**Presiding:** Phillips, John, Chair, EBC

**Present**: Flowers, Melody, EVPFA

Noe, JoLynn, Enrollment Management & Administration

Pistilli, Judy, Pharmacy Central Business Operations

Poston, Lance, LGBTQ Resources

Alexander, Martha, Institutional Equity & Equal Opportunity

Bradshaw, Jennifer, College of Arts & Sciences

Ex Officio:

Wilson, Kimberly, Chief Human Resource Officer

Amos, Richard, Chief Benefits Director

Carbol, Gail, Benefits Manager

Gleason, Melissa, Athletics

Martin, Troy, Staff Senate, Library Administration

Kelley, Scott, Marketing and Supply Chain

Buchheit, Rudolph, College of Engineering

Ward, Tina, sitting in for Shotwell, Christian, College of Agriculture, Food, & Environment

Stamper, Shannan, University Legal Office

**Absent:** Riddell-Peavler, Vicki, College of Dentistry

Tearney, Michael, Retiree

Collins, Craig, UKHC/EVPHA Administration

Ellis, Christy, Retail Pharmacy Services

Martin, Angie, Financial Planning

Krauss, Susan, Treasurer

**Recorder**: Sara Snowden, Employee Benefits

| Agenda Item & Speaker | REPORT | ACTION |
| --- | --- | --- |
| **Call to order – John Phillips** | Mr. Phillips called the meeting to order at 8:32 am. | No action needed. |
| **Review of the November 13, 2018 Minutes** | Mr. Phillips asked for review and approval of the minutes. | Troy Martin made a motion to approve. Lance Poston seconded the motion. Minutes were approved. |
| **Aon Benchmark Review – Curt Dame & Jeff Mudrack, Aon** | Mr. Amos introduced Curt Dame and Jeff Mudrak from Aon. He said that they have compiled data to see how UK’s benefits compare to benchmark institutions. Mr. Dame has been with Aon for 27 years and UK has been his client since 2010. Mr. Mudrak used to work at UK and Transylvania University and has been with Aon for about a year now. Mr. Dame and Mr. Mudrak provided the committee with booklets containing the results of their study of how UK’s benefits compare to other benchmark institutions. One of the sources for this report was The Aon Health Value Initiative (HVI) database. This database contains health care costs and benefit data for 11.3 million health plan participants, 1,260 health plans, and over a billion dollars in health care expenditures. UK’s benchmark group is called the Pathfinder Group which contains higher education institutions. The survey runs on a calendar year, so the numbers are from 2018. They normalized the cost data throughout the year. Ms. Flowers asked if they isolated different factors like demographics and Mr. Dame confirmed they did. The HMO numbers in this report include the EPO plan, as well as the RHP plan, which is like a PPO.  UK was far below the benchmarks for employee contribution and total health plan cost and one reason for this could be the discount with Anthem. Mr. Amos added that it could also be due to UK’s Health & Wellness programs. Mr. Dame explained that the plans on the Actuarial Value by Plan Type chart that are listed as “Account Based – HMO/EPO” and “Account Based – PPO/POS”, which are plans that take the HMO or PPO and attach an HSA-type account to it. UK doesn’t provide this type of plan. In 2018, the benchmark institutions that provide this type of plan rose from 16% to 17%. The higher the actuarial value percentage, the more actual plan richness. HMO’s value is so high that it brings UK’s average up. It is very competitive. UK’s average is just under the Pathfinder Group’s.  Ms. Wilson stated that the HMO, RHP, and EPO plans seem to be in really good shape. She questioned, if we wanted to make changes, would it need to be with the PPO plan. Mr. Dame said that is correct. UK is trying to balance the RHP plan with the richness and cost. That plan is used a lot by the agriculture extension officers. Mr. Amos added that UK just started to incrementally increase the RHP premiums last year because it is such a rich plan. The employee only premiums are slowly being increased because they are so low but there is still a long way to go. Mr. Mudrak suggested that an HSA type account might be something that UK should do. Mr. Amos said that UK has considered it before but decided not to do it last year. It’s being looked at again this year though. You can get triple tax savings with an HSA and its good for saving for the future and retirement. Mr. Phillips asked if HSAs have always been like that or is that something new. Mr. Amos answered that they have basically always been like that. They are always attached to a high deductible plan. Mr. Wilson added that UK tried that a few years back and hardly anyone signed up for it. Mr. Dame said that about 50% of companies in the commercial industry offer HSAs but that doesn’t mean that they have a lot of involvement. This is a type of plan that millennials seem to like. If it was implemented, there would need to be a lot of education about it and you couldn’t expect a lot of participation in the first year of it. Mr. Amos pointed out that participation can depend on many factors.  Mr. Dame showed that the some of the key cost drivers for health care costs are area costs, age and gender, dependent coverage, plan design, and employee contributions. UK’s area costs drive lower health care costs while age is increasing costs. UK’s dependents are driving lower costs because we don’t cover as many dependents as the other benchmarks. We are on the higher side for plan design because it is richer and having such low employee contributions makes UK’s costs higher. Ms. Flowers pointed out that this data could be used to argue for more health programs. On the Financial Efficiency chart, the higher the percentage is over 100%, the richer the plan is. UK’s percentage was the highest which drives significant financial efficiency. Ms. Wilson asked if there was a breakdown of prescription costs and Mr. Dame said that they needed to get a breakdown of that data.  Mr. Dame explained the data about Coverage Election which refers to dependents covered on health plans. UK doesn’t cover as many dependents as the other benchmarks because our employee plus family rate is higher. The benchmarks subsidize more of the family cost than UK does. Overall, UK’s total subsidy percentage was the second highest among the benchmarks. UK’s subsidy percentages for employee plus family and employee plus spouse were the lowest or almost the lowest, while our percentage on employee only was the highest and one of the highest for employee plus child(ren). Mr. Amos stated that adding a spousal surcharge (as mentioned in a previous committee meeting) may be unfair because that is already kind of built into the cost. Mr. Poston questioned if we could be driving people out of adding dependents with our rates. It was discussed that another option for those employees could be KCHIP and some employees have refused a raise because of it. The Federal Exchange/ACA was another option that was discussed. That option doesn’t provide as much availability and the subsidy can dependent on the individual’s employment status and/or pay. Mr. Mudrak asked if UK has tested the tie between salaries and plan choices. Ms. Wilson said that it has been done but it has been a while. Mr. Poston asked if a different subsidy per salary could help. Mr. Martin added that it has been nice that UK hasn’t had many premium changes without overall salary raises. Ms. Flowers said that setting salary bands for premiums/subsidies could cause cliffs with salary changes. Mr. Amos pointed out that UK has increased the employee contribution less than all the other benchmarks over the years since 2014. Ms. Wilson added that you must consider salary increases and parking rates when thinking about raising premiums.  The Enrollment by Plan Type section showed that about 59% of UK employees that are enrolled in a health plan are enrolled in HMO/EPO/RHP (those three plans are lumped together in this data). About 40% are enrolled in PPO and less than 1% are enrolled in Indemnity. Ms. Flowers asked if the reason for more HMO enrollment could have something to do with the available providers. Mr. Amos stated that access to providers for HMO is getting better. Half of the population is actually enrolled in HMO. Mr. Dame said that about 10% of the population is in RHP and that could influence the HMO numbers because they are lumped together in this data. He wants to break them out after Open Enrollment this year. Mr. Phillips questioned if the EPO plan could be throwing off the HMO stats too. Mr. Dame confirmed that it is. RHP is driving the numbers up and throwing them off more. He will do the stand-alone numbers this year. Mr. Phillips said that UK HealthCare is trying to get an access center to help get people with UK plans care more than other plans so we’re helping our plans more. Mr. Dame added that UK is unique in offering a true HMO because the coverage is so rich. Ms. Stamper pointed out that being able to use providers on UK’s campus helps with the HMO plan. Ms. Carbol added that UK is still the most used hospital with the PPO plan, according to Anthem. Ms. Stamper said that the people that want flexibility with providers choose PPO. Mr. Amos noted that people with dependents in college in other places also choose PPO. | No action needed. |
| **Retirement Vender RFP Update – Richard Amos** | Mr. Amos gave a brief update on the Retirement Vendor RFP. He said that there would be a meeting that afternoon with the RFP committee. They are close to having a recommendation for Ms. Wilson. | No action needed. |
| **Retiree UHC Medicare Advantage Update – Richard Amos & Gail Carbol** | A plan guide for the new UnitedHealthcare Group Medicare Advantage (PPO) plan was given to the members of the committee. This is the new health plan for UK’s retirees who are on Medicare. Mr. Amos said that the roll out of the new plan is going well but some people are still needing help with this transition. The plan has as much or better benefits as the old plan and the cost for retirees is 45% less. It is a custom plan for UK. Members can go anywhere if they accept Medicare. There is a whole arm of UnitedHealthcare (UHC) just for retirees. UK is now in the UHC Medicare Advantage Network which is a vote of confidence in UHC. The levels of the premiums for retirees depend on their hire date at UK. There is a subsidy provided for the retirees that were hired before 2006. These retirees are technically not paying a health premium for the first three years of this new plan. They are only paying for the prescription plan. Ms. Pistilli asked if an employee must be enrolled in one of UK’s health plans at the time of their retirement to take advantage of the health plan after retirement. Mr. Amos confirmed that they do have to be enrolled already prior to retirement to get retirement coverage at UK. | No action needed. |
| **Naturally Slim Update – Richard Amos** | Mr. Amos also gave an update on the Naturally Slim program. This is just another offering from Health & Wellness. The program started last fall and involves behavior modification. People have lost an average of ten pounds. Some people are able to reduce their medications because of this program. The enrollment for it would be open until February 1st. The spring session of the program starts February 18th and goes through April. Interested employees must apply for the program and see if they are approved. Once they are approved, they watch ten videos. | No action needed. |
| **Meeting convened – Mr. Phillips** | Mr. Phillips ended the meeting at 9:47 am. |  |