LOYOLA UNIVERSITY CHICAGO

BENEFITS ADVISORY COMMITTEE

Minutes

WORKING GROUP MEETING	
Group Name:	Benefits Advisory Committee
Date:	January 27, 2023
Time and Location:	10:30 AM – 12:00 pm CST | Zoom

ATTENDEES			
☒	Danielle Hanson, Ex-Officio	☒	Jodi Goode, Staff Council
☒	Susan Fargo, Staff Council	☒	Jeremy Mixell, University Senate
☒	Heather Chester, Univ Representative	☐	D. Megan Helfgott, Univ. Representative
☒	Eniko Racz, Univ. Representative	☒	Thomas Kelly, Ex-Officio
☐	Jenny O'Rourke, Faculty Council	☒	Tamika Love, Senior Benefits Specialist
☒	Graham Moran, Faculty Council	☐	
☒	Tisha Rajendra, University Senate		

MINUTES

Introductions of new members:

Susan Fargo, representing Staff Council. Has been at Loyola for almost 3 years. Has been on Staff Council for almost 3 years as well. Regulatory Manager of clinical research office on Health Sciences Campus.

Jeremy Mixell, with LUC about 2 years. Representing Univ Senate. Recruitment/Admissions background.

Kathy Kye from Empower Health, LUC's wellness program provider: Biggest programs are the annual biometrics screening and option to get $75 per quarter for points for various wellness activities. Has provided wellness program to LUC for about 15 yrs. People may not be screened as often or at all without doing so through work.
-LUC only receives aggregate results, so individual data remains confidential. 9 on-site screening events. 1075 participated in on-site events and 252 participated by going to off-site lab. 254 participated by going to own doctors with Empower Health form. Includes spouses and average age of participants was 48 yrs old.

Satisfaction Survey from Biometric Screening: People happy with biometric screeners in terms of talent and attitude. Primary reason employees participated was company encouragement. Convenience was #2. Many thanked LUC for providing the service. Kathy knows everyone not a fan of the lifestyle questionnaire, but employees get a big picture of health risks and recommendations for improvement. We can have discussion on not making it a requirement in future, but some people would lose out if didn't do it.
Metrics. 1581 blood screening participants for 2022. 1384 people completed Health Risk Assessment

in 2022.
Look at risk level: Want people with high or moderate risk to be decreasing.
-Overall, seeing some decreases in LDL (bad cholesterol). Employees in high risk range went from 27% in 2021 to 9% in 2022. LDL Eating habits affecting this. Data shows eating habits have changed in a positive way.
-1% decrease in triglycerides
-2021 probably one of most difficult years for metrics because people weren't focusing as much on health during pandemic. Glucose levels have remained pretty consistent. Diabetes on rise, so we want to keep an eye on glucose levels.
-Seeing overall improvement in blood pressure. Out of range results decreasing.

Enico: Did something change with way we measure LDL from previous years because that's a huge change.
Kathy: We checked data to be sure. The change is dietary habits. Age of population didn't really change.
Tisha: The correlation isn't causation so we don't know why there's a steep drop for LDL in this one year. All of the other numbers are pretty much flat. Is there a new drug on the market? It could be any number of factors - We can't just conclude it's because of behavior.
Kathy: medication definitely has an impact on that as well.

Susan: Is employees' health data saved with their identifiable information, and if not, is there a key that can link the two? Is there authorization to include this on the health record?
Kathy: within portal, employees created username and password, so they have access to their information. Previous years data also included. Employees can fax results directly from portal to primary care physician.

Susan: Is there research that's done on the data at all or quality improvement projects? This is a lot of data. What's done with it and who oversees it?
Kathy: For some of our employer groups, we've been asked to forward data to data warehouses in looking at relationship claims, but we haven't been asked to do this with LUC. We evaluate only with recommendations we can make for your group. Unless we're given other direction, we don't share this information with anyone.

Heather: What was question and selection options for feedback question. Most people I know do the screening based on cost.
Kathy: Will share the questionnaire with Danielle after meeting.

Critical Call Outs per Kathy: All of our metrics have an upper and lower threshold, so if someone is particularly high or low, one of our nurses will call them. We reached out to 16 individuals after fall screening due to critical results mostly in kidney function and glucose. Protocol is to call employee, leave a message, and make two more attempts. If still can't connect, mail report to individuals and ask them to reach out to PCP. Reached 13 individuals and the remaining three, Empower Health mailed info out. From prior year, there were 18 individuals to whom we reached out. Some

participated this year and were part of the group of 16. Some weren't part of the critical call out group, and some didn't participate.

Metabolic syndrome is a cluster of 3 out of 5 partic risk factors. There were 437 individuals who'd be at risk for metabolic syndrome due to these risk factors. Annual medical costs typically higher for people with these risk factors. Empower can create a program and reach out to these people, but they didn't reach out this year.

Jodi: So did employees with metabolic syndrome have this indicated on their reports?
Kathy: The risk factors were indicated but the individual employee reports didn't indicate metabolic syndrome. This was just an aggregate result.

LUC employee Strengths: Low Alcohol & tobacco use

Areas for Improvement: Nutrition and exercise

Recommendations: We want to get as many people as possible screened and ensure that LUC is promoting EAP resources and any other existing resources. Stress and mental well-being critical since pandemic. We can provide nurses, registered dietitians, exercise physiologists either at individual level or group workshops.

Incentive Program: My Empowerment Plan. For Q1, there were 374 people who received the $75 for reaching 125 points. Year-long program to develop healthy habits instead of just wondering what results will be on annual biometric screening.

Tisha: Do you keep track of whether employees follow up with their doctors if concern pointed out in screening report?
Kathy: We don't know. We do the call outs if critical results. If employee in same group the following year, we do mention it's our 2nd year calling you. Open for discussion if you want us to do this, but we find some employees more private we just do the call outs for critical issues, and then employee can follow up with PCP.

Tisha: What % employees get the wellness discount on health insurance?
Danielle: 2000 employees enrolled in medical plans and 1255 receiving wellness premium for 2023, which is 62-63% of enrollment group.

Jodi: Activity variety seemed to be reduced this quarter for incentive program.
Kathy and Danielle: We have 70 activites we look at with employers and then decide which ones to use. We can talk about changing this for next plan year (in September). "Julie" suggested we streamline.

Wellness Industry Research per Kathy: Data not there like it used to be re cost savings. Focus has gone from ROI, Return on Investment, to VOI – Value on investment. 71% looking at improving

worker health and well-being. Value on investment is what orgs focusing on. Goes beyond reducing healthcare costs. Productivity, absenteeism, morale, retention. In the end, orgs can make more money because quality of everything has improved. Employees' qualify of life should be considered when promoting wellness and not cost-control. At the beginning, with companies doing return on investment, it's come down to fact of looking beyond the dollars to look at value of employees' overall health and well-being. Data not there like it used to be regarding health savings.

Eniko: As long as there's a wellness rate and a non-wellness rate, regardless of how we message the info, employees will be looking at the cost-benefit.
Kathy: LUC paid $120,000 for screening and $30,000 for flu shots. What would happen if we didn't do this? The cost of doing nothing might be a lot more.

Tisha: I just want to caution us that the return on value vs. return on investment. Cost is really high to assume that these programs are providing the return on value. I have a sense, anecdotally, talking to colleagues, that there's a feeling of paternalism that lowers morale. Number of articles from economists about potential for these wellness programs to have an affect. Empirical research shows control group that doesn't do the wellness and the variable group that does the wellness program, and there aren't big differences between them. We can speculate that program makes us healthier, but empirical evidence shows otherwise. The wellness industry is a $6 billion dollar industry that's promising something.

Kathy: I've been in industry for so many years, and we hear so many stories about people who learned of a health issue from screening. It hits home a lot harder when an employee or family member is identified with a health concern through biometric screening.

Draft Survey for Governance Bodies re BAC
Heather: Presenting on behalf of Jodi and Susan as well. Megan Helfgott and I have been outspoken in wanting to understand how we gauge what people's interests are and ask the right questions. Before we go of the community, let's talk to the BAC, Senate, Faculty Council and Staff Council if they'd want to ask these questions from consitutents. How do we make sure messaging done in sequence and in collaboration. What's the best way to get info out to community? Heather shared survey questions that were sent to Staff Council. We want to make sure our community has channels for sharing concerns. How are other governance structures sharing info from BAC. How can we support each other and University to gain feedback to drive our mission? People may not know what BAC is, so Staff Council wanted us to remind people what BAC is.

Graham: on Faculty Council side, we include things in newsletter when there's something to say. Tends to be the case towards the end of the benefits cycle. We don't have a formal plan. They know what BAC is and are pretty vocal about it. We don't share low level details. They should at least hear once per year on things that affect them directly.

Heather: How do you poll people on the benefits they want to see? How do we make sure employees feel they're part of a partnership.

Graham: If someone has an issue/concern, they'd float it through their faculty representative to

Faculty Council, and if necessary, we'd bring it to BAC.
Heather: Would it be helpful to send this type of survey to Faculty Council and University Senate.
Graham: Jim Devry is the current chair of Faculty Council, and I can ask him.
Jeremy: With University Senate, once new chair nominated, we can see about getting the survey in front of people.
Heather: Would you – Jeremy and Graham – be willing to provide your lens by looking at the questions. Jeremy & Graham: yes.

Open Enrollment Data Recap:

-Over 2000 views of benefit highlights electronic brocjire
-475 visits to Alex
-Just under 1700 out of about 2000 who are enrolled in benefits who went through Self-Service open enrollment, so 300 did nothing.
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-Total of about 350 employees signed on to the virtual webinars.
-LUC really tried to encourage employees to look at the different health plans to assess if in the right plan. Had a little movement but not a lot. We think people stay in same medical plan because that's what they've always done.
-630 enrolled in PPO 3/HSA for 2023
-40 people switched from PPO1 to PPO3
-21 people moved from PPO2 to PPO 3.

University Benefits Budget:

Salary and benefits close to 60% of LUC budget
Tom: Ways we might want to think about managing healthcare costs so thought it would be helpful to look at total pie and what degree of flexibility we have to some parts of the pie. For example, defined contribution to retirement plan. Over the years, we've looked at percentage we contribute, we've looked at vesting period and waiting periods as ways to try to be current in plan design and make sure we're spending the money the right way. Medical is next big piece – there are a few more levers to pull when we talk about how we manage expenses. FICA and Medicare come next in terms of next big piece of budget on employer side. Tuition is next – it will be about a year or two until we see how tuition exchange impacted anything. When we look at remaining benefits, they're not a huge percentage of budget, so not a lot of levers to push there. This is why we spend a lot of time on healthcare.

Graham: When's vesting on retirement funds, what is it? 2 years?
Tom: one-year waiting period for eligibility for employer contribution and then 2-year vesting period.
Tom: when we were looking at ways to raise contribution to 10%, this is how we got to the waiting period. I was a bigger fan of a longer waiting period because vesting gets complicated for administering it. It's something we can look at again.
Graham: Maybe it should be age-related for waiting period because people in 40s or 50s looking to

work at LUC may go elsewhere because they don't want the gap.
Tom: Not unusual to have waiting periods and eligibility periods for retirement plans. People consider it but in the end, it's the whole package.

Tisha: Is there a net savings because people closer to retirement have more negotiating power. Do you have numbers, Tom, that there's a savings?
Tom: it's about total spent and lots of it depends on new hires and turnover are over time. Not waiving waiting period for highly compensated because that's what we'll get in the most trouble for.
Tisha: potential employee might ask for more money in salary if waiting period.
Tom: Understood.

Benefit LUMCP reimbursement for Loyola Univ Medical Center Physicians. When salaries funded by medical practice plan, benefits funded by that plan as well. Benefits come from hospital and not university. Faculty physicians dually employed get benefits from hospital and not university.

Graham: Why are taxes regarded as a benefit?
Tom: You get the benefit when you get social security and medicare at retirement. Not only does it come out of employees' paychecks, but University must make a contribution as well.
Danielle: Loyola must make these contributions for everyone, including graduate assistant stipends, student workers, adjuncts, all salaries across the university.

Susan: When you're looking at needing to cut overall University budget, where do benefits live? Is it protected or one of the first things to go?
Tom: It's our largest expense, so in an expense reduction world, benefits is one of the places people go to look. We look at benefits as a % of salary. It's about 30%. If we're in serious reduction category, We look at salaries, benefits, vacancies, and then plan design. When looking at plan design do we decide to shift pie around or does pie need to get bigger with more students or more tuition?
Danielle: so not a lot of wiggle room when needing to made reductions. It's either retirement or medical benefits.

Graham: What are those other fees on chart?
Danielle: Vendor fees, compliance
Tom: CBIZ, Empower Health, legal work, actuarial fees

<u>Overview of 3 medical plans</u>:

About 2700 eligible employees
About 2000 employees enroll
About 3700 covered inclu dependents and spouses

4 bands to distribute costs of premiums based on employee salary
LUC pays about 70% of medical costs & employees pay about 30%

Looked at side-by-side of three plans.
Deductibles for individual vs. family
PPO 1 has lowest deductible at $500 indiv/1000 fam. PPO has $1200/2400, and PPO 3 has $3000/5600 for individual (governed by IRS so rules for deductible).

-When we think about plan design, we're thinking about plan deductibles, monthly premiums, out of pocket costs
Once meet deductible, paying co-insurance until meet out of pocket maximum.
-HSA rolls over year to year

FSA – get all at once on Jan 1. $625 rolls over to next year for 2023.
Eniko: what happens if we don't use FSA money?
Danielle: Loyola gets it and it would go towards plan administration.
Tom: or for any of those expenses that went out the door we already paid for.

Eniko: Isn't high deductible allowed to be $1500 and Loyola just decided it would be $3000 for plan design?
Danielle: Loyola has an embedded deductible. Any individual in the family is subject to the individual deductible rather than the family deductible.
Tisha: So once family as aggregate reaches $3000 for PPO3, no one is subject to the deductible?

Embedded Deductible – LUC has this. Any individual subject to individual deductible instead of family deductible. Family deductible for whole policy.

Other big difference between PPO3 vs. PPO 1 and 2: There's a separate prescription drug deductible in PPO 1&2. When deciding on best plan, we need to think about what we spend on prescriptions and medical.

Danielle shared examples of low, medium, and catastrophic spending for employees.

Tom and Danielle: when costs increase, University covering it
Danielle: What kind of plan design changes do we want to consider for Jan 2024 or do we just want to increase premiums?

Tisha: I was really surprised when I saw the catastrophic spend. I'm terrified of choosing wrong plan. If you want people to change plans, it needs to be more personal than Alex.

Jodi: I thought everyone enrolled in health insurance had to go through self-service?
Danielle: No. We could do an active open enrollment, and we have in the past, but it's very painful, and you'd likely hear from your constituents if we did.
Jodi: An active enrollment could be a way to get people to switch plans, but I agree it would be very painful.
Tom: When was the last time we did an active enrollment?