UNIVERSITY OF MICHIGAN

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]

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.

Taking Action to Curb the Rate of Increase

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.
- 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.

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

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