And that could give us an adverse selection in terms of the particular people that would choose to participate in the plan.

But that's something for the actuaries and the University administration to consider. We do feel it's something that's appropriate. We know there are many deserving people that currently do not participate in the plan simply because they don't work the requisite number of hours.

And that is our recommendation. And we're open to any questions, any comments.

MR. FORTUNE: Okay. Hans Gesund?

MR. GESUND: There's one thing you left out in the cost containment. A lot of us or some of us could be covered through other plans. There's nothing in here to encourage people to get out of the U.K. plan if they can be covered elsewhere. And, in fact, you are going to -- By paying for dependent coverage and so on, you're going to encourage more people who could be covered by other plans, by other employers, to enter this plan, thereby raising the cost of this plan.

It seems to me one thing you could do is, if someone does not wish to have dependents or even themselves covered under UK's plan, there should be some benefit given to them. A negative premium, shall we say.

MR. SAMUEL: We did discuss that. That is a -- That's a legitimate issue that we explored in length. The problem will be far less once you get the 90 percent premium in that everybody, I assume, will be participating. At that point if you said to somebody, you could take that maybe 50 percent and go somewhere else, that would be possible. I think the concern right now is the adequacy of coverage is so low at the University that we have to address that first before we try to consider the proposal that you're making.

MR. FORTUNE: Kaveh Tagavi.
MR. TAGAVI: You did a very good job identifying all the groups who were disproportionately affected during the last year. But I didn't see those people who get allergy shots which was free under UKHMO, all of us that take, $5 per shot. And those of us who take shots, some of us have to take it once a week and if you have two kids who also have allergy, this could amount to a lot of money.

But my other comment is -- and after that you can answer -- is anytime a major recommendation is mixed with, let's say, another nine minor recommendations, I'm afraid that the University would come back and say, "All right. We accepted 90 percent of your recommendations." To me, it seems the bottom line is the percentage of the plan which is covered by the University.

And I think it would be nice if your report would delineate that one recommendation from every other 99 recommendations. Because some of them are -- One part of the piece of pizza goes to this group, one part to the other group, although the total size is the same. So my recommendation is to make that one issue very separate. And if you could come back after the University decides what is the confusion and communicate that to the University Faculty, maybe by e-mail, that the University did accept or did not accept our recommendation, or increasing the recommendation. Just tell us how much they increased.

MR. SAMUEL: I think we all know what the University does and does not accept in the budget process. But we certainly will do that.

Let me comment on both. First of all, the idea of additional cost that is being imposed on the individual at the point of a copay, we did try to address that to some extent in terms of the high option. We recognize that -- the cost of health care going up at 15 or 20 percent. In fact, some of our fellow universities went up at the rate of 45 percent this year. There are going to be things imposed that are going to be less benefit this year than next. I mean, that's the reality of the world we live in. So what we did to try to counter that was say, let's get a high option.

Now, the cost of that is going to depend on -- If all people that need more services opt for that plan and those that need less don't, guess what? You're going to pay for it one place rather than

another. But my point earlier: If you, in fact, itemize your deduction, you'll suddenly say, ah-hah, the government's paying for part of this now, because in fact I get that as a pre-tax benefit rather than having to wait until I've got enough to have seven percent of my salary or whatever it is, for the health benefit.

MR. FORTUNE: I know -- Of course, I know Hans and Kaveh, so I call them by name but if those others of you who have questions would give your name, please. Yes, sir?

MR. SEIBLE: Mike Seible, College of Medicine. I have a couple of questions. Number one: What percentage of the cost of health care is consumed by retirees? Is a big percentage, a small percentage?

And, number two--

MR. SAMUEL: How do you mean that, Mike? Explain.

MR. SEIBLE: In terms of the dollar cost.

MR. SAMUEL: In other words, the dollar premium versus the dollar cost?

MR. SEIBLE: The dollar cost.

MR. SAMUEL: I don't think we know that exactly because they're not a separate risk we've done currently. So they're not really accounted that way. However, I think the general feeling is -- and it's probably from our actuaries -- that it's about a breakeven, that the amount of premium they pay in is about what they take out. And about 60 to 65 percent of that is prescription drugs, as I said.

MR. SEIBLE: And then the other question I have is: In terms of the -- I don't know who the benchmarks are. But in terms of the benchmarks, number one, are their benefits -- We've talked about their cost and the percentage that they contribute but are their benefits the same as our benefits? Are they greater? Are they less? And if these are state institutions, is the state contribution to health care for the universities, our benchmark universities, greater, less than or the same as ours?

MR. SAMUEL: I'll call on Ms. Costich to respond to all that because she's our benchmark expert.

Before you start, Julia, let me just say that -- and certainly she knows much more than I -- when you start talking about the level of benefits, one

to another, that's very difficult, as you know, Mike, to really know what that is. It's also difficult in terms of what percentage of the budget is being provided by the state.

Let me just give you an example. At the University of Kentucky we have -- In fact, about 50-some percent of the premium for health insurance at the University is paid for by general funds, net general funds, appropriated by the Legislature. In the Medical Center, for example, that's only 15 percent by general funds. 85 percent comes from the hospital fees, comes from KMSF fees, comes from grants and contracts and et cetera. So only 15 percent of the cost of insurance is paid by general fund. Does that mean the Legislature is supported less in Kentucky than somewhere else? Some of that has to do with where we decided to allocate resources to begin with, that we have less. So I think it's very hard to answer that question.

Julia?

MS. COSTICH: Okay.

MR. SAMUEL: But she does know much more than I do.

MS. COSTICH: On the benchmarks. As some of you are aware, the benchmarks were chosen quite ambitiously. They include the -- let's see -- University of Texas, Texas A&M, Ohio State, Penn State, Purdue, University of Virginia, University of California at Los Angeles, University of Florida, University of Arizona, University of Georgia, University of Michigan, University of Minnesota, University of Washington, University of Wisconsin. Have I left anybody out?

MR. SAMUEL: You should get applause for that.

MS. COSTICH: Anybody?

MR. SAMUEL: It's on the website.

MS. COSTICH: It's on the website. It's easy to see.

What I did, and the -- Dr. Seible, this is on the Health Benefits Task Force website with my name on it, actually. The day I gave the presentation, I went through and found the plan that looked most like UKHMO for each of these institutions.

Now, in the case of the two I left out, University of North Carolina and NC State, they don't have any HMOs. They participate in the State Employee Benefits System, which had this giant catastrophic

blow-up last year and lost all its HMOs. So there's a lot of, as you might imagine, instability with their health benefits right now. And so they are not part of that particular analysis.

There's a separate one for PPO benefits at a lot of the institutions. But I did try to make the benefit analysis as uniform as it possibly could be. And, also -- And the other criteria was that the plan had to be offered in the place where the University's main campus was, just for commonality. So many of our benchmarks participate in state employee benefit systems. And that's the other part of the answer to your question.

Eleven of the 19 benchmarks are just paid in state employee benefit systems. And three others, Georgia, Texas and UCLA, are a part of a very large multi-campus systems. So that all of the universities of California are part of the same health benefit system. You can just imagine how many hundreds of thousands of lives these cover and, likewise, with the University of Texas and University of Georgia.

So it's very difficult to compare across these, all these different systems, and the answer to the state contribution to the employee premium from the universities' perspective. Obviously, if it's part of the whole state employee benefit system, it's going to be uniform across all state employees.

The other important distinction to keep in mind is that the majority of our benchmarks are heavily unionized and often are in states where collective bargaining is the rule for state employees, as well. So this has a very distinct effect on employee benefits and what changes from year to year and what doesn't. This is where you particularly find the huge subsidy of the dependent coverages in these heavily-collectively-bargained sectors.

Also, what makes it even more mind-boggling is that there are often different kinds of benefits for different parts of the university system. For example, the Medical Center has a different benefit system from the people on the main campus. Often, some of the different collective bargaining units will be a little bit different. The University of Illinois has 24 different collective bargaining units, if you can imagine. So there are some blessings we might want to count here.

MR. FORTUNE: If anybody wants to define comparable, we'll gladly take the question.

Yes, sir?

MR. DARAJVLIN: I would like to address your Recommendation #9. My name is Govin Darajvln. I'm sorry. One is, ordinarily, there is a difference between specialist and primary care doctor. Many times we see a primary care doctor if a cold (unintelligible) all that kind of (unintelligible) of something. Sometimes I end up seeing only physician's assistant, for example, on a walk-in clinic. And doctor usually I've see only (intelligible). I've not seen my primary doctor for the last 12 months, for example. I see only interns.

And so when they put the $10 copayment for the specialist, I thought that was to see the specialist or doctor. That's the rationale I thought. But now, instead of taking away the $10, now he want to add $10 to the primary care physician. This is, to me, an issue to be concerned with.

MR. SAMUEL: Well, let me just say that a part of our consideration of this particular issue, number one, we were told there are a number of cancellations -- well, no, no, not cancellations but people just don't show for their primary care appointment. We assume that if somebody was required to pay whether they showed up or not -- In other words, if there's a fee attached to that and if your name's on that appointment and you don't properly cancel and you need to show up that day, a bill is sent whether you were there or not, then we might discourage people actually not showing up for appointments. It is a way of, in fact, regulating the utilization of services.

And also, and quite -- just, in all honestly, we felt we could make that a relatively low copay, not necessarily 10 but maybe 10 and, in fact, contribute additional funding to the plan and prevent some other even more adverse increase in cost to try to, in fact, fund the entire plan. These things are not free. We all know that. It's a matter of trade-off.

I think the thing that the Committee became concerned about was the trade-off being to higher copays at the time you purchase pharmaceuticals; that that is -- that we may be reaching a level where we're actually discouraging people from consuming the most beneficial medical treatment available to them, that is, the consumption of pharmaceuticals. And, therefore, we were looking for a way to try to come up

with additional funding, in addition to regulating no-shows and cancellations.

MR. FORTUNE: Yes, sir?

MR. STEINER: Shelly Steiner, Biology.

One question. You said you considered dental methods in this process.

MR. FORTUNE: Did we consider dental?

MR. SAMUEL: No, not much. In fact, we had a couple letters on dental benefits. But currently dental benefits at the University are basically a plan that people purchase on out of their own pocket in terms of premiums. And, therefore, we did not focus on dental benefits. That is correct. We focused primarily on those benefits that currently the University participates in the cost of.

MR. STEINER: Another question not linked to that but is there a possibility of having an ombuds-something person to people. There are issues that come up and it's catharsis, if nothing else, but in some cases and, for instance, a drug is changed. They don't recognize a drug somebody's been taking for 20 years, even though it's generic. People want to understand why and to have an outlet and then to accumulate information. People would tend to contact an ombudsperson or people to express that. And you can get kind of -- There's some way to vent your displeasure with something that's happening in the system, either waiting too long or whatever, whatever the cases are.

MR. SAMUEL: Well, we really, I think, through the Benefits Office, and particularly through the Employee Benefits Committee, saw that as the way of having -- We didn't think of it, I don't believe, as a direct individual -- You could complain to the Benefits Office and something would happen. We didn't think of it in the terms of an ombuds. And maybe we should consider that.

Certainly, if you'll give that to us, the Committee will take that back in our deliberations next Wednesday and see if we should add something to that effect. But I think we were considering that basic thrust in terms of the Benefits Office having more funding.

Other questions? Yes, sir, in the back.

MR. LABUNSKI: I'm Richard Labunski from the College of Communications and

Informational Studies.
Did anybody during your many, many public hearings suggest that employees who smoke ought to pay higher premiums than those who don't? And if the Committee did not consider that, why did the Committee not consider that?
MR. SAMUEL: I don't think anybody...
MS. COSTICH: There is the answer.
MR. SAMUEL: Yeah, I know. But we didn't have that direct recommendation to begin with; right? Yeah, sure.
MR. FORTUNE: The reason that we didn't consider it is, that we cannot consider it under state law. The Legislature in its wisdom has defined smokers as a protected class and we cannot discriminate against smokers anymore than we can discriminate on the base of race, gender or religious preference or anything else.
MR. LABUNSKI: Well, how can our insurance companies, for example, have lower rates for--
MR. FORTUNE: Well, because we're the State of Kentucky. It runs -- The State law runs to the State of Kentucky. And as far as the State of Kentucky is concerned, smokers are as protected from discrimination by state government as anyone else.
MR. LABUNSKI: But, Professor Fortune, will it necessarily, though, be discrimination? And if you charge people who engage in activities that increase their health costs, why is considered to be then discrimination?
MR. FORTUNE: Well, it's -- The way the Statute is written, the thrust of it is, as I recall, and I was shocked when I saw it, too, but it is that the State cannot -- I don't think that it uses the term "discriminate." But basically it says that the State cannot do anything with regard -- have adverse effect on smokers except workplace regulations such as where you smoke. But T. Lynn Williamson told us, because this came to my mind immediately, of course, that T. Lynn Williamson said, "You just can't go down that road." I'm not sure we would have wanted to, anyway, to be honest. But we did not. We could not. That's the answer.
MR. SAMUEL: And the other point is, if we get down to every behavior that has an

adverse impact--

MR. FORTUNE: Where do you stop?

MR. SAMUEL: --try to make it proportionate -- most of us in this room would probably not get health insurance. And I'm not saying that -- I know I'm -- I'm not trying to make light of your comment because, being a reformed smoker for 20 years, you know, I want benefit from not smoking but -- other than to be able to walk and read better than I could before. But the point is, I think, that if you start down that road, there's almost no end as to where you've got to go in terms of impact.

MR. FORTUNE: Well, Liz Demsky.

MS. DEMSKY: Biological Sciences.

I was wondering if you were at all worried by advocating the offering of a lower benefit option for whatever fine reasons they were that you might be planning a strategy in front of the University that might make it more possible to move towards that 90 percent funding without actually putting in the additional resources necessary to do that.

MR. SAMUEL: I'm not. No. I think that this was entirely at the proposal of the Committee. This was not something that the University Administration proposed. And I don't think it's something the University would want to pursue. We quite frankly do not think there'll be a very significant -- many significant number of takers of this particular plan. Very few people will choose that because it will be a lesser benefit and one that people are not likely to say, "Gosh, boy, I like this plan."

Go ahead.

MS. DEMSKY: I guess I was suggesting that maybe that it would be difficult to move, since we're at 32 percent, to 90 percent. That's a long way to go. And that, again, one of the strategies might be then to make it not so much of a choice for employees, to make a lower benefit option more of, you know, what -- more of an offering than a choice.

MR. SAMUEL: I really don't believe -- I don't see this as a threat at all. I think this is such -- It's going to be such a lesser benefit that I cannot foresee the University Administration -- I don't think they set this

Committee up, said, "Go out and do what you do and come back with a report that says you ought to fund 90 percent." And then say, "Well, what we'll" -- "The way we'll get there is we'll cut the benefit level by 40 percent." I just -- I guess I just don't--

I personally have met with the President and other people in the administration. We've met with the administrative -- the President's cabinet this morning. I just -- I find no inclination to do that in the administration. And I don't believe it would work, anyway. I think they'd be right back to where they were last spring if they did that. So no, I don't think so.

MR. FORTUNE: Lee's going to talk about it, I guess.

MR. MEYER: Well, Bill asked me to comment on the Minority Report and I guess that labels me in a certain way--

(Crowd laughs)

MR. MEYER: --just a coincidence that--

MR. FORTUNE: Lee Meyer, for those of you that don't know him.

(Crowd laughs)

MR. MEYER: Some of us discussed the concept of moving more aggressively towards the 90 percent goal. And one way of doing that would be rather than just designate one percent of any increase in the salary pool, is to designate one percent of a salary pool, regardless if there was money for an increase, which in this year might mean an actual decrease in net nominal pay.

One of the reasons we supported -- There's a couple of reasons we supported that. One thing it does is that--

MR. SAMUEL: We being a minority.

MR. MEYER: --we being a minority of three. One reason is what that would do is, it takes taxable money and moves into non-taxable. There's a benefit there. But, more importantly, it really supports the very large number of lower-paid employees. So what it would do is take one percent of the average salary, by moving that which go primarily into dependent care program, dependent tiers of the program, what that would do is really bring us much more quickly forward and making the program eligible for those lower-paid employees.

I don't think there was any disagreement among the Committee at all in terms of the sentiment of doing that. It was more, I think, an acceptance of the University community of being that aggressive about it. That might cause some dissension. We really wanted to have a program that there was pretty much full buy into. And so that was the reason I think that the Committee didn't support that. It wasn't a lack of interest with that group.

So if there's comments--

MR. MULLADAHR: I had a question about this earlier.

MR. FORTUNE: If you will, your name, sir.

MR. MULLADAHR: Yes. Chris Mulladahr from the College of Business & Economics.

Essentially either way, whether we take a reduction or a raise, in essence, we are saying that we're going to put in the money, or at least the extra money other than the 9.6 million, we are going to put in the money one way or another. So whether it's, you know, premiums or monies coming from raises, it's still our money. And like the State or the University, itself, you know, how much are they contributing to the enhancement of our medical program, is my question.

MR. MEYER: I'll answer again. Well, it's really a shared effort. We're asking the University to put basically all the increase in revenue of this year into the health cost or the health insurance program. One of the things we noticed in the very beginning is that with 15 to 20 percent increases in health care costs, that health insurance is not going to fix that.

And I think a lot of people came to our Committee and wanted us to fix the underlying problems with the whole health industry. And so we can only really focus on the insurance side of things. And given that we're running -- we need to run to even keep up, it has to be the shared effort. And so the shared effort would be we take smaller increases in salaries in future years and the University tries to reallocate resources towards helping us do that.

MR. SAMUEL: To comment -- Sort of the ultimate comment on your comment, which I agree a lot with, by the way, that there's a movement to define contributions on a national level. That may be slowed down by the events of 9/11. Now, the government's not all bad. But that, in fact, would

have allowed people to use their own discretion as to how much they were going to shelter their income. Because I happen to think that all my contributions by the University, including my salary, are mine. And the University makes allocation decisions that I agree with or don't agree with. The point is, I don't have a choice. The amount that goes into my retirement is predetermined. I might choose to have that in a different form but I don't have that option.

We recognize that, in fact, what we're suggesting is that more decision be made "in the initial allocation process" and it not come to us in the form of salary and the University make the decision to spend that for us, for our benefit, in terms of health. We think that's important in terms of particularly lower-paid employees. But we think in terms of all employees that this really is beneficial to move to a higher payment level in terms of the premium.

Certainly -- I'll be honest with you -- if I could have all the money in my pocket and could make my own decisions, I happen to think I'd make better decisions. But Ben Carr [phonetic] and the University don't let me do that. In all fairness, I mean, that is our system. That's the way it works.

Let's see if we have--

MR. DARAJVLIN: I just want to make a comment. And I'd like to--

COURT REPORTER: I can't hear you, sir. I can't hear you.

MR. FORTUNE: We've got a court reporter here.

MR. DARAJVLIN: If you compare the benchmark (unintelligible), UK's 30 percent behind in salaries. And I don't think anybody would like to take a cut in the salary. And I would like to support the majority point and, also, it affects the pension. So...

MR. SAMUEL: I do want to, if I could, just to echo Lee's point. It was not that the majority of the Committee did not have sympathy with the idea of somehow reducing our compensation and putting that into health care. But we just did not want the dissension that we think -- we thought would arise within the University community if we proposed that.

MR. FORTUNE: Let's see ... Kaveh, let's see if there's anyone else who has not

spoken who would like to comment and then come back to you.

Yes, sir?

MR. CLAYTON: I'm Tom Clayton from the English Department.

The one percent that you're talking about, not the minority group but the majority group, this is to last for how long? You say until the goal is achieved. But won't it have to continue forever?

MR. SAMUEL: No. Well, the amount that's taken out, that amount, that one percent would. But let's say -- Let's just give an example. If we had a three percent increase in 2003, 2004 and then every one thereafter and we took one percent out of that, which means there'd only be two percent left, it would take three years to fully fund the plan. We're about 12 million short this year of University contributions.

MR. CLAYTON: Just one point for clarification. You're talking about one percent of raises?

MR. SAMUEL: That's correct.

MR. CLAYTON: And I would point out that at least some campuses that are unionized pay a one percent union dues which go, at least in part, toward health insurance, dental insurance, vision coverage. So that's one percent of salary, not one percent of salary increase.

MR. SAMUEL: No. We'd be talking about one percent of salary in the pool. In other words, when we have a pool that says you're going to get -- there's going to be a three percent salary increase, we'd be saying we take 1/3rd of that and apply that to health benefits. So it is, in fact, one percent of salary. But it would take approximately three years to achieve that level of funding if, in fact, our plan was adopted of 90 percent, if in fact the plan was adopted to take one percent of any increase available in salary.

MR. FORTUNE: Okay. Jeff Demrow.

MR. DEMROW: Jeff Demrow [phonetic]. Two points. One is to -- Somebody has to speak to what Shelly brought up. So I'll do it since I'm from the College of Dentistry.

I think until this country does not separate oral health from the rest of the body cell we'll continue to have that as an add-on or for an

option. I, of course, feel that it's integral to health of the entire body.

The second point is, if one of your goals is medical literacy among the insureds and you want to promote the Wellness Program and we want to somehow acknowledge that non-smokers might be better insureds in some respects, then, perhaps there's another way to approach it. And that's to tie some type of tangible benefits of people who participate in the Wellness Program, much as if you have air bags or whatever you get discounts in your auto insurance.

MR. SAMUEL: David, do you want to -- Do you currently have a smoking cessation as your primary thrust in wellness, now?

MR. HOKE: We're actually--

MR. SAMUEL: This is David Hoke.

MR. HOKE: I'm David Hoke with the Wellness Program.

We're currently starting about -- well, less than a year ago now working with -- getting with UK to join the Kentucky Clinic to work on some specific risk areas, smoking which is one, to work with the physicians to provide incentive for behavioral modification on those risk and/or health conditions which most adversely affect health care utilization costs. So we're kind of in the infancy of that process now toward the proposal that we have to become more aggressive in developing that. So, hopefully, you'll be seeing some of that here as we go forward.

MR. SAMUEL: Eva Arehardt had a question.

MS. AREHARDT: I don't have a question. I have a comment. And I thank you for making something that has always been unclear to me a whole lot clearer. And it seems to me that you've thought things through and made just a very clear presentation to us and I appreciate it. It helps me understand something I haven't done. So thank you.

MR. SAMUEL: Thank you.

I will -- Let me just say one thing on the dental. As somebody who has my teeth bleed every three, four months or something, I have the fear of now knowing that my heart is probably being adversely affected by the condition of my teeth. I think that if the dentists were out there pushing that, we might actually get there. I don't know. But the thing is, from the Committee's perspective, to get there would

have been really a stretch. We were -- Because the key issue was the issue of health insurance.

MR. FORTUNE: Let's see ... We have a question way in the back there.

MS. BLACK: Kate Black. I'm wondering if you can tell us why the Committee decided to put health insurance for domestic partners in the Additional Recommendations instead of in the Core Recommendations.

MR. SAMUEL: Probably because we saw political implications, probably something not dissimilar to our issue around a reduction in salaries. We see it as very important. I don't want to -- The Additional Recommendations are not something that we think shouldn't be done. We think they're important.

The Core Recommendation really had to do with what took place last spring. The whole issue around affordability of insurance, particularly the families and employees and dependents. We really tried to address -- keep our focus on those four issues. There's nothing to say that's a lesser recommendation in terms of what's there, other than I think the charge of the Committee from the President and something that we think is extremely important in terms of reaching a Top 20 status.

Yes?

MR. STEINER: From what I've heard from--

MR. SAMUEL: Let me get your name again. I'm sorry.

MR. STEINER: Shelly Steiner, Biology.

Basically, retired people have health insurance on administrative regulation. I don't think it's really codified. It's not much -- probably doesn't amount to much of a difference. But I think it's a good thing in terms of -- I've heard it from many people retiring. They feel kind of insecure about it.

MR. SAMUEL: As somebody who's going to retire soon, I'm very much in favor of retired health--

MR. STEINER: Would it be possible to codify that and make it, you know, instead of an administrative regulation, which can be changed as an administrative regulation, as a part of your retirement package, whatever benefits they're given, but just to codify the fact that people who are

retiring are entitled after so many years to have health insurance as part of their retirement.

MR. SAMUEL: Well, that's certainly a -- That's a very complicated issue. You're probably aware Polaroid, one of the hallmark companies of the United States, recently went bankrupt. The first thing they did was stop retiree health insurance coverage. I think that's something that we could certainly bring up to the University Administration. I think that really, to some extent, goes beyond the scope of the Committee. And it really makes this not a health insurance benefit but a retirement benefit that's going beyond where I think -- I thought the President pushed it.

Kaveh Tagavi.

MR. TAGAVI: To add all the deductibles, out-of-pocket expenses, copayments, what's the ratio of that number to all of the premiums? And has that ratio changed in the last year, dramatic change in copayments for prescription?

MR. SAMUEL: One of the problems that I don't think -- We can't stand in front of you or the University community and say "We did not get the information we requested when it was available." That particular information, that breakdown and the particular way you're talking about, is not something the University has nor do our insurers have. I believe that Humana is beginning to collect that now. But we did not have it from Blue Cross/Blue Shield previously.

MS. COSTICH: Yeah, it's -- What we'd have to do is set up a hypothetical typical consumer. And we did model some of these market baskets of benefits. And if you look on the Task Force website in the presentation that I did sometime ago -- and it has my name on it, Costich, C-o-s-t-i-c-h -- on that presentation, if you get toward the end of that presentation you'll see some models comparing UK with the mean of the benchmarks.

Now, what I did not do was to compare that market basket analysis with a previous year's market basket. That could certainly be done. I had basically two hypothetical households, one with some serious health problems and the other just what you might think of normal activity, using the health benefits. So that might go a little way towards answering your question.

MR. SAMUEL: But I do think

that we'll begin to gather that information in the future. We don't have it from the past. So we could not make the particular comparison you're talking about.

MR. FORTUNE: Other questions? Phil Kraemer.

MR. KRAEMER: I'm curious. What percent of the benchmarks are self-insured, as opposed to being part of the network?

MS. COSTICH: About three-quarters of them have some. And some of them have, particularly the big, big state plans, they'll have the, you know, icon, PPO, that is the standard plan, kind of like the Blue Cross Plan for federal employees, if you're familiar with that system. And then they'll have a variety of other plans, depending on where you happen to live in the state. And others are completely self-insured from end-to-end. Some are not self-insureds at all but that is definitely a minority of our benchmarks. Most large employers in this day and age tend to find self-insurance a little bit more cost effective.

MR. SAMUEL: That question was certainly on a regular basis. And I think our consultant's recommendations over and over was self insured is a better deal. Yes, ma'am?

MR. FORTUNE: Liz Demsky.

MS. DEMSKY: You've set the same goal of 90 percent for the different groups, individual and family and spouses and such. Is that common for the benchmarks? Do they all fund at the same level?

MR. SAMUEL: Pretty much so. Pretty much so. Now, I'm not saying that's everywhere but pretty much you have the same level of funding for the family and the child, the dependent, as well as the individual. I think one of the suggestions that was made earlier, if you had an option to utilize your individual premium by taking it somewhere else, would that be beneficial? Right now, as I said, we did consider that but the cost was just prohibitive right now. Once you get to 90 percent, then if you offered a portion of that, that could, in fact, be a viable option that would be available.

MR. FORTUNE: Clara Pomroy.

MS. POMROY: I have two questions. If this $9.6 million is pumped into the

employer contribution, what percent will the employer contribution rise to next year?

MR. SAMUEL: Forty-some percent, I believe.

MS. POMROY: I'm sorry?

MS. COSTICH: What is it, like, 46 percent?

MS. POMROY: So it will rise from approximately 32--

MR. SAMUEL: Thirty-two to 46.

MS. POMROY: --to 46 percent?

MS. COSTICH: Something like that.

MS. POMROY: The second question is: Did you discuss incremental milestones that you expected rather than just waiting for five years and saying 90 percent at the end of five years?

MR. SAMUEL: Yeah, I think that is -- The way we set that up, we didn't do it in exactly that fashion but I think what we were asking the administration to do -- we probably ought to be clear on this -- is that we wanted either the adoption of a one percentage point out of the pool availability until it's met or some alternative to that. If they don't agree to that, half a percent for five years instead of one percent for three, whatever it might be. But we know one percent for salary increase is about five to six million dollars. So we know that in three years, if you had salary increases that were available, in three years you've met the goal because we're about 12 million short now.

MS. POMROY: Assuming premiums don't increase. But they are likely to increase significant--

MR. SAMUEL: I'm sorry.

MS. POMROY: That would assume that the premiums aren't going to increase--

MR. SAMUEL: No, no. No, no.

MR. POMROY: --but you could lose ground.

MR. SAMUEL: No. Let me -- The way that recommendation is worded, we're assuming the University will have to fund the necessary cost to maintain the current coverage. The only thing we're talking about from the one percent is to, in fact, move toward this 90 percentile. In other words, if the cost of premiums go up 15, they have to fund 15, then they get one percent to move further along the way to

increase the percentage funding.
MR. CANON: Is that realistic?
MR. SAMUEL: Yes.
MR. FORTUNE: That's Brad Canon who just made that interjection.
MR. SAMUEL: Now, when the President comes, you can ask him if that's realistic. From our perspective, that's realistic, because I think the point earlier that it's really simply -- I mean, currently the University funds at about that rate. We've talked with the Benefits Office and the actuaries. That's what the University's been funding for years, is the continuation. So the only add-on that we're asking for is, in fact, the ability to move toward the 90th percentile.
MR. CANON: Last year it could not.
MR. SEIBLE: Last--
MR. FORTUNE: Mike Seible.
MR. SEIBLE: That's one point is that that stopped last year. And now I don't think you can assume that they're going to be picking up that ten to 15 to 20 percent annual increase in the cost of the--
MR. SAMUEL: Let me just say that I have talked to a number of people within the administration, including the Benefits Office, including the President, Jack Blanton, Steve Williams, et cetera. I think they all admit that they have an obligation to fund the ongoing increase in the cost of health care.
MR. SEIBLE: I'm not sure that that's clear from your presentation. I mean, it wasn't clear to either Clara or myself.
MR. SAMUEL: We will clarify that.
MR. SEIBLE: Yeah.
MR. SAMUEL: But we tried -- We've tried -- We've, as a matter of fact, talked among ourselves as to whether that was clear to begin with and we just need to be more straightforward about what we're saying. But the intent was that that -- It requires ongoing funding. And given that the current cost of that plan to the University, I believe, is somewhere around 40-some million dollars, that in fact that will continue to increase at whatever the rate of increase is.
MR. FORTUNE: Other questions

or comments? (No response.)
This has been an excellent presentation. And I think Tom deserves--
(Crowd applauds)
MR. SAMUEL: Let me just -- I do really want to thank the Committee, the Task Force, Julia and everybody's active participation at the University has been. And this is all the way -- You name it and they worked for us over the last four or five months. We've tried to drive people pretty hard.
MR. FORTUNE: And if you have comments on those sheets, you can put them on the table outside.
MR. SAMUEL: Yes. If you could please leave comments, we'd appreciate it.
Thank you.

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(SESSION CONCLUDED AT 4:35 P.M.)

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C E R T I F I C A T E

COMMONWEALTH OF KENTUCKY)
)
COUNTY OF FAYETTE)

I, STEPHANIE K. SCHLOEMER, a Court Reporter and Notary Public in and for the Commonwealth of Kentucky, whose commission as such will not expire until June 25, 2004, do hereby certify that the foregoing transcript is a true, complete and accurate transcript of the captioned proceedings, as taken down verbatim by me at the time, place and for the purposes stated herein. I further certify that I am not related to nor employed by any of the participants herein and that I have no personal interest in the outcome of these proceedings.

WITNESS my hand on this the 21st day of November 2001.

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STEPHANIE K. SCHLOEMER