Appendix A

Committee Membership

Committee Membership

Kyle Grazier, Chair: Professor of Health Management and Policy, School of Public Health, and Professor of Psychiatry, Medical School

Anne Berens: Assistant Vice Provost, Office of the Provost

Tom Buchmueller: Waldo O Hildebrand Professor of Risk Management and Insurance, Professor of Business Economics and Public Policy, Stephen M Ross School of Business and Professor of Health Management and Policy, School of Public Health

Tony Burger: Director of Financial Analysis

Patricia Butler: Vice President of UM Retiree's Association, Retiree

Tom Campbell: Associate Vice President for Strategic Planning and Business Development, EVPMA and Director, UMHS Contracting office

Marty Eichstadt: Director, Benefits Administration Office

Robert Ernst: Medical Director, Health Service Clinic Operations and Adjunct Clinical Associate, Internal Medicine, Medical School

Robert Fraser: Assistant Director, Mardigian Library, UM-D

Richard Hirth: Professor of Health Management and Policy, School of Public Health

Helen Levy: Assistant Research Scientist, Health & Policy, School of Public Health, Research Assistant Professor, Survey Research Center, Institute of Social Research, Adjunct Assistant Professor of Economics, College of LSA and Adjunct Assistant Professor of Public Policy, Gerald R Ford School of Public Policy

Joel Slemrod: Paul W McCracken Professor of Business Economics, Ross School of Business; Professor of Economics, College of LSA

Lynette Wright: Manager of Materials and Moving Services, Plant Operations

Staff:
Rich Holcomb: Director of Compensation, UMHS Human Resources

Etta MacDonagh-Dumler: Project Manager, University Human Resources

Brian Watson: Financial Analyst, Benefits Administration Office

Heather Desgrange: HR Assistant, Benefits Administration Office

Appendix B

Committee Charge

Appendix B
Committee Charge

UNIVERSITY OF MICHIGAN

Committee	Committee on Sustainable Health Benefits (COSHB)
Sponsorship	Robert Kelch, Executive Vice President for Medical Affairs Tim Slottow, Executive Vice President and Chief Financial Officer Teresa Sullivan, Provost and Executive Vice President for Academic Affairs Laurita Thomas, Associate Vice President for Human Resources
Charge of the Committee	As a responsible employer, the University aims to provide high-quality, comprehensive and affordable health plans while being a good steward of limited resources. By 2003, the University had faced several years of double-digit health care cost increases. It sought to manage these increasing costs by analyzing and then adopting a new health insurance premium-sharing model based on the University paying 85% of the aggregate cost of premiums and a new four-tier premium rate structure. These strategies proposed by the Committee on Health Insurance Premium Design (CHIPD) and implemented in 2005 did not consider employee out-of-pocket costs such as co-pay and deductibles. Currently, for employee-only coverage, the University contributes 95% of the average total premiums of the two lowest cost comprehensive health plans. For dependent coverage, the University contribution is reduced, resulting in the 85% aggregate contribution. When out-of-pocket co-pays and deductibles are included, our current aggregate ratio is 80% University and 20% employee cost share. Like most employers in the U.S., the University of Michigan continues to face escalating health care costs. Increasingly, larger amounts of resources are being devoted to health care insurance, creating upward pressure on tuition and making resources less available for salaries and other important priorities. This newly formed 2008 Committee on Sustainable Health Benefits (COSHB) is charged with making recommendations about the cost-sharing mechanisms to achieve aggregate new target for University and employee contributions. Premiums and out-of-pocket co-pays and deductibles will be considered in the cost-sharing ratio. Implementation of the recommendations may be phased over a two-year time period to reach an aggregate 70% cost share from the University and 30% from employees toward the total cost of premiums and out-of-pocket co-pays and deductibles. The committee will also consider part-time employees and retirees in their recommendations. Salaries are to be considered in recommendations on contribution amounts. This effort is part of the University's commitment to effectively balance responsible financial stewardship with the ability to recruit and retain outstanding faculty and staff by offering benefits that are competitive in the marketplace. A Case for Change and further information is available at the Stewardship of Benefits website (available September 2): www.hr.umich.edu/benefitsstewardship/
Objectives	The primary objective of the COSHB is to provide advice, guidance, and recommendations with regard to: 1. health plan cost sharing targets for the University, employees, and retirees; and to identify and address how these targets can be incorporated in the rate development process 2. co-pay and deductible levels, and contribution-level cost containment measures with regard to part-time benefits and retiree health contributions 3. approaches and alternatives for recognizing employee salary levels in setting employee co-premium contributions and out of pocket costs 4. a re-evaluation of the models of co-premium sharing based on the two lowest-cost plans 5. the current ratios used to set relative premium levels across tiers

<table>
<tr><td>Scope and Boundaries</td><td>The primary focus of the COSHB is on the impact and implications of cost sharing as it relates to the total cost sharing (co-premium and out of pocket costs) as noted above to insure that the University has identified possible outcomes and consequences including any inherent potential for unintended incentives or disincentives for faculty, staff, and retirees.

The Committee may form and charge subcommittees to work on specific tasks, as appropriate.</td></tr>
<tr><td>Membership</td><td>Kyle Grazier, Chair: Professor of Health Management and Policy, School of Public Health, and Professor of Psychiatry, Medical School
Anne Berens: Assistant Vice Provost, Office of the Provost
Tony Burger: Director of Financial Analysis
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Tom Buchmueller: Waldo O Hildebrand Professor of Risk Management and Insurance, Professor of Business Economics and Public Policy, Stephen M Ross School of Business and Professor of Health Management and Policy, School of Public Health
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Helen Levy: Assistant Research Scientist, Health & Policy, School of Public Health, Research Assistant Professor, Survey Research Center, Institute of Social Research, Adjunct Assistant Professor of Economics, College of LSA and Adjunct Assistant Professor of Public Policy, Gerald R Ford School of Public Policy
Joel Slemrod: Paul W McCracken Professor of Business Economics, Ross School of Business; Professor of Economics, College of LSA
Lynette Wright: Manager of Materials and Moving Services, Plant Operations

Content experts will attend meetings as needed.

Subcommittees or working groups drawn from areas representing the issues may be formed (see Objectives).</td></tr>
<tr><td>Staff Support</td><td>Heather Desgrange: Administrative support, Benefits Administration Office
Rich Holcomb: Director of Compensation, UMHS Human Resources
Etta MacDonagh-Dumler: Project Manager, UHR
Brian Watson: Financial Analyst, Benefits Administration Office</td></tr>
<tr><td>Timeline</td><td>Sept-November 2008: Committee meetings
Dec 2008: Committee Recommendations</td></tr>
<tr><td>Progress Reports</td><td>• Agendas and Meeting Notes
• MHC-AC for advice: Sept 11, Oct 9
• Status Reports
    o BLT October 30
    o EVPs Nov 11
• Final report December 2008</td></tr>
</table>

Appendix C

A Case for Change

Appendix C
The Case for Change

Stewardship of Benefits

The Case for Change

SUMMARY

Why Change?

The University is deeply committed to creating and encouraging a culture of health for its faculty, students, staff, retirees and dependents. Sustaining high quality, market competitive benefits, and affordable health care coverage is vital to honoring that commitment. Yet, the rate of annual increase in our costs, if left unchecked could place in jeopardy our ability to sustain high-quality, deeply competitive benefit programs in the future. Taking prudent, fair steps to evaluate and adjust is the best method available to slow our rate of increase, helping to curb the growing draw on our overall budget. This helps reduce tuition escalation, better protect our general financial security and safeguard our standards for high-quality benefits much further into the future than might otherwise be possible. With thoughtful analysis and measured action, we believe we will succeed without compromising the principles of plan choice and plan quality that have helped make us effective at recruiting and retaining some of the most outstanding faculty and staff in the country.

What is our Current Situation?

To better understand our benefit spending compared to other organizations and study emerging benefit trends and strategies, the University engaged the consulting firm of Hewitt & Associates in the spring of 2008. Hewitt assisted in the University's evaluation of the current state of our benefit programs, provided comparative peer benchmarking, and supported exploration of an array of options to influence health care costs and balance resourcing of our core education, research and service missions with our commitments to a competitive benefits package and to a culture of health.

The evaluation revealed that the University's overall benefits package for employees and retirees is greater than those of university and health system peers, both in terms of the quality of benefits offered and in the amount of the University's financial contribution. The most significant differences were:

- retirement savings plan contributions;
- richer University plan designs; and
- lower contributions from U-M employees and retirees for health benefits.

Retirement Savings

Hewitt benchmarking of the University's retirement savings plan and an internal study by the University found that the U-M's contribution is greater on average than at peer universities and health systems, and that vesting and/or waiting periods are common features of comparator organizations. By contrast, the University's requires no waiting period and employer contributions are immediately vested. These differences in vesting and waiting periods are a principal reason the University's retirement savings plan contribution expense is higher than average.

Health Care
Health care benchmarks by Hewitt indicated that the portion of total health cost paid by our active faculty and staff, for health insurance coverage (co-premiums) and for health care services (co-pays and deductibles) is considerably lower than the average of the 23 of our academic and health system peers. University employees currently pay approximately 20% of total aggregate health costs compared to 30% at peer organizations. For retiree health benefits, Hewitt benchmarks revealed the University contribution is markedly higher than peer averages.

What's Next?
The University's Executive Vice Presidents have concluded that:

(i) changes in health care cost sharing between the University and its faculty, staff and retirees are necessary and attainable, and
(ii) the University should examine the vesting and waiting periods of its retirement savings plans for future hires.

The Executive Vice Presidents have set a new target for aggregate health care cost sharing of 70% University and 30% faculty, staff and retirees on average, which is to be phased in over two years beginning in 2010. The amounts employees pay on average toward health insurance co-premiums plus average out-of-pocket costs paid by employees and retirees for co-pays, deductibles and coinsurance will all be counted toward the aggregate 30% goal for employee contributions.

Two committees will be formed and charged by the University's Executive Vice Presidents and the Associate Vice President for Human Resources:

1. The Committee on Sustainable Health Benefits (COSHB) will examine and recommend methods to achieve the new aggregate health cost sharing ratio. The committee will also investigate ways to consider how to mitigate the financial impact of any changes for lower paid employees.

2. The Committee to Study Vesting Options for the Retirement Savings Plan will provide guidance and recommendations on vesting options and waiting periods applicable to future hires, and will include a careful assessment of impacts and implications of any changes.

BACKGROUND

National Health Care Costs and Trends
Rising health care costs are a national issue. National health expenditures climbed to $7,026 per capita in 2006 and totaled $2.105 trillion. Health expenditures in 2006 were 16 percent of the Gross Domestic Product in the U.S., up from 10.8 percent in 1987 and 13.7 percent in 1997. By 2017, national health expenditures are forecasted to climb to a total $4.227 trillion, $13,101 per person and 19.5 percent of projected Gross Domestic Product[1].

[1] National Health Expenditures available online at Hhttp://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdfH , and Projected National Health Expenditures from table NHE Historical and projections, 1965-2017 (ZIP, 34 KB) available online at Hhttp://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPageH

The persistent increase in costs for both health care services and insurance coverage are straining the budgets of private businesses, public employers, families and public programs. Employer health insurance premiums have increased rapidly over the recent past, growing a cumulative 78 percent between 2001 and 2007, as reported in the 2007 annual survey of national employers conducted by the Kaiser Family Foundation and HRET[2].

Hewitt and Associates report that employers across the U.S. are challenged by rising health costs to balance a spectrum of competing objectives (e.g., cost management vs. employee affordability, employee choice/accountability vs. administrative simplicity, and enhanced health/productivity vs. gaining employee acceptance and measuring the return on investment).

While some employers have discontinued health care coverage or have reduced the quality of their health care plans, the University is committed to providing high-quality plans with substantial University support.

University of Michigan Health Care Cost Trends

The University of Michigan, like other large employers in the U.S., has been confronted with unsustainable increases in health care costs throughout the past decade.

During the ten year period between FY98 and FY08, annual health insurance premiums for active and retired employees of University of Michigan increased by 226 percent from $92 million to $301 million. The University's share of premiums for active and retired employees increased by 203 percent, from $85 million to $258 million during the same time period.

While some portion of the cost increase can be attributed to a growing workforce, increases in premium rates for both medical and drug insurance have been the primary drivers of overall cost increase. From FY98 through FY08, the annual costs of insurance coverage per active employee increased 133 percent (from $3,130 to $7,296) and 179 percent for retirees (from $1,846 to $5,155).

The University's annual contributions for health insurance co-premiums, viewed as a percentage of its overall annual budget increased from 3.3 percent in FY97, to 4.1 percent in FY02, and to 4.8 percent of the overall budget by FY07. As a percentage of salaries, University contributions toward health insurance increased from 7.5 percent in FY97, to 8.6 percent in FY02, and to 10.4 percent by FY07.

<u>Taking Action to Curb the Rate of Increase</u>
The University launched a variety of innovative initiatives and programs over the past several years, with notable results, to contain rising health care costs, and also improve health care delivery and to promote a culture of health. These efforts included:

- In 2003, prescription drug coverage was separated from the medical insurance plans to take advantage of savings that can accrue from an actively self-managed prescription drug program.

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[2] Kaiser Family Foundation/Health Research and Educational Trust, Employer Health Benefits 2007 Annual Survey. Available online at: Hhttp://www.kff.org/insurance/7672/index.cfmH.

- In 2003, medical plan co-pays increased to $15 per visit for office visits, urgent care, physical/occupational/speech therapies, and to $50 for emergency room visits, and a three tier co-pay structure was implemented in the drug plan.
- Health insurance co-premium sharing changes were adopted in 2004, and adjusted in 2005 based on recommendations from the Committee on Health Insurance Premium Design (CHIPD). New health premium rate structures based on four coverage tiers were also implemented in 2005. These changes were designed to encourage faculty and staff to select the plan best suited to their health insurance needs, while ensuring that the price of the plan is one of the factors considered in decision-making.
- Michigan Healthy Community (MHealthy) was formed in 2004, with goals of promoting healthy living, improving health care delivery and containing health care costs. Pilot programs to promote health and well-being were launched in 2005 and 2006.
- Under-subscribed plans have been discontinued due to the high costs associated with low-enrollment plans.
- Vendor contracts were aggressively negotiated to obtain the best possible rates.

MHealthy's five year strategic plan was approved in 2008, and will continue to make cost-effective investments in the health of the U-M community to promote health and well-being as a strategy contributing toward long-term cost containment. In 2009, new voluntary programs will help employees inventory and self-manage personal health risks for healthier lifestyles, and improve their management of chronic disease or disability.

How U-M Compares
Hewitt and Associates conducted a comprehensive market analysis for the University in 2008, confirming the findings of internal studies performed by the University. Hewitt found the University's health plan is performing at a high level of financial efficiency and that the University is doing many of the right things to keep our health costs lower than average.

The University's Financial Efficiency
For 2008, under the relative financial efficiency measures of the Hewitt Health Value Initiative (HHVI), U-M's university and health system peers all fared generally better than the average for the labor market. Peer institutions scored 5.5 percent better on average for the financial efficiency of their health plans, while the University of Michigan's health plan financial efficiency scores were an extraordinary 13.4 percent better than the average of the extensive HHVI data set.

The University's sound financial efficiency score can largely be attributed to the quality and efficiency of University physicians and hospitals, successful contracting with benefit vendors, and savings achieved by internal management and initiatives of the prescription drug plan.

University Health Plan Cost Sharing
Hewitt performed a market analysis focused on the proportionate sharing of health costs between employers and employees. The cost analysis looked at "total health costs" per active employee, which included health insurance premiums contributed by the employer and employee, and the out-of-pocket costs paid by employees as co-pays, deductibles and coinsurance for medical services and prescription drugs.

Results from the Hewitt Health Value Initiative (HHVI) comparison of total per employee costs for 2008 indicated that University of Michigan employees pay 20 percent of total health costs while the University pays 80 percent of the total. In comparison, among the select comparator peer group of 24 academic and health system peers (including the University) employees pay an average of 30 percent of total health costs and their employers pay 70 percent of the total. Results for the southeastern Michigan labor market are similar to our peers, with employees paying almost 29 percent of total health costs and employers contributing just over 71 percent of the total.

Conclusions

The University's current health cost sharing policies result in considerably greater University contributions than our peers, and these policies have not been adjusted for several years. Health insurance co-premium sharing formulas at the University were last changed in 2005, and co-pays and deductibles have been in place since 2003. Our faculty, staff and retiree community has benefited from the multi-year stability in their portion of health costs, and an adjustment is now required to help ensure the longevity of our benefit plans in the face of continuing cost escalation.

Most universities try to affect healthcare costs through combinations of quality/utilization management programs, plan design and cost sharing. Many are implementing or currently have wellness and health risk reduction programs as a means of curbing the rate of increase.

The University will move to an aggregate health cost sharing model, in which the University's share will average 70%, and the employees' and retirees' share will average 30% of total aggregate health costs including health insurance premiums and employee out-of-pocket costs for co-pays, deductibles, and coinsurance for health care services and prescription drugs. The change will be phased in over two years, beginning in 2010.

The University's proven financial efficiency is expected to help keep health expenditures lower compared to our peers.

The new Committee on Sustainable Health Benefits will explore and recommend options that achieve the new cost-sharing ratio.

University of Michigan Retirement Savings Plan Trends & Key Market Data

The University's retirement savings plan represents another area of significant expenditure for the University. In FY 1997, employees received $96 million in University contributions to their accounts. By FY 2007, University contributions had increased to $187 million. Contributions by the University toward retirement have increased at a rate faster than our overall budget and our salary budget.

Matching Contributions

The Hewitt Benefit Index study revealed the University's 10 percent of pay contribution to employee accounts is more generous than the 8.75 percent average of 24 other universities in the comparator group of 27 peer organizations.

Vesting

A supplemental internal study by the University revealed that vesting and/or waiting periods are common features of comparator organizations. While contributions can begin on an employee's hire date and are immediately fully vested at the University, 12 of 31 surveyed peers do not contribute until new employees have service ranging from six months to twenty-four months (with 12 months most common).

Similarly, at 9 of 31 peer organizations surveyed, employees are not immediately fully vested in University contributions. Full vesting periods range from one to five years of service. U-M's lack of vesting and waiting periods for University contributions is a principal cause of the higher-than-average retirement savings plan expenses at U-M as compared to other universities and health systems.

The Committee to Study Vesting Options for the Retirement Savings Plan will provide guidance and recommendations on vesting options and waiting periods applicable to future employees hired **after** the implementation date of any change. The Committee will assess impacts and implications of any recommendations to ensure outcomes and consequences have been identified. The University is not considering a change in its 10 percent of pay matching contribution.

TIMING

The committees will begin meeting in September 2008 and will submit reports of recommendations to the Executive Vice Presidents and Associate Vice President for Human Resources by December 2008. Decisions on changes will be made and communicated in the first quarter of 2009. We expect that changes will begin to be implemented beginning in 2010 and will be completed by the 2011 benefit year.

Appendix D

Current and Recommended (Model C) Tier Ratios

Appendix D
Coverage Tiers and Coverage Tier Ratios:

Current Formula Tiers and Tier Ratios (2009)					
	Regular	Tier		Medicare - Eligible (M-E)	Tier
Tiers	Tier Description	Ratios	Tiers	Tier Description	Ratios
1	Employee Only	1.00	A	1 Medicare Eligible Person	1.00
2	Employee + Adult	2.00	B	2 Medicare Eligible Persons	2.00
3	Employee + Adult + Child(ren)	2.82	C	3+ Medicare Eligible Persons	2.82
4	Employee + Child(ren)	1.54	D	2 Person Mixed (One Non-M-E & One M-E)	.5 (Tier 2+Tier B)
			E	3+ Person Mixed (at least One Non-M-E & at least One M-E)	.5 (Tier 3+Tier C)

Recommended Model (Model C) Tiers and Coverage Tier Ratios:
This model adjusts the tier ratios based on the 30 month actual utilization. This model then adjusts the Children Ratios for tiers 3, and 4, by averaging the number of dependent children in those contracts. A single Per Member Per Month (PMPM) cost is applied to the average number of dependents to calculate a child dependent ratio of 0.76 that is applied to Regular Tier contracts with child dependents.

Model C Coverage Tiers and Coverage Tier Ratios (Recommended)					
	Regular	Tier		Medicare - Eligible (M-E)	Tier
Tiers	Tier Description	Ratios	Tiers	Tier Description	Ratios
1	Employee Only	1.00	A	1 Medicare Eligible Person	1.00
2	Employee + Adult	2.00	B	2 Medicare Eligible Persons	2.00
3	Employee + Adult + Child(ren)	2.76	C	3+ Medicare Eligible Persons	2.76
4	Employee + Child(ren)	1.76	D	2 Person Mixed (One Non-M-E & One M-E)	.5 (Tier 2+Tier B)
			E	3+ Person Mixed (at least One Non-M-E & at least One M-E)	.5 (Tier 3+Tier C)

Appendix E

Summary of Differential Premium Alternatives

Models A - F

Appendix E
Summary of Differential Premium Models and Alternatives Considered

The Committee agreed that:

- All employees should share some of the increase in premium contributions.
- Lower-salary employees should be protected from the full impact of the contribution increases.

In addition to these guidelines, two issues came up repeatedly in the Committee's discussion of premium contributions based on salary:

- The Committee struggled with the fact that there is no simple definition of what is fair. Approaches that would be considered fair using one definition are unfair according to another. For example, one common-sense notion of fairness dictates that premium increases should be borne disproportionately by those with a greater ability to pay for them. A different notion of fairness would suggest that since a high-salary employee and a low-salary employee receive the same expected benefit from employer-provided health insurance, they should pay the same amount for it, as is the case with on-campus parking. The fact that there are multiple conflicting notions of fairness complicates the use of "fairness" as a criterion for deciding whether premium contributions should depend on salary.

- The Committee was aware that the University competes to hire and retain employees in a competitive labor market and that employees consider their total after-tax compensation package – both salary and fringe benefits - in making decisions about employment. Any increase in premium contributions required from workers may be offset by an increase in salary. Salary increases can lessen the risk of losing highly mobile employees who are being asked to pay more for their health insurance.[1] However, such salary increases reduce the net savings the University will realize by increasing employee premium contributions. While these principles apply to any proposed increase in employee premium contributions, they came into particularly sharp focus during the Committee's discussion of linking premium contributions to salary.

Alternative Considered:

- The Committee did not recommend one of the salary banding approaches (Model A) because of the "notches" the discrete bands create. In such a system, for an employee whose salary is close to the threshold between one band and the next, an annual salary increase could lead to the loss of more than the increase in premium contributions from the University.

- The Committee also did not recommend a percent-of-pay approach (Model B) because of the very large decrease in net compensation this model imposes on higher-salary employees. This may compromise the University's ability to retain or recruit very highly skilled faculty and staff. To remain competitive, the University would have to increase current salaries and future salary offers to offset this disadvantage, eliminating any short-run cost savings; but probably not before losing some highly valued faculty and staff in the process.
- The recommended model, Model C, targets the full cushioning of the cost sharing by employees in the lowest quartile of salary (Band 1). The selection of the span of Band 2 from the 25th percentile of salaries to the 50th percentile, rather than to the 75th percentile, reduces the burden of premium contributions increases on the University's lowest-paid employees without imposing an undue burden on higher-paid employees. Part-time employees and retirees are included in Band 1 (salaries up to and including the 25th percentile.)

The question that remained before the Committee was whether even well-designed differential premium contributions are desirable. The complexity of these arrangements is a significant drawback. The fact that they violate one notion of fairness (Why should some employees pay more than others for the same benefit?) is another.

Committee members were committed to the principle of buffering the economic impact of the proposed contribution increases on lower-salary employees, but were not necessarily convinced that differential premium contributions were the best way to achieve this. Therefore, the Committee discussed two other options for compensating these employees; neither relies on differential premium contributions.

The first of these, Model D, imposes the same (flat) premium contribution but also allocates the same amount per employee into a Health Reimbursement Account (HRA) to cover the employee's out-of-pocket medical spending. The Committee ultimately rejected this model for two main reasons. First, HRAs can only be used to pay an employee's medical expenses not covered by insurance, such as copayments or eyeglasses. Since most of the University's health insurance plans expose beneficiaries to low out-of-pocket cost sharing, HRAs are not a good fit with our current menu of plans, and funds in an HRA might encourage unnecessary medical spending. While it is permissible under the Internal Revenue Code to use the funds for co-premiums, the administrative and record keeping burdens on employees were viewed by the Committee as onerous for the HRA to be proposed as a viable alternative at this time.

Some Committee members were more enthusiastic about Model E. Under this model, premium contributions percentages would not vary with salary, but merit pay increases would be disproportionately targeted to lower-salary employees in the year contribution increases were implemented to help them absorb the increase in cost. This targeting would be budget neutral in the sense that higher-salary employees would receive correspondingly smaller merit pay increases. This would be a one-time adjustment (or, rather, timed to correspond to the implementation of the premium contribution increases, which might actually occur over two years). Although some Committee members expressed the view that employees might in subsequent years forget the disproportionate one-time increase or the amount itself, others felt that the main objective of helping them to absorb the increase in costs would still be achieved, and without making the health benefit program more complex.

Committee members remained divided about whether flat premium contributions as in Model E would be preferable to Model C *if* the University would with certainty provide one-time targeted pay increases to lower-salaried employee. But since decisions about salary are beyond the scope of this Committee and all Committee members were committed to the principle of protecting lower-salary employees from the full impact of premium increases, this led to a consensus in favor of Model C over Model E.

Finally, the possibility of adding a High-Deductible Health Plan with a Health Savings Account (Model F) to the menu of plan choices available to employees came up repeatedly in our discussions of how to meet the needs of lower salary employees. This could be achieved through modifications to the existing Comprehensive Major Medical Plan. Making available a lower-cost option, perhaps accompanied by "cash back" to the employee via an HSA, would alleviate concerns about the affordability of coverage for lower-salary employees without limiting the choices available to all. A full evaluation of this option is beyond the scope of this Committee; nonetheless, the Committee recommends that the University consider this option as part of any ongoing review of its benefits design.

Appendix F

Recommended Model with

Differential Premiums Based on Salary (Model C)

Appendix F
Recommended Model with
Differential Premiums Based on Salary (Model C)

This model creates 3 pay bands for determining full-time employee contribution rates. Full-time employees were placed into 3 pay bands based on their full-time equivalent (FTE) pay + additional pay. Part-time employees receive 80% of the Band 1 University contribution that full-time employees receive. Retirees receive Band 1 rates. For full-time active employees, Band 1 rates represent the minimum employee contribution level and Band 3 rates represent the maximum employee contribution level for each plan and coverage tier. The middle Band 2 rates are determined by a percent-of-pay calculation that phases out the higher contribution from Band 1 to Band 3. Band 1 covers the lowest 25th percentile of full-time employees based on pay. Band 2 covers the 25th to 50th percentile of full-time employees and Band 3 covers the 50th percentile to 100th percentile of full-time employees based on pay. Co-premium rates and out-of-pocket expenditures are adjusted to reflect a $20 office visit copayment (OV), $75 emergency room (ER) visit copayment, and a $45 non-preferred brand (NPB) copayment.

Model E presents the cost-sharing rates without salary banding premiums; it is also the baseline model for Model C. The premium savings from changing the co-pays are reflected in the following schedule:

Impact of Co-Pay Changes on Contributions OV $15 to $20, ER $50 to $75, NPB $30 to $45	
University Contributions	$ 6,350,000
Employee Contributions	$ 1,870,000
Total Contributions	**$ 8,220,000**

The different contribution percentages for Model C and the number of contracts can be found in the chart below. The University Contribution percentages for the three recommended salary bands for full-time employees are based on quartiles of the actual salary distribution, and thus, the dollar amounts of the ranges will vary from year to year.

Recommended Model (Model C)	Single Contract	Dependent Portion	Aggregate	Full-Time Contracts	Part-time Contracts	Retiree Contracts
Current Formula	95%	Variable (74.777%)	85%	28,671	3,406	6,615
Model E: (Without Salary Banding)	90%	60% Adult, 75% Children 75% Medicare	Variable	28,671	3,406	6,615
Model C: (Recommended)						
Band 1: $37,600 and below	93%	66% Adult, 75% Children	Variable	7,020	3,406	
Band 2: $37,601 - $50,400	% of Pay			7,422		
Band 3: $50,401 and above	90%	57% Adult, 70% Children	Variable	14,229		
Retirees (Based on Band 1)	93%	66% Adult, 75% Children 70% Medicare	Variable			6,615

Based on 2009 University Contributions. March, 2008 Enrollment Counts.

Part-time employees will receive 80% of the University Contribution that Full-time employees receive in band 1.

The changes in 2009 annual University and employee shares of premiums for Model C are shown in the following chart.

Change in 2009 Annual University and Employee Contributions					
	Estimated University Contribution	**Estimated Employee Contribution**	**Aggregate**	**University Cost %**	**Employee Cost %**
Full-Time Employees and Retirees:					
Current Formula	**246,420,000**	**42,140,000**	**288,560,000**	**85.4%**	**14.6%**
Model E	**222,090,000**	**59,240,000**	**281,330,000**	**78.9%**	**21.1%**
Model C FTE Salary Banding:					
Band 1: $37,600 and below	45,560,000	9,600,000	55,160,000	82.6%	17.4%
Band 2: $37,601 - $50,400	47,900,000	11,380,000	59,280,000	80.8%	19.2%
Band 3: $50,401 and above	99,350,000	32,900,000	132,250,000	75.1%	24.9%
Retirees (Based on Band 1)	29,440,000	5,200,000	34,640,000	85.0%	15.0%
Total	**222,250,000**	**59,080,000**	**281,330,000**	**79.0%**	**21.0%**
Part-Time Employees:					
Current Formula	**27,550,000**	**5,160,000**	**32,710,000**	**84.2%**	**15.8%**
Model E	**19,470,000**	**12,250,000**	**31,720,000**	**61.4%**	**38.6%**
Model C	**20,440,000**	**11,280,000**	**31,720,000**	**64.4%**	**35.6%**
All Employees and Retirees:					
Current Formula	**273,970,000**	**47,300,000**	**321,270,000**	**85.3%**	**14.7%**
Model E	**241,560,000**	**71,490,000**	**313,050,000**	**77.2%**	**22.8%**
Model C:					
Part-Time (80% UC Band 1)	20,440,000	11,280,000	31,720,000	64.4%	35.6%
Band 1: $37,600 and below	45,560,000	9,600,000	55,160,000	82.6%	17.4%
Band 2: $37,601 - $50,400	47,900,000	11,380,000	59,280,000	80.8%	19.2%
Band 3: $50,401 and above	99,350,000	32,900,000	132,250,000	75.1%	24.9%
Retirees (Based on Band 1)	29,440,000	5,200,000	34,640,000	85.0%	15.0%
Total	**242,690,000**	**70,360,000**	**313,050,000**	**77.5%**	**22.5%**

Current and Recommended University and Employee Cost Sharing Models (Estimated Amounts and Percentages)					
	University	Employee	Total	University	Employee
Current Model (80%/20%)	**Cost**	**Cost**	**Cost**	**Cost %**	**Cost %**
Premium Contributions	$ 273,970,000	$ 47,300,000	$ 321,270,000	85.3%	14.7%
Estimated Out-Of-Pocket*	$ -	$ 20,780,000	$ 20,780,000	0.0%	100.0%
Total	**$ 273,970,000**	**$ 68,080,000**	**$ 342,050,000**	**80.1%**	**19.9%**
Recommended Model (70%/30%)					
Premium Contributions	$ 242,690,000	$ 70,360,000	$ 313,050,000	77.5%	22.5%
Estimated Out-Of-Pocket*		$ 29,000,000	$ 29,000,000	0.0%	100.0%
Total	**$ 242,690,000**	**$ 99,360,000**	**$ 342,050,000**	**71.0%**	**29.0%**

Out-of-Pocket: Co-pays, deductibles and co-insurance paid by person using services.
Estimated out-of-pocket costs for 2008 are $20,780,000.
Recommended changes in out-of-pocket costs result in an additional estimated $8,220,000

Implications of Model C (Based on 2009 Rates):

1) This Model will shift a total of $31.3 million from the University to employees/retirees. The model shifts $6.4 million through increases in out-of-pocket co-pay levels and $19.9 million from moving everyone to the full-time contribution level. An additional $5.0 million was shifted to part-time employees based on the University contributions being equal to 80% of the full-time rates. This model brings the University's share of total health care spending down from 80% to 71%.
2) **Full-Time:** On a single U-M Premier Care employee contract (tier 1), employee contributions will increase between $127 for Band 1 to $275 per year for Band 3. **Part-Time:** The increase is $1,046 for tier 1.
3) **Full-Time:** On an Employee + Adult U-M Premier Care contract (tier 2), employee contributions will increase between $544 for Band 1 to $1,137 per year for Band 3. **Part-Time:** The increase is $2,115 for tier 2.
4) **Full-Time:** On a Family U-M Premier Care Contract (tier 3), employee contributions will increase between $448 for Band 1 to $1,228 per year for Band 3. **Part-Time:** The increase is $2,582 for tier 3.
5) **Full-Time:** On an Employee + Children U-M Premier Care Contract (tier 4), employee contributions will increase between $384 for Band 1 to $719 per year for Band 3. **Part-Time:** The increase is $1,866 for tier 4.
6) See Exhibit 1 for an example of % of Pay (Band 2) rates for full-time employees.
7) **Retirees:** The rate impacts for retirees are the same as those shown for band 1. On a single U-M Premier Care Medicare contract (tier A), the increase for retirees would be estimated at $62 per year. On Medicare dependent contracts, the annual increase in retiree contributions is estimated between $198 (tier B) and $371 (tier D).

The full-time/part-time employee and retiree contribution changes are shown on the next page.

Estimated Change in Monthly Employee/Retiree Contribution Rates for Phase in Year 2 (2011)
For UM Premier Care and BCBS PPO
Model C: Salary Bands Based on Full-Time Equilvalent (FTE) Pay + One Time Incentive and Other Pay

		Monthly Employee Contributions for UM Premier Care						Annual $ Change from Current Formula				
		Current	Model C					Model C				
Tiers	Rates	Formula		Band 1	Band 2	Band 3			Band 1	Band 2	Band 3	
Salary Ranges		All Employees / Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees
1	Employee (EE) Only	$ 17.96	$ 105.14	$ 28.56	% of Pay	$ 40.90	$ 28.56	$ 1,046	$ 127	Varies	$ 275	$ 127
2	Employee + Adult	$ 122.92	$ 299.18	$ 168.26	% of Pay	$ 217.64	$ 168.26	$ 2,115	$ 544	Varies	$ 1,137	$ 544
3	EE + Adult + Child(ren)	$ 208.98	$ 424.12	$ 246.28	% of Pay	$ 311.32	$ 246.28	$ 2,582	$ 448	Varies	$ 1,228	$ 448
4	EE + Child(ren)	$ 74.62	$ 230.08	$ 106.58	% of Pay	$ 134.56	$ 106.58	$ 1,866	$ 384	Varies	$ 719	$ 384
A	1 Medicare-Eligible (M-E) Person	$ 14.34					$ 19.52					$ 62
B	2 Medicare-Eligible (M-E) Persons	$ 86.74					$ 103.22					$ 198
C	3+ Medicare-Eligible (M-E) Persons	$ 146.12					$ 166.82					$ 248
D	2 Person Mixed (One Non-M-E and One M-E)	$ 104.86					$ 135.76					$ 371
E	3+ Person Mixed (At least One M-E and at least One Non M-E)	$ 177.56					$ 206.56					$ 348

		Monthly Employee Contributions for BCBS PPO						Annual $ Change from Current Formula				
		Current	Model C					Model C				
Tiers	Rates	Formula		Band 1	Band 2	Band 3			Band 1	Band 2	Band 3	
Salary Ranges		All Employees / Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees
1	Employee (EE) Only	$ 90.52	$ 175.48	$ 98.90	% of Pay	$ 111.24	$ 98.90	$ 1,020	$ 101	Varies	$ 249	$ 101
2	Employee + Adult	$ 268.04	$ 439.86	$ 308.94	% of Pay	$ 358.32	$ 308.94	$ 2,062	$ 491	Varies	$ 1,083	$ 491
3	EE + Adult + Child(ren)	$ 413.60	$ 618.26	$ 440.42	% of Pay	$ 505.46	$ 440.42	$ 2,456	$ 322	Varies	$ 1,102	$ 322
4	EE + Child(ren)	$ 186.38	$ 353.88	$ 230.38	% of Pay	$ 258.36	$ 230.38	$ 2,010	$ 528	Varies	$ 864	$ 528
A	1 Medicare-Eligible (M-E) Person	$ 14.34					$ 19.52					$ 62
B	2 Medicare-Eligible (M-E) Persons	$ 86.74					$ 103.22					$ 198
C	3+ Medicare-Eligible (M-E) Persons	$ 146.12					$ 166.82					$ 248
D	2 Person Mixed (One Non-M-E and One M-E)	$ 177.40					$ 206.08					$ 344
E	3+ Person Mixed (At least One M-E and at least One Non M-E)	$ 279.86					$ 303.64					$ 285

Exhibit 1
Band 2 Phased Percent of Pay Examples for Full-Time Employees

Model C								
Full-Time Employee Contributions for UM Premier Care and BCBS PPO								
	UM Premier Care				BCBS PPO			
Tiers	1	2	3	4	1	2	3	4
Tier Description	Employee (EE) Only	EE+Adult	EE+Adult+ Child(ren)	EE+Child(ren)	Employee (EE) Only	EE+Adult	EE+Adult+ Child(ren)	EE+Child(ren)
Minimum Salary	$ 37,600	$ 37,600	$ 37,600	$ 37,600	$ 37,600	$ 37,600	$ 37,600	$ 37,600
Maximum Salary	$ 50,400	$ 50,400	$ 50,400	$ 50,400	$ 50,400	$ 50,400	$ 50,400	$ 50,400
Minimum EC Rate	$ 28.56	$ 168.26	$ 246.28	$ 106.58	$ 98.90	$ 308.94	$ 440.42	$ 230.38
Maximum EC Rate	$ 40.90	$ 217.64	$ 311.32	$ 134.56	$ 111.24	$ 358.32	$ 505.46	$ 258.36
Salary:								
$30,000	$ 28.56	$ 168.26	$ 246.28	$ 106.58	$ 98.90	$ 308.94	$ 440.42	$ 230.38
$35,000	$ 28.56	$ 168.26	$ 246.28	$ 106.58	$ 98.90	$ 308.94	$ 440.42	$ 230.38
$37,500	$ 28.56	$ 168.26	$ 246.28	$ 106.58	$ 98.90	$ 308.94	$ 440.42	$ 230.38
$40,000	$ 30.87	$ 177.52	$ 258.48	$ 111.83	$ 101.21	$ 318.20	$ 452.62	$ 235.63
$42,500	$ 33.28	$ 187.16	$ 271.18	$ 117.29	$ 103.62	$ 327.84	$ 465.32	$ 241.09
$45,000	$ 35.69	$ 196.81	$ 283.88	$ 122.76	$ 106.03	$ 337.49	$ 478.02	$ 246.56
$47,500	$ 38.10	$ 206.45	$ 296.58	$ 128.22	$ 108.44	$ 347.13	$ 490.72	$ 252.02
$50,000	$ 40.51	$ 216.10	$ 309.29	$ 133.69	$ 110.85	$ 356.78	$ 503.43	$ 257.49
$55,000	$ 40.90	$ 217.64	$ 311.32	$ 134.56	$ 111.24	$ 358.32	$ 505.46	$ 258.36
$60,000	$ 40.90	$ 217.64	$ 311.32	$ 134.56	$ 111.24	$ 358.32	$ 505.46	$ 258.36
$65,000	$ 40.90	$ 217.64	$ 311.32	$ 134.56	$ 111.24	$ 358.32	$ 505.46	$ 258.36
$70,000	$ 40.90	$ 217.64	$ 311.32	$ 134.56	$ 111.24	$ 358.32	$ 505.46	$ 258.36
$75,000	$ 40.90	$ 217.64	$ 311.32	$ 134.56	$ 111.24	$ 358.32	$ 505.46	$ 258.36
$80,000	$ 40.90	$ 217.64	$ 311.32	$ 134.56	$ 111.24	$ 358.32	$ 505.46	$ 258.36
$90,000	$ 40.90	$ 217.64	$ 311.32	$ 134.56	$ 111.24	$ 358.32	$ 505.46	$ 258.36
$100,000	$ 40.90	$ 217.64	$ 311.32	$ 134.56	$ 111.24	$ 358.32	$ 505.46	$ 258.36

Appendix G

Implementation Option 2
50% of All Contribution Changes Implemented in 2010

Appendix G
Recommended Implementation Option
50% of All Contribution Changes Implemented in 2010

Alternative 2: Proposes making changes to co-pays and introducing the salary band system in 2010. All employees (full time and part time) and retirees are placed in the three bands, co-premiums would increase by 50% of the full amount in 2010 and the remaining 50% in 2011. In addition, the University's contribution for part-time employees would be reduced to 90% in 2010 and to 80% in 2011

Model C is the baseline model for phasing in changes over 2 years (Calendar Year 2010 & 2011). This model creates 3 pay bands for determining Full-Time contribution levels. Full-time employees were placed into 3 pay bands based on their Full-Time Equivalent (FTE) Pay + Additional Pay. Part-time employees will receive 80% of the Band 1 University contribution that full-time employees receive. Retirees receive Band 1 rates. For full-time active employees, Band 1 rates represent the minimum contribution level and Band 3 rates represent the maximum contribution level for each plan and coverage tier. The middle Band 2 rates are determined by a percent of pay calculation that phases out from Band 1 to Band 3. Band 1 covers the lowest 25th percentile of full-time employees based on pay. Band 2 covers the 25th to 50th percentile of full-time employees and Band 3 covers the 50th percentile to 100th percentile of full-time employees based on pay. Co-premium rates and out-of-pocket expenditures were adjusted to reflect a $20 office visit (OV), $75 emergency room (ER) visit, and a $45 non-preferred brand (NPB) co-pay change.

The potential changes that could be implemented for 2010 are highlighted below:

1) **Change Coverage Tier Ratios:** Coverage Tier Ratios will be based on 30 months of actual utilization and use the average child dependent ratio of 0.76.

Model C Coverage Tiers and Coverage Tier Ratios (Recommended)					
	Regular	Tier		Medicare - Eligible (M-E)	Tier
Tiers	Tier Description	Ratios	Tiers	Tier Description	Ratios
1	Employee Only	1.00	A	1 Medicare Eligible Person	1.00
2	Employee + Adult	2.00	B	2 Medicare Eligible Persons	2.00
3	Employee + Adult + Child(ren)	2.76	C	3+ Medicare Eligible Persons	2.76
4	Employee + Child(ren)	1.76	D	2 Person Mixed (One Non-M-E & One M-E)	.5 (Tier 2+Tier B)
			E	3+ Person Mixed (at least One Non-M-E & at least One M-E)	.5 (Tier 3+Tier C)

2) **Change Co-Pays:** Office visit (OV) co-pay will change from $15 to $20; emergency room (ER) visit co-pay will change from $50 to $75; and the non-preferred brand (NPB) co-pay will change from $30 to $45.

3) **University Contributions:** Base University Contributions on the contract-weighted average premiums of the two lowest cost comprehensive health plans. Phase in over two years the contribution level changes based on Model C. The co-premium differential structure based on salary will be implemented, as well as differentiated part-time contributions. The co-premium sharing percentages for CY 2010 and CY 2011 is illustrated in the table on the next page:

2010 and 2011 Contribution Levels				
50% of All Contribution Changes are Implemented Over Two Years				
	Calendar Year 2010		Calendar Year 2011	
	Single	Dependent	Single	Dependent
Employees/Retirees	**Contract**	**Portion**	**Contract**	**Portion**
Part-time Employees	90% of Band 1 Rates		80% of Band 1 Rates	
Full-Time Employees:				
Band 1	94%	72% Adult, 75% Children	93%	66% Adult, 75% Children
Band 2	% of Pay		% of Pay	
Band 3	93%	68% Adult, 73% Children	90%	57% Adult, 70% Children
Retirees	94%	72% Adult, 75% Children	93%	66% Adult, 75% Children
		73% Medicare		70% Medicare

The overall savings for CY 2010 and CY 2011 from the above changes are shown in the chart below (illustrated based on 2009 Rates):

Phase in for Calendar Year 2010 and 2011 Based on March, 2008 Enrollment			
CY 2010:	**Estimated University Contributions**	**Estimated Employee Contributions**	**Estimated Total Contributions**
Current Contributions	**$ 273,970,000**	**$ 47,300,000**	**$ 321,270,000**
Change in Co-Pays	$ (6,350,000)	$ (1,870,000)	$ (8,220,000)
Contribution Formula Changes	$ (12,670,000)	$ 12,670,000	$ -
Total Changes	**$ 254,950,000**	**$ 58,100,000**	**$ 313,050,000**
Change in University Cost	**$ (19,020,000)**		
CY 2011:	**Estimated University Contributions**	**Estimated Employee Contributions**	**Estimated Total Contributions**
Current Contributions	**$ 254,950,000**	**$ 58,100,000**	**$ 313,050,000**
Contribution Formula Changes	$ (12,260,000)	$ 12,260,000	$ -
Total Changes	**$ 242,690,000**	**$ 70,360,000**	**$ 313,050,000**
Change in University Cost	**$ (12,260,000)**		
Two Year Change in University Cost	**$ (31,280,000)**		

If these changes were adopted, the University's share in the first year of implementation will be reduced by approximately $19.0 million in 2010 and approximately $12.3 million in 2011.

The Employee (Part-Time & Full-Time) / Retiree Contributions for the first and second year of implementation are shown on next 2 pages (illustrated based on 2009 Rates). The University Contribution percentages for the three recommended salary bands for full-time employees are based on quartiles of the actual salary distribution, and thus, the dollar amounts of the ranges will vary from year to year.

Estimated Change in Monthly Employee/Retiree Contribution Rates for Phase in Year 1 (2010)
For UM Premier Care and BCBS PPO
Model C: Salary Bands Based on Full-Time Equivalent (FTE) Pay + One Time Incentive and Other Pay

		Monthly Employee Contributions for UM Premier Care						Annual $ Change from Current Formula				
		Current	Model C Phase In Year 1					Model C Phase In Year 1				
Tiers	Rates	Formula		Band 1	Band 2	Band 3			Band 1	Band 2	Band 3	
Salary Ranges		All Employees/ Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees
1	Employee (EE) Only	$ 17.96	$ 63.14	$ 24.44	% of Pay	$ 28.56	$ 24.44	$ 542	$ 78	Varies	$ 127	$ 78
2	Employee + Adult	$ 122.92	$ 207.78	$ 139.44	% of Pay	$ 160.02	$ 139.44	$ 1,018	$ 198	Varies	$ 445	$ 198
3	EE + Adult + Child(ren)	$ 208.98	$ 309.26	$ 217.46	% of Pay	$ 244.30	$ 217.46	$ 1,203	$ 102	Varies	$ 424	$ 102
4	EE + Child(ren)	$ 74.62	$ 164.62	$ 102.46	% of Pay	$ 112.82	$ 102.46	$ 1,080	$ 334	Varies	$ 458	$ 334
A	1 Medicare-Eligible (M-E) Person	$ 14.34					$ 16.74					$ 29
B	2 Medicare-Eligible (M-E) Persons	$ 86.74					$ 92.06					$ 64
C	3+ Medicare-Eligible (M-E) Persons	$ 146.12					$ 149.32					$ 38
D	2 Person Mixed (One Non-M-E and One M-E)	$ 104.86					$ 115.76					$ 131
E	3+ Person Mixed (At least One M-E and at least One Non M-E)	$ 177.56					$ 183.40					$ 70

		Monthly Employee Contributions for BCBS PPO						Annual $ Change from Current Formula				
		Current	Model C Phase In Year 1					Model C Phase In Year 1				
Tiers	Rates	Formula		Band 1	Band 2	Band 3			Band 1	Band 2	Band 3	
Salary Ranges		All Employees/ Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees
1	Employee (EE) Only	$ 90.52	$ 133.48	$ 94.78	% of Pay	$ 98.90	$ 94.78	$ 516	$ 51	Varies	$ 101	$ 51
2	Employee + Adult	$ 268.04	$ 348.46	$ 280.12	% of Pay	$ 300.70	$ 280.12	$ 965	$ 145	Varies	$ 392	$ 145
3	EE + Adult + Child(ren)	$ 413.60	$ 503.40	$ 411.60	% of Pay	$ 438.44	$ 411.60	$ 1,078	$ (24)	Varies	$ 298	$ (24)
4	EE + Child(ren)	$ 186.38	$ 288.42	$ 226.26	% of Pay	$ 236.62	$ 226.26	$ 1,224	$ 479	Varies	$ 603	$ 479
A	1 Medicare-Eligible (M-E) Person	$ 14.34					$ 16.74					$ 29
B	2 Medicare-Eligible (M-E) Persons	$ 86.74					$ 92.06					$ 64
C	3+ Medicare-Eligible (M-E) Persons	$ 146.12					$ 149.32					$ 38
D	2 Person Mixed (One Non-M-E and One M-E)	$ 177.40					$ 186.08					$ 104
E	3+ Person Mixed (At least One M-E and at least One Non M-E)	$ 279.86					$ 280.48					$ 7

Estimated Change in Monthly Employee/Retiree Contribution Rates for Phase in Year 2 (2011)
For UM Premier Care and BCBS PPO
Model C: Salary Bands Based on Full-Time Equilvalent (FTE) Pay + One Time Incentive and Other Pay

		Monthly Employee Contributions for UM Premier Care						Annual $ Change from Current Formula				
		Current	Model C Phase in Year 2					Model C Phase in Year 2				
Tiers	Rates	Formula		Band 1	Band 2	Band 3			Band 1	Band 2	Band 3	
Salary Ranges		All Employees / Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees
1	Employee (EE) Only	$ 17.96	$ 105.14	$ 28.56	% of Pay	$ 40.90	$ 28.56	$ 1,046	$ 127	Varies	$ 275	$ 127
2	Employee + Adult	$ 122.92	$ 299.18	$ 168.26	% of Pay	$ 217.64	$ 168.26	$ 2,115	$ 544	Varies	$ 1,137	$ 544
3	EE + Adult + Child(ren)	$ 208.98	$ 424.12	$ 246.28	% of Pay	$ 311.32	$ 246.28	$ 2,582	$ 448	Varies	$ 1,228	$ 448
4	EE + Child(ren)	$ 74.62	$ 230.08	$ 106.58	% of Pay	$ 134.56	$ 106.58	$ 1,866	$ 384	Varies	$ 719	$ 384
A	1 Medicare-Eligible (M-E) Person	$ 14.34					$ 19.52					$ 62
B	2 Medicare-Eligible (M-E) Persons	$ 86.74					$ 103.22					$ 198
C	3+ Medicare-Eligible (M-E) Persons	$ 146.12					$ 166.82					$ 248
D	2 Person Mixed (One Non-M-E and One M-E)	$ 104.86					$ 135.76					$ 371
E	3+ Person Mixed (At least One M-E and at least One Non M-E)	$ 177.56					$ 206.56					$ 348

		Monthly Employee Contributions for BCBS PPO						Annual $ Change from Current Formula				
		Current	Model C Phase in Year 2					Model C Phase in Year 2				
Tiers	Rates	Formula		Band 1	Band 2	Band 3			Band 1	Band 2	Band 3	
Salary Ranges		All Employees / Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees	Part-Time	$37,600 and below	$37,601 - $50,400	$50,401 and Above	Retirees
1	Employee (EE) Only	$ 90.52	$ 175.48	$ 98.90	% of Pay	$ 111.24	$ 98.90	$ 1,020	$ 101	Varies	$ 249	$ 101
2	Employee + Adult	$ 268.04	$ 439.86	$ 308.94	% of Pay	$ 358.32	$ 308.94	$ 2,062	$ 491	Varies	$ 1,083	$ 491
3	EE + Adult + Child(ren)	$ 413.60	$ 618.26	$ 440.42	% of Pay	$ 505.46	$ 440.42	$ 2,456	$ 322	Varies	$ 1,102	$ 322
4	EE + Child(ren)	$ 186.38	$ 353.88	$ 230.38	% of Pay	$ 258.36	$ 230.38	$ 2,010	$ 528	Varies	$ 864	$ 528
A	1 Medicare-Eligible (M-E) Person	$ 14.34					$ 19.52					$ 62
B	2 Medicare-Eligible (M-E) Persons	$ 86.74					$ 103.22					$ 198
C	3+ Medicare-Eligible (M-E) Persons	$ 146.12					$ 166.82					$ 248
D	2 Person Mixed (One Non-M-E and One M-E)	$ 177.40					$ 206.08					$ 344
E	3+ Person Mixed (At least One M-E and at least One Non M-E)	$ 279.86					$ 303.64					$ 285

Appendix H

Community Input and Engagement

Appendix H
Input and Engagement

On September 4, 2008, an e-mail from the Executive Vice Presidents to the faculty and staff community announced the formation of two committees, one to study health care cost sharing, and one to study retirement savings plan waiting periods and vesting options. Members of the University community were invited to use a new website on benefit stewardship to learn more about the need for change and the charges of these newly formed committees (see Appendix B: Case for Change at http://benefitsstewardship.umich.edu/). Comments and questions were invited from the U-M community through the website.

The Committee on Sustainable Health Benefits met from September through December. Concurrently, Associate Vice President for Human Resources Laurita Thomas led or participated in multiple informational meetings with constituency groups to discuss overall benefits strategy and the role of the Committee.

In addition, group discussions about the work of COSHB and the topics under consideration by the committee were held with the following two groups for their best advice and input:

- Voices of the Staff: Benefits, Health and Well-Being Team
- MHealthy Advisory Committee

Comments and suggestions received from the campus community and discussions with the Voices of the Staff and the MHealthy Advisory Committee were documented and made available to the Committee members for review and consideration.

On December 1, a campus information forum was held and simulcast on the web for the University community to discuss benefits strategy and the work of both COSHB and the Committee to Study Retirement Savings Plan Vesting Options – see www.benefitsstewardship.umich.edu/forum.html Laurita Thomas responded to questions submitted from attendees and online viewers. Comments and input from the benefits stewardship website and the informational webinar were provided to the Committee members through early December.

Appendix I

Glossary of Terms

Appendix I
Glossary of Terms

Active employee: A faculty or staff member of the University of Michigan with an active, benefits-eligible appointment.

Base plan for calculation of University contribution: The premium structure upon which calculation of the University's share of premium is based.

Benefit design: The level of benefits offered to plan members, the degree to which members will be expected to share the costs of such benefits, and how a member can access medical care through the health plan.

Comprehensive plan: Basic health insurance plan (either insured or self-insured) that provides covered services for most types of basic health expenses (excluding prescription drugs) with no or with relatively low initial deductibles.

Contract holder: The individual who elects insurance coverage. In the University plans, the contract holder is the employee or the University retiree.

Co-payment (also known as co-pay): A specified dollar amount that a member must pay out-of-pocket for a specified service at the time the service is rendered.

Co-premium: The share of the insurance premium paid by the contract holder.

Covered dependent: Other individuals that the employee or retiree covers through their health insurance plan election. Covered dependents can be other qualified dependents (OQA), spouses, or children.

Employee contribution: The share of the cost of an insurance premium paid by the employee or retiree.

Full-Time Equivalent (FTE) + Additional Pay: The annualized full-time rate of pay. Included in this figure are monies that may be received by employees, such as: summer teaching and/or summer research, extension teaching, incentive payments, clinical service and temporary administrative differentials. Overtime pay would be excluded from this figure.

Health Reimbursement Arrangements (HRA): A tax-free health care reimbursement account established and exclusively funded by employers. Employees use the funds in the account for general health care expenses. These are notational accounts; benefit dollars remaining in the account at year-end can roll over and may be used to cover future medical costs.

Health Savings Accounts (HSA): A tax-advantaged trust or custodial account created for the benefit of an individual covered under a high-deductible health plan. Contributions can be made by the employer or the employee. Amounts not distributed are carried forward. Like an Individual Retirement Account, the HSA is owned by the individual who is the account beneficiary.

High-Deductible Health Plans (HDHP): A health insurance plan with lower premiums and higher deductibles than a traditional health plan, often offered in conjunction with a Health Savings Account or Health Reimbursement Account.

Group health insurance plan: Coverage underwritten on members of a natural group, such as employees of a particular business.

Medicare-eligible retiree: A retiree who is eligible for Medicare coverage (generally because he or she has reached age 65 or qualifies due to disability).

Medicare: A federal government health insurance plan primarily for elderly and disabled persons.

Medicare Part A: The part of Medicare that provides basic hospital insurance coverage automatically for most eligible persons.

Medicare Part B: A voluntary program that is part of Medicare and provides benefits to cover some of the costs of physicians' services.

Non-Medicare eligible retiree: A retiree who is not yet eligible for Medicare coverage (generally because he or she is less than age 65).

Opt-out payment: A payment made to an employee who waives participation in University of Michigan provided health insurance coverage by certifying that he or she has insurance coverage elsewhere.

Premium: A periodic payment made by a policyholder (employer, individual) for the cost of insurance.

Pricing: In this context, the process of determining the cost of the insurance provided by a health plan for a given set of benefits.

Rate: The cost of a particular insurance coverage expressed as a cost per some measure of time. The University of Michigan typically notes insurance rates per month.

Rate ratio (also known as premium rate relationships): The relationship among the premium rates.

Salary Banding: The practice of grouping individuals according to their rate of salary and then differentiating either the premium cost or the employer contribution among the bands. Generally, Banding is implemented to provide health insurance coverage at a lower cost when employees earn less.

Self-insured (also known as self-funded): A health plan under which an employer or other group sponsor, rather than an insurance company, is financially responsible for paying plan expenses, including claims made by group plan members.

Tier (also known as coverage tier): The grouping of a health plan's enrollees by the number and type of members covered by a contract for the purpose of determining premium rates. As examples, Tier 1 generally represents a single individual-the contract holder. If the contract holder also is covering dependents, then they would be included in the appropriate tier for the number and type of dependents added to the contract. For instance, the proposed Tier 4 includes the employee (the contract holder), another adult (spouse or other qualified adult), and any number of dependent children.

University Contribution: The share of the cost of an insurance premium paid by the University for coverage for employees, retirees, and their covered dependents.