

University Benefits & Issues
White Paper
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The common non-salary compensation items are:

- Medical insurance
- Dental insurance
- Vision coverage
- Legal coverage
- Basic and optional term life insurance
- Travel accident insurance
- Long term disability
- Retirement saving plan
- Dependent tuition scholarships

To these items could be added such areas as parking and University-funded research grants, but the variables there are great and my information is sparse. Other areas not covered include FASAP, mediation services, integrated disability management, worklife resource centers, the website for vendor discount for employees (need to use UMID), recreational sports, the golf club and ActiveU.

It makes many nervous when we are told that our coverage is market-based. Who is the market? Ford? GM? Is the University looking at plans to divest itself of as much benefit coverage as possible? The Chief Financial Officer of the University has stated (on 14 March 2008) that the peers in our market group are all universities. The peer group varies depending on the benefit and on the current needs. The example provided involved attracting a prospective researcher from San Diego and including UC-San Diego as the market peer group *du jour*. We have requested the current set of peer institutions for each of the benefit areas. We have received assurance in writing that we will receive those lists this week, although too late for this report.

Medical Insurance: Medical insurance is not the only issue under the umbrella of benefits, but it is certainly the most critical one.

A little history: In the 1970's and for some years after that decade closed, all employees of the University received an annual statement that included , the first change to retirement healthcare benefits was in 1986. The Standard Practice Guide was modified to allow the University to change the benefits it offered to its employees. Previously, the SPG stated that it would cover all costs for retirees up to the level of Blue Cross – Blue Shield.

Standard Practice Guide 203.2 -- II. M.):

CONTINUATION OF COVERAGE AFTER RETIREMENT: Insurance for staff members (and eligible dependents) covered at the time of retirement will be continued by the University for all official retirees. Under present policy, which is subject to change,

[underline added] *the University pays the total cost of the Blue Cross-Blue Shield coverage for retirees, and contributes up to that amount for comparable HMO coverage. Refer to SPG 201.83 for information concerning health insurance continuation during phased retirement. Any excess HMO premium must be paid each month by the retiree. If the necessary premiums are not paid by the retiree, the HMO coverage will be canceled and the retiree will be reenrolled in Blue Cross-Blue Shield.*

-----modified 12-1-1986

The next change occurred in 1988. The *University Record* for 20 June 1988 stated:

Retirement Rules Adopted

The current retirement rules for faculty and staff, permitting retirement before age 50 with 30 years of service, will become permanent. They were adopted five years ago on a trial basis.

However, those who are hired after July 1, 1988, and retire before age 62 must pay “the full cost of health, dental, prescription drugs, life insurance and any other plans that might be made available” before age 62.

The current rules we adopted in 1983 “in an effort to liberalize the rules somewhat to facilitate retirements to the mutual benefit of departments and staff,” Vice President James F. Brinkerhoff noted.

Under the rules, faculty and staff members must accumulate a certain number of years of service by certain ages to be considered retirees: 30 years of service at age 50 or under; 28 years of service at age 51; 26 at 52; 24 at 53; 22 at 54; 20 at 55; 18 at 56; 16 at 57; 14 at 58; 12 at 59; and 10 at 60 or older.

Employees who meet these rules are allowed to stay in the University’s group health, life and dental plans [when they retire] with the University paying the full cost for the employee and dependents. [underlining added]

“Although we have seen some savings under these rules, we are recommending that the University’s contribution be made less liberal for employees hired on or after July 1, 1988, Brinkerhoff said.

“The growing number of retirees and their survivors, combined with health care costs that are rising faster than inflation, will likely put a disproportionate strain on the University’s already taxed budget in the years ahead.

“We recommend that anyone hired on or after July 1, 1988, and who retires before age 62 pay the full cost of benefit plans until age 62. At age 62, the University would begin to contribute the same amount that is paid for current retirees/survivors. It also is recommended that a department be given the option of paying the pre-age 62 cost if it wishes to encourage early retirement.”

The cost of medical coverage

Before 2004, the University paid 100% of the insurance premiums for both current and retired employees. In 2003, the University premiums were as follows:

Plan	University paid	Payroll deduction
M-CARE HMO Individual	\$269.40	None
M-CARE HMO 1 dependent	\$514.53	None

M-CARE HMO 2 or more dependents	\$537.00	\$63.74
Care Choices Individual	\$297.88	None
Care Choices 1 dependent	\$537.00	\$31.95
Care Choices 2 or more dependents	\$537.00	\$127.28
Health Alliance Plan Individual	\$288.97	None
Health Alliance Plan 1 dependent	\$537.00	\$14.93
Health Alliance Plan 2 or more dependents	\$537.00	\$107.41
M-CARE POS Individual	\$310.88	None
M-CARE POS 1 dependent	\$537.00	\$55.81
M-CARE POS 2 or more dependents	\$537.00	\$155.11
BCBSM/United Individual	\$445.21	None
BCBSM/United 1 dependent	\$537.00	\$313.36
BCBSM/United 2 or more dependents	\$537.00	\$455.82
Comprehensive Major Medical Individual	\$274.06	None
Comprehensive Major Medical 1 dependent	\$523.44	None
Comprehensive Major Medical 2 or more dep.	\$537.00	None

In 2003, the benefits office drew together the Committee for Health Insurance Premium Design (CHIPD). This committee met without any public face. No representatives chosen by the faculty were invited. Indeed, when the Chancellor in Dearborn requested that his Chief of Staff be allowed to sit in on the meetings as an observer, he was refused. The CHIPD report was released at the end of October 2003. (See <http://www.hr.umich.edu/chipd/> for the full report.)

In 2004, the University changed its long standing policy and promise of covering employee and retired employee insurance premiums as the costs of insurance rose. Here is a table of some of the medical premium costs (with the change from the previous year in parentheses.)

Plan	University paid	Employee paid
M-CARE HMO Individual	\$304.64 (\$35.24)	\$16.02 (\$16.02)
M-CARE HMO 1 dependent	\$581.86 (\$67.33)	\$30.62 (\$30.62)
M-CARE HMO 2 or more dependents	\$626.46 (\$89.46)	\$88.64 (\$24.90)
Care Choices Individual	\$306.14 (\$8.26)	\$16.10 (\$16.10)
Care Choices 1 dependent	\$584.74 (\$47.74)	\$30.76 (-\$1.19)
Care Choices 2 or more dependents	\$626.46 (\$89.46)	\$92.16 (-\$35.12)
Health Alliance Plan Individual	\$312.14 (\$23.17)	\$16.42 (\$16.42)
Health Alliance Plan 1 dependent	\$596.20 (\$59.20)	\$31.36 (\$16.43)
Health Alliance Plan 2 or more dependents	\$626.46 (\$89.46)	\$100.26 (-\$1.15)
M-CARE POS Individual	\$339.56 (\$29.18)	\$17.86 (\$17.86)
M-CARE POS 1 dependent	\$626.46 (\$89.46)	\$56.22 (\$0.41)
M-CARE POS 2 or more dependents	\$626.46 (\$89.46)	\$170.62 (\$15.51)
BCBSM/United Individual	\$479.80 (\$35.39)	\$25.24 (\$25.24)
BCBSM/United 1 dependent	\$626.46 (\$89.46)	\$338.20 (\$24.84)
BCBSM/United 2 or more dependents	\$626.46 (\$89.46)	\$499.82 (\$44.00)

Comprehensive Major Medical Individual	\$289.06 (\$15.00)	\$15.20 (\$15.20)
Comprehensive Major Medical 1 dependent	\$552.10 (\$28.66)	\$29.04 (\$29.04)
Comprehensive Major Medical 2 or more dep.	\$626.46 (\$89.46)	\$52.06 (\$52.06)

Those costs have only continued to escalate. The University has changed coverage and some companies have been bought out, but three of the continuing plans show the rise in costs between 2003-2008.

Plan	Emp 2003	Emp 2004	Emp 2008	Univ 2003	Univ 2004	Univ 2008
MCare or Premiere Ind.	\$0	\$16	\$18	\$269	\$305	\$382
MCare or Premiere + adult	\$0	\$31	\$116	\$515	\$582	\$684
MCare or Premiere +adult & kids	\$64	\$89	\$195	\$537	\$626	\$932
HAP Ind	\$0	\$16	\$22	\$289	\$312	\$382
HAP + adult	\$15	\$31	\$125	\$537	\$596	\$684
HAP + adult and children	\$107	\$100	\$208	\$537	\$626	\$932
Major Medical Ind	\$0	\$15	\$0	\$274	\$289	\$366
Major Medical + 1 adult	\$0	\$29	\$49	\$523	\$552	\$684
Major Medical + adult and kids	\$0	\$52	\$101	\$537	\$626	\$932

The premium change from 2003 to 2008 is remarkable. In six of the options of these three plans, employees were charged nothing in 2003. A family person with an HMO would have doubled or tripled the monthly contribution. For the same coverage, the University costs increased almost 75% over five years. Coverage that includes an additional adult underwent an even more remarkable change for the employee. In two of the above cases, the employee had no co-premium and the current charge is over \$100 a month. The third had more than an eightfold increase. The cost to the University increased 30 per cent.

The economic model is unsustainable. Neither employees nor the University can bear these increases if they continue into the near future; there is no evidence that the trend will not persist unabated. Adding pressure is the increasing number within the University eligible to retire in the next five years. Currently 1294 faculty members and 3629 staff members are eligible to retire. The number of faculty newly eligible to retire each year will increase from 168 in 2008 to 216 in 2013; for staff the increase is even more dramatic: 721 in 2008 and about 1000 in 2013. Staff members tend to retire younger than do faculty members (62 vs. 65) and this is built into this data.

Unrevealed by the premium increases are changes in the coverage. For example, at the beginning of the period, a physician could refer a patient for a round of physical or occupational therapy. That therapy could occur three times a week and no co-pay was required. If the round was insufficient to resolve the condition, it could be repeated. If a nurse was enduring back pain and could not lift patients, therapy could be prescribed on a continuing basis as needed. That coverage has changed. Now a patient can be referred for physical or occupational therapy one time for a limited number of sessions over a

three-month span. The patient can never be covered for that condition again; not that year, not any year. Another change occurred, this time with Health Alliance Plan (HAP) coverage. At the beginning of this period, a plan participant could receive a hearing aid if needed, with the benefit available every three years. That coverage is no longer included. We have no list of specific benefits that have been reduced or eliminated during the past five years.

Without a doubt, the insurance premiums would have increased more had the benefit itself not have been reduced. But this is a more hidden area where costs have shifted to the employee. The healthy community benefit and the benefit to the University should be evaluated by those other than the cost-savers. I suspect they are and that it is a hard call, but what benefit is it to the University if a nurse with back pain cannot lift a patient and a second person must be hired as an aid?

Issues with Medical Coverage

1. The primary issue we face is affordability. As stated, the current economic model cannot be sustained. If unchecked, it must finally crush the University and its employees.
2. If the issue is considered only from the employee side without considering the total cost of medical coverage for the University, some Universities offer tiered or proportional systems to allow all to obtain coverage at a level affordable to their income. Some Universities (such as the Ohio State University) offer very distinct levels of coverage. For modest co-premiums, employees may purchase a modest coverage level. For significantly greater employee contribution, a significantly superior coverage may be purchased. Other Universities charge a co-premium that is proportional to salary. No employee is charge the full expense, but those earning the least also pay the least. This makes working at the University affordable for the vast and essential support staff that enables us to teach and research and do all that is expected of faculty at this great University. When Eastern Michigan University negotiated a new contract recently, in exchange for the inauguration of co-premiums, all the retirement contribution of the University will be increased to 11 per cent beginning with the third year of the contract.
3. Aggressive research must be pressed in finding new models for medical coverage. Eventually, these models will have to be national models. No industry will be able to support the costs flying solo. It could involve a two-payer model with a national base and the University offering its employees additional benefits. For example, knee surgery on a national plan might involve a substantial delay, but a supplementary insurance offered by the University to its employees might make the wait short. Currently, the administrative overhead for Medicare and Medicaid is between 2 and 5%. In Canada, it is 1.3 per cent. In 2004, *The International Journal of Health Services* (Volume 34, Number 1, Pages 79–86, 2004) placed the 2003 administrative overhead of corporate healthcare at 25 per cent. Are the administrative costs of the providers we utilize similar? Did we lose control of these costs by shifting to BCN? If we had control of these costs before, why was

the premium of MCare so similar to some of the other HMOs?

4. Medical benefits are an area for which we need to be at the table. By “we,” I mean colleagues chosen by the faculty. The administration loses an opportunity to gain credibility for the inevitable changes that must be made by leaving faculty-chosen figures out. Having “our people” “there” also heightens the chance of good communication, understanding, and even “buy-in.”
5. The proactive thrusts of the Healthy Community, exemplified by the Focus on Diabetes, are still in pilot stages. Currently, the University has only committed to continue the diabetic coverage until the end of this calendar year. This next year, the University plans to add cardiovascular coverage. While many in the medical community believe the proactive care will be cost-effective in the long run, the Chief Financial Officer says the jury is still out on that. Moody’s, he claimed, would rate the pro-active plans at a “B” level, not junk bond level, but a long way from “A paper.” So far, no implementation of this strategy nationally has been shown to be cost-effective. The idea is too new. The strategy requires at least 80 per cent of the participants to follow the discipline. University data that will show the level of compliance has not been tabulated. But a strategic tension is evident. The Chief Financial Officer sees the issue as a financial one – will it be revenue-neutral? A different perspective needs to be brought to the fore: does it support the Healthy Community initiative? Are the faculty and staff members of the University healthier because of the initiative? Does it improve their long term prognosis? If so, does that bear a significant impact not only at the individual level, but at the unit level where those persons make a better contribution for a longer time?
6. We should encourage the University to support the five identified conditions that can benefit from this type of proactive care. It is commendable that the coverage includes diabetes and soon cardiovascular-risk conditions.
7. Until recently, the University covered most of the Medicare B premium for retirees. This support ceased for those retiring after March 31, 2007. Those who retired before that date had the University contribution capped at just under \$50. That change is a cost shift for retirees of \$600 per year, even disregarding the increases the University had made in their contribution up to that point. Medicare B premiums are increasing in cost and the federal government is varying the rate according to income.
8. This is an area in which we must maintain open lines of communication with employee unions negotiating with the University. The next union contract up for negotiation is that of the nurses. After that, I believe, is “skilled trades.” When CESF met with negotiators representing the nurses, skilled trades, and LEO earlier this year, it was evident that a lack of communication among us all resulted in a weaker position.

9. Finally, it would be useful to have a detailed report of the medical coverage changes over the past five years. It is easy to make the assumption that the coverage offered from one year to the next is the same, although the premiums are higher. Such is not the case. The premiums are higher, but we are receiving less as well.

Dental insurance

The current dental coverage (Metlife) by the University is weak. Three plans are offered; most at the University choose the most basic plan (one) unless they anticipate more extensive dental needs. Plan three provides better coverage. (Almost no one chooses plan two). Knowing that a crown or braces are in the offing, many delay the expense until they can move from Plan one to Plan three. Herein lays the quandary. The benefit of insurance is that risk is spread. By self-selecting on the basis of risk, a smaller pool of patients use plan three and usually only when they anticipate incurring greater expense.

Late last year, the Benefits Office issued an RFP (Request for Proposal) to replace the current dental plan. SACUA office has recently requested copies of the proposals received; the bidders were specifically alerted that the proposals were FOIA-able. We have yet to receive the proposals.

Issues with the dental coverage

1. The current Metlife coverage is inadequate for even the basic charges of the Ann Arbor area. When I questioned the representatives several years back during a Dearborn presentation, they said the “usual and customary charges” were based on a much wider area in Michigan because Ann Arbor was too expensive. Many dentists charge more than the plan coverage for the routine cleaning or the annual x-rays; some dentists, even at the dental school, will not accept the University insurance. Even with Plan three, dental coverage for more extended needs is appallingly insufficient. Employees inevitably face significant out-of-pocket expenses.
2. The current plan is not melded well with the Healthy Community initiative. The outstanding example of this is in the “Focus on Diabetes” program. Studies at this University have shown that sugar level maintenance with diabetics is enhanced with four cleanings a year instead of the standard two. Delta Dental has implemented this finding in some of its plans. Metlife does not offer this under its current University offering, nor have I read of Metlife offering this coverage in any of its plans.
3. The RFP issued by the benefits office proposes many of the right questions, including the coverage for additional cleaning for particular medical conditions. It asks for the vendors to be creative in their responses. It contains a poison bullet, however. Whatever proposal is made, it must be cost neutral. The University will not increase its contribution. This in effect freezes the University contribution level at the dollar rate (without inflation) of the beginning of the

previous contract with Metlife. This guarantees that the coverage will be less adequate than it is now.

4. Retirees have been locked in to Plan option one. Many retirees have asked that they be allowed to make an annual choice about their level of coverage.
5. Some have suggested that one structure that would even out the income the University would expect in the higher level plans would be to make the commitment for more than one year – two or three being suggested. This would provide a wider base to better endow more extensive insurance needs.

Vision coverage

The Davis Vision product is not insurance. Those University employees that choose this coverage are paying for an eye examination (also covered by many medical insurance plans) and a pair of prescription eyeglasses purchased through an in-network provider. Frame selection is limited; those wishing designer frames pay additional. Many brands of contact lenses are also covered. The University does not contribute to this plan.

Issues with vision coverage

The benefit of the University participating in this plan is the cost-saving of group purchase. An annual eye examination is covered by most of the medical coverage plans. Many employees of the University do not choose this coverage, opting to purchase their eyewear without a coverage plan.

Legal coverage

The Hyatt plan is arranged for, but not financially supported by, the University. Provides professional legal assistance for a variety of matters, including wills, family matters, debt defense, real estate matters and document preparation.

Issues with legal coverage

The single observation I have heard was that participants had to call the plan to find the extent of the coverage. I have heard no complaints, but this seems to be a service used largely by folks who wish to make or update a will. (Simple will preparation services are also available for participants in the University's optional life insurance plan.)

Basic Life Insurance

The University pays for \$30,000 in life insurance for every employee. Retired employees are covered in varying amounts according to age and years of service with a benefit of \$15,000 (age 50-55 with 30-20 years of service) to \$2,000 at age 66 and older.

Term life insurance

This is funded solely by the participants, although the University is able to negotiate a group rate. Coverage is up to 6x salary, capped at \$1,000,000. Children are covered for \$5,000 and partners for \$25,000 or \$50,000.

Issues with optional term life insurance

Some would like to be able to buy into a plan through the University that would cover some retirement years as well. A package with terms for a decade might fit the needs of these. While this type of insurance can be purchased on the “outside,” it does not offer the potential savings of a group.

Travel accident insurance

The University provides a benefit to those travelling on University business. The coverage level was increased last September. For death, the University provides \$100,000 or ten times the annual salary (whichever is greater) with a ceiling of \$500,000. There are also benefits for dismemberment or disability (maximum \$4,000,000 per incident). The University pays the entire premium. This coverage includes professional meetings and sabbatical, but not vacation or travelling to and from work.

Long-term care plan

The University is offering a new long-term care plan with an enrollment period between April 1 – May 2 2008.

Long term disability

This benefit is available for faculty (and others) upon hire to a 50% or more appointment lasting at least eight months; the University begins contribution after four years. It is for total disability. This provides 65% salary replacement minus other income from public sources. Maximum one can receive is \$23,000 per month. Health insurance, prescription care, basic retirement plan contribution, and group life insurance benefits continue to be covered by the University.

Basic retirement savings plan

The University matches an employee’s five per cent retirement contribution with a ten per cent contribution. This money goes to a TIAA-CREF of Fidelity account, diversified according to the employees wishes.

Issues with basic retirement savings plan

Concerns have been raised whether the University’s contribution might go on the chopping block. The advantage to the University is that this amount is easy to budget. At hiring, this is an automatic ten percent added on to the salary. Medical coverage is very different; the costs of that coverage continue to escalate. In the most recent contract negotiation at EMU, the University exchanged an agreement for co-premiums on medical insurance for an eleven per cent match starting in the third year of the contract.

Dependent Scholarships

Every year the University retains the overage of the prepaid medical and dependent care reimbursement accounts. Faculty and staff estimate how much they are going to spend in these areas and some overestimate. Federal law does not allow the return of those monies to the contributor so the University has placed this money into a

scholarship fund available to the dependents of faculty and staff of the entire University. The application for potential recipients of the Ann Arbor campus is available at: http://www.finaid.umich.edu/media/pdf_scholarships_autogen/umfacstf.pdf

The Dearborn and Flint campuses have instituted a 50% scholarship for dependents of faculty and staff in an effort to boost enrollment. This has been in place for about three years. The Dearborn description is:

[The] Dependent Tuition Scholarship provides scholarship support for tuition only to the IRS tax dependents of regular part-time and full-time staff and faculty at the University of Michigan-Dearborn (50% appointment or higher). The 50% tuition scholarship is restricted to first time undergraduate study. The application process is through the Office of Admission and Orientation. Participants in this program must meet all admission and eligibility requirements of the University in effect at the time of enrollment.

Issues: Faculty members have been asking for years for scholarship funding to be set aside for their qualified dependents. From our perspective, it is a benefit that supports both recruitment and retention of desirable faculty members. The vast majority of public and private universities and colleges in the United States offer this benefit. The response from the University to this request has been consistent and is typified in the “Management Response” to the 2005-2006 CESF report:

This does not appear to be feasible at the Ann Arbor campus because it would not be an equitable benefit. Public universities who offer dependent tuition scholarships or discount plans typically have enrollment volatility and/or under-enrollment concern, have a salary and benefit structure that leads to a non-competitive position, or have been mandated to offer such a program. The University of Michigan – Ann Arbor is a highly selective institution; we receive applications from thousands of qualified students but are able to admit only a small number of those applicants based on our enrollment plans. While the University controls who benefits from a dependent tuition policy, it would be difficult to have it apply evenly across those who are ‘eligible’. A dependent tuition discount policy benefits quite a small subset of individuals at any time, even over a number of years. Discounted tuition rate policies are, in effect, extra compensation to the employees who can avail themselves of it, and it is compensation that is based on a factor unrelated to merit and performance. The University has made other choices for our investments in employee compensation and benefits. When putting together compensation packages, the University considers a number of factors, and if necessary and warranted, can take action to enhance a package in other ways.

In a nutshell, the response is (1) we have an abundance of highly-qualified applicants and do not need to support that pool and (2) such a scholarship would be too egalitarian and not allow us to select those faculty members we seek to recruit or retain; we have other means of rewarding them. What is of interest in the response, however, is the notice that some institutions require this benefit because it is mandated. This may be worth investigating.