March 19, 2009

TO: UUA Board of Trustees

FROM: Paul Bluestein, MD, Chair of the UUA Employee Benefits Trust Board of Trustees

RE: Executive Summary of the Strategic Benefit Advisors Report, with EBT Chair's Comments

The prelude to this report must rightly be recognition of those people who took the UUA health plan from an idea to a reality:

The courage and vision of the UUA Board and Reverend Ralph Mero provided the springboard for everything which has followed.

Jim Sargent deserves our thanks and congratulations; he has been an excellent Director. The decisions he has made have been consistently right and the foundation he established has allowed the plan to survive and grow.

The COC selected a well-qualified and enthusiastic group of men and women to serve as the first EBT Board and it has been a privilege to work with them, including the ex-officio members Dan Brody and Tim Brennan, advisor on the history of plan development Ralph Mero, and more recently, Acting Office of Church Staff Finances (OCSF) Director Richard Nugent.

There are, I'm sure, many others whose names I've overlooked, and I ask them to forgive me for the omission. It is not a reflection of their lack of contribution or commitment, which we appreciate.

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In January, 2007, the UUA launched a self-insured health plan for employees of UU congregations, affiliated organizations, and UUA staff. Prior to that time, the UUA had had no health plan available to employees of congregations for eight years, the prior insured plan having collapsed. UUA staff had coverage through Boston-based Harvard Pilgrim Health Care, an HMO.

Two years of investigation by the Office of Church Staff Finances (OCSF) from 2004 through early 2006 established that no insurer would be willing to underwrite a group whose size, geographic distribution, age mix, and claims history were both unknown and undiscoverable. The discussion might have ended there, except for a survey that showed that at least 15% of all church staff around the country, in 1000+ congregations in all fifty states, who might otherwise meet the criteria for joining a health plan had either unacceptable, marginal plans, or no health insurance at all. The reality of 400 staff with inadequate access to health insurance drove the exploration of other options.

After unsuccessful attempts to find other denomination-based health plans that might be willing to fold in the UUA, OCSF reached out to the Church Benefits Association (CBA) for

information and direction. Those discussions led OCSF to formulate a self-insurance strategy. The lead vendor of health plan administrative services to members of the CBA was and is now Highmark Blue Cross Blue Shield of Pittsburgh. OCSF brought the self-insurance proposal to the UUA Trustees with details of the proposed plans, rating, reinsurance arrangements, a proposed contract with Highmark, plans for a separate Board of Trustees to administer the new Employee Benefits Trust, and a marketing plan. The Trustees granted their approval to begin the marketing process in April, 2006.

The plan actuaries had set a minimum goal of 500 employee subscribers for the plan to launch, and the UUA Trustees endorsed that number. The enrollment drive reached its target in September, 2006, and in October the UUA Trustees granted approval for the plan to go live on January 1, 2007.

The UUA Health Plan completed its first year of operation with an operating gain that surpassed the actuaries' expectations. The second year is followed a similar pattern. The overall rate increase for the January 2008 renewal was 4%, and for January 2009, rates were not increased at all. Benefits were significantly improved for both renewals. After the 2009 open enrollment, membership stood at 740 employee subscribers; total membership now exceeds 1,200. The expected premium revenue for 2009 is approximately $6.5 million.

The Goals for Performance Review

The UUA Trustees asked the simple question, "Did we get our money's worth with the plan we approved?"

The body of this introduction summarizes the report of Strategic Benefit Advisors (SBA), a consulting group engaged at the request of the UUA Board. Their full report responds to several specific issues which were raised in the RFP and also makes some recommendations formulated by SBA. The Executive Summary concludes with a list of Critical Success Factors developed by the EBT members.

Based on SBA's analysis and the feedback from various stakeholders, the UUA Health Plan is a successful program:

- The benefits are generally competitive in the marketplace.
- The cost and utilization analysis did not reveal significant aberrations in any of the key indicators
- The feedback from the stakeholder interviews was overwhelmingly positive.
- The plan's success is most evident when we compare outcomes to the UUA objective: to make quality health insurance broadly available to our congregations, affiliates and staff.
- An area of concern for the UUA Health Plan is that, in certain instances, the premium is higher than what the congregations and/or employees can afford. UUA has acknowledged that a contingent of uninsured employees remains as a result of this.

RFP Questions

The UUA requested that SBA respond to seven broad topics outlined in the RFP. The first two directly addressed the UUA Trustees' fundamental question; the others were designed to capture enough detail to drive strategy, if change were warranted. The RFP questions can be briefly summarized as follows:

1. Strategy for enrolling the current uninsured population
2. Analysis of how SBA would have consulted to UUA several years ago when first developing a health plan strategy
3. Ranking Highmark against the best national carriers
4. Potential of establishing a stand-alone health plan outside of the CBA.
5. Carrier positions on offering specialized (better defined as controversial) benefits
6. Possible carve-out of Massachusetts participants to a local plan
7. Carrier alternatives to Highmark

Following is a summary of how SBA addressed these topics. My comments as Chair are in brackets.

1. Strategies for enrolling the current uninsured population

- Despite its market competitiveness, the UUA health plan is cost-prohibitive for some. Further, there are ineligible employees (e.g. those who do not meet the minimum hours requirements) who may not have access to health coverage.
- These issues of cost and access are not unique to the UUA, and there is no "silver bullet" to solve this problem. Several innovative strategies including consumer driven health care, age-banded rates and geographic rate adjustments have been implemented and are the remedies that SBA would typically recommend to address the affordability issue.
- There may be areas of the country (California, for example) where it may make sense to look at a local health plan (such as Kaiser) as an additional offering if a more cost-competitive plan could be offered.
- Limited medical plans, known as "mini-med" plans, provide limited coverage – routine office visits and some prescription coverage – but no coverage for acute or catastrophic conditions and these plans typically exclude pre-existing conditions. Limited medical plans are not consistent with the UUA's objectives or values. [Mini-med plans are not recommended by the EBT.]
- The UUA recommends that congregations pay an average of 80% of the premium, but the actual contribution strategy is determined locally. The UUA EBT may want to consider adding health plan bylaws related to contributions or offering subsidies to low wage earners.
- Sizeable gains (in the range of $2M) net of required reserves have accumulated which could be used to subsidize lower-income employees. This possible use is currently being considered by the EBT. [While subsidization falls in the general category of using plan surpluses solely for the benefit of plan participants, it also raises financial, administrative and ethical risks that the EBT has to balance.]

2. "Retrospective Consulting"

- For an association group with fewer than 700 employees, no claims experience and no revenue to support the program, SBA would not have recommended a self-funded approach. Given that the UUA did not meet critical criteria for self-insurance, your execution is to be commended on many levels including joining the CBA to provide access to Highmark, learning lessons and best practices from other CBA groups, establishing a separate Employee Benefit Trust Board, utilizing effective actuarial and legal consultants and fiscally responsible management by the Executive Director and EBT.

[In simplest terms, our nascent health plan faced long odds, and we met that challenge with creativity, determination, and many solid strategic and tactical decisions.]

3. Ranking Highmark against the best national carriers

- Highmark is a dominant health plan in Pennsylvania – an independent, local health plan that licenses the national Blue Cross/Blue Shield network. It serves a total membership of over 4.5 million and had revenues of $12.4B in 2007. It has an S&P "A" (strong) rating and an A.M.Best "A" (excellent) rating.
- Highmark has an excellent reputation for quality and member satisfaction and has received recognition for this from the National Committee on Quality Assurance (NCQA) and J.D.Powers and Associates.
- The BCBS network is appropriate with regard to breadth and depth.
- In summary, neither SBA [nor the EBT] sees any reason to recommend a change from Highmark. A full review of Highmark is being conducted by the CBA in conjunction with the negotiations for the contract renewal effective 2010 – 2012.

4. Establishing a stand-alone UUA health plan

- Although the UUA could *theoretically* establish a stand-alone plan outside the CBA, this strategy is not recommended. There is no visible advantage for the UUA to leave the CBA arrangement and contract directly for services. The UUA is benefitting from the collective purchasing power of the CBA as demonstrated by the lower administration costs (the current administrative fee is less than what the UUA would pay as a stand-alone group), dedicated customer service and more comprehensive reporting.
- The marketplace is not responsive to Association groups and would likely show interest only in a sizeable prospect. To put this in perspective, the CBA has over 71,000 subscribers (participating employees) of which the UUA represents about 1%.

5. Carrier positions on offering specialized, controversial benefits

- All health plans interviewed by SBA indicated that the plan sponsor has, as an ERISA plan, the discretion to determine the benefits that can be covered.

- "Controversial" coverage such as voluntary termination of pregnancy and sexual reassignment surgery could be accommodated and there are no rules regarding excluding or including coverage services under a self-funded plan.

6. Possible carve-out of Massachusetts participants

- We are aware that the Boston members previously had an HMO through Harvard Pilgrim and that these members are dealing with the loss of first dollar coverage and the loss of the Harvard Pilgrim brand name, but the UUA would not gain any significant economic advantage through contracting with a local health plan and members would not gain substantial additional network access.
- The only advantage to the UUA in implementing a local plan is that it would satisfy members who perceive that local health plans are better. The disadvantages are that such an arrangement would increase the complexity and cost of the health plan administration and send a confusing message to other UUA members.

7. Carrier alternatives to Highmark

- While there are many reasonable alternatives to Highmark, including Aetna, BCBS of Massachusetts, CIGNA, Harvard Pilgrim, Tufts and United Healthcare, as described above, neither SBA [nor the EBT] sees any reason to recommend a change from Highmark.
- Periodic competitive bidding is the most effective way to validate this and a full review of Highmark is being conducted by the CBA in conjunction with the negotiations for the contract renewal effective 2010 – 2012.

Recommendations made by Strategic Benefit Advisors (SBA)

Supplier Sourcing

The UUA is receiving value through the CBA's collective purchasing. SBA does not see compelling reasons for UUA to leave this arrangement. The UUA is receiving the benefit of lower administrative fees, dedicated customer service, and reporting and benchmarking against the larger CBA group. At the same time, the UUA retains the flexibility and autonomy to supplement with additional population management programs, if it sees value in such programs. The CBA is currently conducting a comprehensive review of Highmark to negotiate the most favorable terms for the upcoming contract period. The CBA should continue to conduct periodic bidding analyses to ensure that Highmark remains the best partner.

We do not consider carving out any particular Highmark service to be a viable option for the UUA group on a *stand-alone* basis, but the UUA should continue to evaluate joint purchasing opportunities with other CBA groups that opt out of Highmark service components.

Reporting

The Highmark reports provided to us by the UUA contain high level data focused primarily on the financials of the health plan. The UUA should request that semi-annual or annual reporting be expanded to include better detail on the key cost drivers and clinical conditions of your covered population.
Highmark should include, at least annually, a consultative summary of key clinical findings and program/intervention recommendations for UUA to consider.

Program Management/Wellness

SBA recommends that the UUA focus additional efforts on helping to develop a workforce that:
_ is better informed of their individual health status
_ receives the appropriate preventive care, immunizations, and screenings
_ understands and uses the information and resources available to manage their personal health, including online tools and resources, disease management programs and seminars/webinars focusing on various health issues
_ is encouraged to improve or maintain health through medical plan incentives (over time)

SBA recommends defining the overall health management program goals and working with internal and external constituents to build the program specifications.

SBA's Closing Remarks

It is noted by SBA that the UUA EBT Board and other plan advisors are engaged and highly knowledgeable. The groups bring significant expertise and commitment to the UUA and are clearly a positive contributor to the plan's successful operation.

Going forward – Chair's Comments

The members of the EBT, in general, agree with the recommendations in the SBA report but we also see them as recommendations and not as directives. We regard the recommendations as destinations toward which to move and, in some of the recommendations, SBA has provided examples of roads that might be taken to get to the destination. We may or may not choose to follow all of the tactical detail of these suggestions, but regardless, we will, all of us, find our way to our objectives.

During the December, 2008 meeting of the EBT, a discussion about health plan values and success factors was begun. The result of those, and subsequent, discussions was a summary of objectives that the EBT believes are important to the continued operation and success of the health plan. We are taking a very practical approach: the goals have to be specific, attainable, and measurable – and they have to be useable as a tool to measure the performance of the UUA staff dedicated to the Health Plan. These critical success factors are summarized in the chart below:

8 Critical Success Factors

Critical measure	Goal	Status as of January 2009	Comments
Grow our membership	5% net growth per year; 90% retention rate	15.2% net growth; >90% retention	Most reliable growth measure, because the count is readily available and verifiable.
Increase the percentage of participating UU congregations; i.e. congregations with at least 1 employee in the UUA health plan	30% on 1/1/2010	28% on 1/1/09, up from 25% on 1/1/08	Good penetration measure. Can be combined with GIP penetration to get good picture of overall presence in congregations' financial planning.
Increase the percentage of congregational staff that has health coverage from some source	100% of eligible staff covered Intermediate goal: 2% gain per year, for the next 5 years	Best estimate, 90% of eligible staff (750 hours / year) Based on congregational reporting of total staffing, among participating congregations. Currently, even using a stringent 750 hours test, there are probably fewer than 100 staff with no coverage.	Subject to establishing a reliable data collection methodology. OCSF will be addressing the difficulty of collecting this information by introducing a formal, periodic census in 2009. Progress can inform discussion of strategies to directly increase participation, including grants, subsidies, and "entry level" plans.
Increase member satisfaction, as measured by Highmark survey data and EBT survey data	1. Overall = 90% 2. Network = 90% 3. Customer Service = 80% 4. Claims = 80% In 2009, design and test a UUA-specific survey tool.	1. Overall = 87% 2. Network = 89% 3. Customer Service = 77% 4. Claims = 73%	See accompanying notes on the HM survey data. We are also free to establish higher "stretch" goals. Would allow us to focus on key issues that we identify.
Preserve the financial health of the plan; i.e. adequate financial reserves	Maintain reserves of 6-8 months of premium	4.7 months, projected to grow to 5.7 months during 2009.	
Improve Enterprise Risk Management profile; i.e. protect the UUA's investment	1. Retention & succession plan drafted and implemented 2. No avoidable legal or regulatory actions	1. First drafts ready for review 2. No issues to date	Discussion of EBT role in a UUA environment began in earnest with the Dec 2008 board meeting.
Be a competitive choice for coverage; provide competitive premium pricing	1.Hold increases to rate of medical inflation. Stretch goal is med inflation – 2%, before adjustments for benefit changes. 2. Decreases should match or exceed competitive trend.	2009 @ 0% was 8-10% below market. From 2007 – 2009, plan was at least 15% below market.	Plan experience and rating refinements should bring us closer to the market by 2010. Discussion will then turn to 1) advanced strategies to improve member health and 2) allocation of surplus.
Promote member health	1) Outperform the Highmark PPO benchmarks, after adjusting for UUA age/sex mix. 2) Show year to year improvement in health status, measured by risk factor scores 3) Develop data resources to build understanding of racial / ethnic / cultural / economic differences in member experiences with the Plan.	1) Plan has outperformed benchmarks for 1st 2 years 2) Highmark will provide detailed analysis of 2008 vs. 2007 at March 28 EBT meeting. 3) Have begun exploring data availability and other denominations' experience with similar analysis.	After review of 2 years of data, set goal of 75% of our clinical measures exceeding HM PPO book of business, based on specific HEDIS results.