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Chair of the Assembly of the Academic Senate
Faculty Representative to the Regents
University of California
1111 Franklin Street, 12th Floor
Oakland, California 94607-5200

August 3, 2018

**JANET NAPOLITANO, PRESIDENT
UNIVERSITY OF CALIFORNIA**

Re: Interim Report of the Retiree Health Working Group

Dear Janet:

Thank you for accepting the Interim Report of the Retiree Health Working Group. As you know, the Working Group found that no significant changes are needed to the Retiree Health Care Plan offerings or benefit design for 2019. This finding was based on a report from UC HR that the cost increase for the program next year will be between 2% and 2.5%, significantly lower than the current working threshold of 4%.

The Academic Council also appreciates your commitment to allowing the Working Group to meet regularly as a committee through 2019. We believe it is critically important that the Working Group fulfill its original charge to "*design strategies to effectively manage costs to be able to sustain the benefits and evaluate the implications of the different options to both UC and retirees.*" Going forward, advice from external consultants will generally not be necessary.

The Working Group will provide great value to the University by addressing the sustainability of the retiree health program and the key issues listed in its interim report under "*Further Considerations,*" through a final report. Council is especially supportive of the recommendation to explore a mechanism to smooth premium increases.

Thank you again for your commitment to ensuring a robust and viable health benefit for the next generation of retirees. Please do not hesitate to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Shane N. White".

Shane N. White, Chair
Academic Council

Encl.

Cc: Academic Council
Senate Director Baxter
Senate Executive Directors



July 3, 2018

Dear President Napolitano,

As Co-chairs of the Retiree Health Working Group, we are submitting their report with recommendations on behalf of the working group participants. The group spent a significant amount of time learning about the University's current retiree health plan, digesting the vast battery of information and focused on developing principles and strategies to go forward. The group also conveyed ideas for accommodating potential future increases in retiree health care costs in response to the charge for the group. We would like to recognize the efforts of the group and their careful diligence in considering all the options to develop their recommendations contained in the attached report.

If you have any questions or would like for the group to consider further options or alternate recommendations from you, please let us know.

On behalf of the working group,

Handwritten signature of Dwaine B. Duckett in black ink.

Dwaine B. Duckett
Vice President
Systemwide Human Resources

Handwritten signature of Peggy Arrivas in black ink.

Peggy Arrivas
Associate Vice President
Systemwide Controller

UNIVERSITY
OF
CALIFORNIA

RETIREE HEALTH BENEFITS WORKING GROUP

Interim Report

July 3, 2018

2019 Retiree Health Benefits Working Group Appointees:

Dwaine B. Duckett, Co-Chair
Chief Human Resource Officer, Systemwide HR

Shane White, Faculty
Academic Senate Representative

Rick Kronick, Faculty
Campus faculty Representative, UC San Diego

Andrew Bindman, Faculty
Campus faculty Representative, UCSF

Edward Abeyta, Staff
Staff Representative, UC San Diego

Paul Brooks, Represented UC Employees
Union Representative, UC Berkeley

Roger Anderson, Retirees
CUCEA Representative, UC Santa Cruz

Ramona Agrela, Campus Leadership
Chief Human Resources Executive, UC Irvine

Tim Maurice, UC Health
Chief Financial Officer, UC Davis Medical Center

Peggy Arrivas, Co-Chair
Systemwide Controller, UCOP

Robert May, Faculty
Academic Senate Representative

Bob Anderson, Faculty
Campus faculty Representative, UC Berkeley

Lina Layiktez, Staff
CUCSA Representative, UC Davis

Jason Valdry, Staff
Staff Advisor to the Regents, UC Irvine

John Meyer, Retirees
CUCRA Representative, UC Davis

Teresa Costantinidis, Campus Leadership
Vice Chancellor/Chief Financial Officer, UCSF

Sarah Latham, Campus Leadership
Vice Chancellor, UC Santa Cruz

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INTRODUCTION

Health coverage for University of California retirees is one of the most valued benefits provided by the university. Its value resides in its contributions to the material well-being of UC retirees, and in the expectations for post-employment benefits that have played a crucial role in the university's maintenance of a highly qualified and motivated active workforce, inclusive of faculty, staff and service employees. Concern with the long-term sustainability of the retiree health benefit was a focus of the Post-Employment Benefits Task Force convened by President Yudof in 2009, and recently in a report from the Academic Senate ([link](#)). For 2018, the projected overall cost of the premiums for the medical part of the program is \$408 million, of which the UC employer share is 70% (plus an additional \$35 million for dental, covered 100% by UC). The overall cost of retiree health benefits has been rising over time, and will continue to rise in the future because of general medical inflation accompanied by an increase in the number of retirees due to demographic factors. While the impact to employer costs over the last several years has been mitigated as the UC share of medical premiums has been reduced to the 70% floor mandated by the Regents, this floor has now been reached.

In response to continuing concerns about benefit sustainability in the face of projected rising costs and liabilities, President Napolitano formed the Retiree Health Benefits Working Group in January 2018, co-chaired by Associate Vice-President and Controller Arrivas and Vice-President and Chief Human Resource Officer Duckett. After some initial uncertainty, the charge to the Working Group was established as follows:

The 2019 Retiree Health Benefits Working Group (“Working Group”) will explore potential strategies and develop options for UC leaders to consider to ensure the long-term financial viability of the retiree health benefits program. The Working Group will design strategies to effectively manage costs to be able to sustain the benefits and will evaluate the implications of the different options to both UC and retirees.

The Working Group met eight times between January and June 2018. The first meetings, primarily informational, were largely devoted to briefings from UC Human Resources and Deloitte Consulting. These provided information on the University's current retiree health funding model and retiree health plan offerings, projections for future growth in retiree health care costs, and on alternatives in the market place for health plans for Medicare and non-Medicare coordinated retirees. The last two meetings focused on developing principles and strategies for accommodating potential future increases in retiree health care costs.

FINDING AND RECOMENDATIONS

Based on its discussions, the Working Group can make the following finding and recommendations:

Finding: The Working Group finds that the UC Retiree Health program will remain substantially unchanged for 2019.

Recommendation: The Working Group recommends that the University percentage contribution to retiree health premiums for eligible retirees aged 65 and older not coordinated with Medicare be lowered gradually to levels comparable to Medicare coordinated retirees.

Recommendation: The Working Group recommends that the Group continue to meet through 2019 with its present membership in order to address principles and mid to long-term strategies. It further recommends that there be extensive consultation with active employees and retirees during this period.

The Working Group's *finding* is based on a report from UC/HR that the cost increase for the Retiree Health Program for 2019 will be between 2% and 2.5%. This is significantly under the 4% maximum increase cap in place for 2019. The assessment to the campuses will be \$2.70 per \$100 of covered compensation for 2019 (vs. a projected assessment of \$2.95) and will retain UC's floor of 70% per capita contribution to health plan premiums. Consequently, no alterations to plan offerings or plan benefit design is being contemplated for 2019.

The Working Group's first *recommendation* applies to non-Medicare retirees - retirees over 65 who are not coordinated with Medicare. There are approximately 1,600 current retirees in this group, divided between those who elected in 1976 not to coordinate with Social Security and those who are unable to coordinate with Social Security, primarily safety personnel. The premium contribution by UC for this small group of retirees is presently at the active employee pay band 2, which is approximately 85% of premium cost. This is substantially higher than the UC contribution for Medicare retirees. Reducing the UC contribution to 77% will result in an additional on average monthly premium increase of approximately \$60 to retirees (above any annual rate changes). The effect of this change will be to bring premium costs for non-Medicare retirees into accordance with average costs for Medicare retirees on a per dollar basis. While it is recognized that this group has a proportionally high number of retirees with limited incomes who would be negatively impacted by this increase, the Working Group finds that it would be equitable to reduce the percentage UC contribution for over 65 non-Medicare retirees to bring it into alignment with the UC contribution for Medicare retirees. This reduction should be gradually phased in over a period of no less than three years.

The Working Group's second *recommendation* is based on its understanding that fulfilling its charge requires developing, at least in outline, a principled framework for the management of retiree health that insures the long-term viability of a robust, substantive benefit. Due to the complexity of the retiree health program, and in part because of the initial diversity in knowledge of the program among the Working Group's members, discussions of a decisional framework for future planning only commenced in depth during the Group's final meetings. This left insufficient time for the Working Group to come to any conclusive recommendations for strategies for dealing with potential future increases in retiree health care costs. In the Working Group's

estimation, to complete its task in a robust manner satisfying to all stakeholders will take approximately another year and a half.

DISCUSSION

Retiree health costs are driven by several factors including plan type and design, plan experience, and general medical and pharmaceutical inflation. Although health care spending increases have been moderate to low for the past five years, it is incumbent on the university, its retirees and its current employees to plan for the contingency of sharply higher levels of health care inflation in the future. Higher levels of inflation more acutely raise the issue of how year-to-year increased costs are to be absorbed, if they are not to be fully covered by the employer. The differential can be made up by cost-shifting, benefit design limitations or reductions in the rate of growth of payments to UC Medical Centers and Medical Groups for patient care. To the extent that such measures are required in the future, these should adhere to principles that limit retirees' exposure to health or financial risk, while allowing the University to be fiscally prudent without attenuating the viability and robustness of retiree health benefits. In general, UC as the employer should seek to limit cost impact to retirees, while ensuring that any changes in benefits, premiums or out-of-pocket costs do not undermine retiree's access to quality health care, nor disproportionately affect the less healthy or those on limited incomes.

Currently, there are approximately 45,000 UC retirees receiving retiree health benefits, with a total of approximately 62,000 covered lives (retirees, dependents and survivors). Of the UC retirees, 72% are Medicare retirees, 16% are pre-Medicare retirees (under 65), 4% are non-Medicare retirees (over 65) and 8% are Medicare retirees live outside of California. For in-state Medicare retirees, UC offers a choice of two Medicare Supplement plans (High Option, Medicare PPO) and two Medicare Advantage plans (Health Net, Kaiser). Pre-Medicare and non-Medicare retirees plan options are the same as for active UC employees, inclusive of UC Care, Health Net Blue & Gold and Kaiser. Out-of-state Medicare retirees purchase individual plans through the Via Benefits medical plan exchange. UC contributes on aggregate 70% of premiums for in-state Medicare and pre-Medicare retirees; for non-Medicare retirees the UC contribution level is tied to active employees' pay band 2 (approximately 85%). For out-of-state retirees, UC funds up to \$3000 in an HRA account for premium costs, with any overage paid by the retiree. The estimated total 2018 cost for retiree health benefits (medical and dental) is \$443 million, divided between UC (\$327 million) and retiree (\$116 million) contributions.

In this context, the Working Group's discussions centered around two themes: Savings that could be generated from plan choice or plan design, and savings that could be generated from contribution strategies as applied to the segments of the retiree population. Presentations from Deloitte and UC/HR presupposed that UC's contribution to retiree health premiums would maintain their current 70% floor; that UC's year-over-year contribution to retiree health premiums would be fixed at 4%; and that year-over-year UC retiree medical inflation would be

7%. (Of these, the Working Group would embrace the first, but believes that the latter two warrant further critical evaluation.)

Plan Choice and Design: The Working Group was presented with a range of variations from the status quo that would impact non-Medicare and Medicare retirees.

For pre- and non-Medicare retirees, who have the same health plan choices as active employees, the strategy presented would be to shift retirees from UC Care, the most expensive plan, into the less expensive plans currently offered, among them Blue & Gold, Kaiser and high deductible plans (HRA/HSA plans). The potential savings appeared to be relatively modest, and the Working Group is making no recommendation regarding these changes at this time.

For Medicare retirees, the Working Group was presented with strategies for moving retirees from Medicare Supplement plans (High Option, Medicare PPO) to Medicare Advantage plans (Health Net and Kaiser Medicare Advantage plans), or to a Medicare Advantage PPO (not currently offered by UC). The savings impact of these changes in offerings range from \$200,000 to \$12 million, with the larger amounts generated by replacing current plans with a Medicare Advantage PPO.

In the Working Group's view, the potential savings generated by these changes are relatively small, and in conjunction with the disruptions that would be caused, are not sufficient to argue for limiting the choices available to retirees by eliminating more expensive plans (High Option, UC Care). Accordingly, at this time the Working Group is taking these options as presented for informational purposes only and is *not* recommending the adoption of any of these alternatives to the current plan structure.

Willis Towers Watson's Via Benefits made a presentation to the Working Group on extending the Medicare Exchange that they currently provide for out-of-state UC retirees to in-state retirees. On this plan, retirees receive \$3,000 in an HRA account that they can use to pay for premiums for an individual Medicare Supplement or Medicare Advantage plan brokered by the Exchange; this is sufficient to cover premiums of approximately 90% of out-of-state retirees. Unlike other alternatives presented to the Working Group, the Exchange has by far the most significant potential cost savings for the University, in the range of \$50 million. It appears that this saving arises to an extent from a reduction in the benefits provided rather than from greater efficiency in the provision of benefits, and that the available plans favor relatively healthy individuals over those with complex medical needs. Replacing UC's current plans with the Exchange attained no favor from the Working Group aside from one member. Problems that were noted were instability in management, the potential in certain cases for extremely large out-of-pocket expenses for pharmacy, and very high levels of dissatisfaction reported in letters received by the Working Group from out-of-state retirees currently using the exchange.

Contribution Strategies: Aside from strategies to incentivize retirees to enroll in lower cost plans, the Working Group considered changing the premium for the dental benefit from being fully paid by UC to the premium being shared between the university and retirees. Premiums were

modeled at 10%, 20% and 30% levels to retirees; this translates into approximately a \$4.50 monthly premium for single coverage at the 10% level (and double/triple multiples at the higher levels). At this level, savings of approximately \$3.8 million would be realized.

The Working Group is very concerned that any future cost shifts from the university to retirees not invite behavior that could affect individuals' overall health or financial well-being. The Working Group is particularly sensitive in this regard for retirees on limited incomes. Relative to this principle, the Working Group felt that the premium levels envisaged for dental benefits is acceptable if needed to maintain the financial stability of the retiree health program. It is recognized however that adding costs has the potential to cause retirees to opt-out of dental coverage, especially if the premium were ramped up to higher levels. This could lead to worse health outcomes if dental care is eschewed.

70% Contribution Floor: In their December 2010 meeting, the Regents approved as part of their revisions to employee post-employment benefits the following policy on retiree health:

The University's aggregate annual contribution to the Retiree Health Program be lowered, over time, to a floor of 70 percent.

This action was based on the recommendations of the Post-Employment Benefits Task Force convened by President Yudof in 2009.

To date, the Regents' action has been interpreted to mean that the 70% floor applied solely to the medical benefit. It appears to the Working Group that it is compatible with the Regents' action item that the value of other retiree health benefits could be included in calculating the 70% level. If the cost of dental benefits is added to that of medical benefits, then currently the university's contribution to the overall retiree health program would be at approximately 73%.

Under this interpretation, the possibility was discussed of leaving the premium level of the dental benefits unchanged (i.e. no premium cost to retirees) but adding a 1% addition to medical benefits paid by retirees, and hence lowering the university's contribution by approximately 1%. The additional dollar amount paid in premiums by retirees would be the same as if retirees paid a 10% dental premium. (Similarly, a 2% addition would have an equivalent yield to a 20% dental premium, etc.) The advantage of this approach is that the additional medical premium paid by retirees is much smaller on a percentage basis than the dental premium, and it avoids the possible incentive for opting-out of the dental benefit. On the negative side, it abrogates at least in spirit the university's commitment to the 70% floor, which as noted has been understood to this point to apply solely to the medical benefit. If calculated against the medical benefit, the university's contribution would drop below the floor.

It is the Working Group's opinion that either a dental benefit premium or calculating the 70% floor against total retiree health care costs could be entertained as a first option *in the event that cost-shifting became necessary to maintain the financial viability of the retiree health program.*

Although it was unable to explore this option in any detail, the Working Group recognizes that additional headroom against reaching the 70% floor could be attained if the implicit subsidy of non-Medicare retirees' medical and dental care premiums is also included in calculating the floor. The subsidy, approximately \$100 million, arises from non-Medicare retirees' premiums being calculated by being aggregated with active employees with whom they share health plans. (The greater health care costs of retirees vs. active employees drives up the overall costs of the plans.)

FUTURE CONSIDERATIONS

The main recommendation of the Working Group is that it continue the work it has been doing towards fulfilling its goal of presenting a principle-based framework for addressing the maintenance of a robust retiree health benefit. This work is framed by the following question:

Do future projections call for substantial changes in retiree health plans or in the financial burden borne by retirees, or do they call for careful management of the existing benefit structure in the context of the University's overall contribution to retiree benefits

In this context, some of the specific issues that the Working Group has begun to discuss and intends to address at greater depth are the following:

- Evaluate assumptions regarding projections for medical inflation and UC contributions, especially in the context of the University's long-term overall contributions to retiree benefits (inclusive of pension benefits) as discussed in the Academic Senate's October 2017 report on retiree health ([link](#)).
- Establish principles for introducing plan design changes and/or cost sharing to the extent that these become essential for the maintenance of the benefit, including consideration of whether retiree contributions should be adjusted based on individual financial circumstances.
- Establish flexible guidelines for setting UC's increased contributions to retiree health benefits that do not lock the University into a fixed year-over-year percentage.
- Explore establishing as soon as possible reserves during years of low medical inflation that can be used to smooth premium increases or plan benefit roll backs when medical inflation rates are greater than the university employer contribution.
- Explore pre-funding retiree health benefits as an alternative to the current pay-as-you-go funding basis, and making retiree health a vested benefit.
- Re-examine health benefits for out-of-state retirees in light of the skepticism discussed above of the Via Benefits Medicare exchange.
- Consider effects of including the implicit subsidy of non-Medicare retirees' premium costs as part of the Retiree Health Program subject to the 70% floor.

- Establish principled guidelines for sharing cost uncertainty among UC as employer, the UC Medical Centers and Medical Groups as primary providers of health care to UC retirees, and UC retirees as the beneficiaries.