Report of the Committee on Compensation

Health Insurance Programs

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Executive Summary:

Recommendations for 2007-08:

1. To retain Great West Healthcare as the College provider.
2. To raise the stop-loss insurance liability limit from $100,000 to $150,000. This makes CC liable for claims up to $150,000 for an individual and reduces the premium.
3. To eliminate aggregate stop-loss insurance coverage. The current policy covers losses that go beyond 125% of expected claims. Eliminating the premium and saves the insurance plan $40,093 in addition to the reduction of premium achieved by recommendation #2.
4. To switch to Plan H offered by EyeMed Vision Care from Superior Vision
5. To increase the co-payment for mail-order co-pay for mail-order drugs to 2.5 times the co-pay for retail drugs. Mail orders are typically for three-month supplies, retail purchases for a single month.
6. To make no substantive changes in either the Point of Service (POS) or Preferred Provider Organization (PPO) insurance plans.
7. To raise both college and employee premiums 3% for the POS plan and 14.3% for the PPO. Our consultant estimates that only a 1% increase would be necessary for the POS, while the PPO plan is likely to increase 20% in cost. The 3-14.3 allocation represents a compromise that gives some relief to those on the less expensive POS plan and requires somewhat greater contributions from those on the more expensive, PPO plan.
8. To postpone what we regard as necessary adjustments in premium rates among tiers of coverage until next year. Employees who subscribe to single coverage are currently subsidizing employees with dependent coverage, and the employee-employer division of premium burdens currently varies from one type of coverage to another, without any clear rationale.
9. To urge, once again, that the college contribution to TIAA-CREF be increased by .3% in pursuit of a policy to bring the college share from 9.0 to 10%.

* * *

Our current policies have developed incrementally. They represent a long series of decisions, each undoubtedly rational at the time, each doubtless sanctioned by committee discussion as well as administrative action. One therefore approaches a complicated set of policies with great caution and some sense of satisfaction, because the choices before us are not dramatic. Self-funding has helped Colorado College keep the increasing cost of health care under control in the last three years. Our system appears to be working to the satisfaction of most employees.

Tom Nycum, vice president for Business and Finance, came to an eleventh-hour meeting and informed us that President Celeste had declared last fall that the structure of medical insurance would not change this year, although rates would be adjusted. The president was apparently responding to complaints about recent changes in college policy affecting employee compensation (parking, Emeriti, ER/PR, etc.) The Nycum intervention caused us to set aside an effort to rationalize the structure of premiums and caused the Committee to question its role in college governance. We might have decided on our own to back off for this year but did not get a chance to reach an independent judgment. The episode sparked some sharp expressions of frustration at the time and effort spent on futile deliberations.

If we had known earlier in the spring that a restructuring of premiums would not be acceptable, members of the committee, the department of Human Resources, and Gallagher Benefits would have been spared many hours of work. In the hope that the extra labor will ultimately prove useful in preparing a path toward reform next year, we present some of our findings as a part of recommendation #8.

Recommendation #1:

Gallagher Benefit Services, our new consultant on medical insurance, believes that Great West is a satisfactory provider. They deal with Great West on behalf of other clients and have no reason to suggest a change. We are not aware of major problems with Great West.

Recommendations #2 and #3:

The committee endorses the Gallagher recommendations, already confirmed by the administration, to raise the stop-loss liability limit and to eliminate aggregate stop-loss insurance. The college, already engaged in self-funding, believes it now has sufficient reserves to cover a greater portion of potential losses. These changes save money and bring down the cost of medical insurance for everyone.

Recommendation #4:

We endorse the Gallagher suggestion that we switch vision plans. Human Resources identified a plan offered by EyeMed Vision Care (Plan H) that appears superior to our current plan at lower cost to participants. The plan guarantees rates over a four-year period. The vision program is voluntary.

The dental plan seems utterly in balance. There was no need to re-evaluate it.

Recommendation #5:

While our overall increase in medical costs remains relatively reasonable by recent standards, the cost of prescriptions has increased rapidly. Prescriptions currently represent a fourth of all medical claims. For the last six months, medical insurance (POS and PPO) paid a total of $613,421 in claims for the six months ending January 1, 2007. Employees paid an additional $161,248 in co-pays or about 21% of the total cost of these prescriptions. Thirty one prescriptions (out of 8,314) amounted to payment of $99,575, or roughly one-sixth of the total paid out by insurance.

Our current plan sets co-pays for prescriptions as follows:

Retail		**Mail Order**	
Generic	$10	Generic	$20
Preferred	$25	Preferred	$50
Non-Preferred	$50	Non-preferred	$100

Gallagher recommended that we introduce a co-insurance (20% with caps) on each of those tiers and that we create a fourth tier for specialty drugs. (Preferred drugs are those listed as "preferred"

brands on the Great-West list.) The idea was to increase incentives for consumers (and physicians) to consider relative cost in making decisions.

The committee considered creating a fourth tier with an out-of-pocket maximum for drugs, but backed off from making that recommendation now. It was uncertain about the definition of a fourth tier and uncertain that co-insurance would have a significant effect on choices. Gallagher said its recommendations were not likely to make a significant difference in the short-term but would help keep down drug costs in the long run. Other institutions seem to be moving in this direction. Next year's committee may want to revisit this issue.

The committee decided to reduce the incentive to use mail-order drugs, which are not necessarily cheaper, by increasing the co-pay to 2.5 times that of retail drugs. Mail orders are typically for a three-months supply. Retail sales are limited to a one-month supply. We recommend that co-pays for mail order drugs be increased to $25, $62.50 and $125 respectively for generic, preferred, and non-preferred drugs. Each mail-order co-payment is 2.5 times the retail co-pay.

Recommendation #6:

Gallagher did not recommend, and the committee did not consider, any fundamental reformulation of our insurance plans this year. We did not consider changing coverages, deductibles, conditions, or any other fundamental aspect of either the POS or the PPO plan. Barbara Wilson, aware of the President's desire for no big changes this year, asked that Gallagher proceed on that basis, even though she believes the PPO plan should be redesigned to make it richer than and more differentiated from the POS plan. It might be useful to ask Gallagher to propose a Health Savings Account/High Deductible option next year or in the near future.

Gallagher offered several comparisons of coverage with other institutions, principally public educational institutions in the state of Colorado. Such comparisons are extraordinarily difficult, but nothing suggests our plan is either uniformly richer or poorer than others.

Our plan paid 84% of all claims in the six month period ending January 1 (86% for medical claims and 79% for prescriptions). Employees paid the other 16% in co-pays, deductibles, and coinsurance. Gallagher indicated that our percentage falls within the normal range of 15 to 20%. In addition, employees pay about 22% of all premiums, on average. (See Table 3.)

Recommendation #7:

In their report dated March 8, 2007, Gallagher initially calculated that we needed to raise premiums 9.4% (4.7% for the POS plan and 23.5% for the PPO plan), based on claims of filed in the sixth month period ending January 1. After changes in the stop-loss insurance coverage carried by the college, and a renegotiation of fees with Great West, Gallagher reduced its estimate to 5.8% (1% for the POS and 20.3% for the PPO plan.) The POS plan currently enrolls 498 employees; 141 participate in the PPO plan, which permits the use "out of network" physicians and hospitals. Employees who need flexibility, need to work outside Colorado Springs, and want access to physicians and institutions not included in the POS plan use the PPO. Barbara Wilson distributed data that showed 78% of those on the POS plan have salaries less than $60,000; 55% of those on the PPO plan earn more than $60,000.

The pattern of high medical claims under the PPO plan is not new. The committee has traditionally sought to keep the PPO plan alive by keeping premiums within reason, because some employees have virtually no choice but to use this plan. But the committee has also sought to recommend premium increases that are somewhat proportional to the cost of the two plans. Only three times in the last ten years have the increases for the POS and the PPO been identical. (5.7% in 2205-06, 27% in 2001-02 (!!!), and -12.85% in 1998-99).

Given the great discrepancy in performance between the two plans this year, the committee recommends increases of 3% for the POS and 14.3% for the PPO. We want to keep the increase for the POS under 4%, which we are told may be the average staff raise this year.

The rate structure we recommend is as follows:

Table 1

Recommended Changes in Monthly Premiums for Employees

Employee Premiums				
POS	**Current**	**New**	**Difference**	**% change**
EE	$79.23	$81.60	$2.37	3.0%
EE + Spouse	$167.26	$172.28	$5.02	3.0%
EE + Child(ren)	$141.62	$145.87	$4.25	3.0%
EE + Family	$228.89	$235.75	$6.86	3.0%
PPO				
EE	$104.76	$119.74	$14.98	14.3%
EE + Spouse	$216.34	$247.29	$30.95	14.3%
EE + Child(ren)	$185.37	$211.88	$26.51	14.3%
EE + Family	$314.26	$359.22	$44.96	14.3%

Recommendation #8:

The committee decided to postpone any effort to bring our premium structure into line with national norms. for three reasons:

1) We learned that the Vice President for Business and Finance would regard such a process of adjustment as a violation of the President's promise not to make changes this year. We decided it was unwise to pursue the option further.

2) We developed one model for adjustment that called for the college to increase its contribution to medical insurance by more than 7% in order to soften the increased burden on families and employees with children. We were told that such an increase in the college contribution to health insurance would jeopardize the chances for an increase in the college contribution to TIAA-CREF. **(See recommendation #9)**. That additional contribution has been a priority of the AAUP and of this committee for several years.

3) Many, but not all employees, would gain from the adjustments. We ran out of time in this academic year to explain the rationale for adjustments and win broad acceptance.. This fact alone might have caused us to postpone normalization.

Split as it was on the question of normalization for this year, **the committee nonetheless believes that the tiers of medical insurance coverage should be adjusted in the near future**. There was surely a rationale for the current rate structure, when it was adopted four years ago, apparently at the moment the college moved to self-funding of the health insurance program, but the rationale is no longer apparent.

Until 2004-05, our total premiums (paid jointly by employees and the College)matched the demographic standard of cost for employees and dependents.. That is, family medical costs are, on the average, 2.85 times as great of those of a single employee. Costs of an employee covered with a spouse are 2.05 times those of the employee alone. Until 2004-05 the college ratios (there were only three tiers in that period) closely approximated these normal tier ratios. See the table below. If the ratios were currently normal, the total premiums paid by employee and college together would have been lower for the employee-only tier and the employee -plus-children tiers, higher in the others.

Table 2
Normalizing Total Premiums (Employer plus Employee)

	Tier Ratios 1996-97 to 2003-04	Tier Ratios 2006-07	Normal Tier Ratios	Total Premiums 2006-07	Normalized Premiums 2006-07	Difference
HMO						
EE only	1.00	1.00	1.00	$440.16	$358.50	-$81.66
EE +1	2.11	1.65	2.05	$727.23	$734.93	$7.70
EE+ childe	0.00	1.61	1.85	$708.09	$663.23	-$44.86
Family	2.76	2.00	2.85	$880.33	$1,021.73	$141.40
PPO						
EE only	1.00	1.00	1.00	$523.77	$429.54	-$94.23
EE +1	2.11	1.65	2.05	$865.36	$880.56	$15.20
EE+ childe	0.00	1.61	1.85	$842.59	$794.65	-$47.94
Family	2.76	2.00	2.85	$1,047.54	$1,224.19	$176.65

The tier ratios are only a part of the story. Once a total premium is established, someone must decide how that premium should be split between the employee and the college. We (the college community) have been doing that on the basis of what is called a "total cost" method. The percentages currently in use are in the first column of the following table. Those percentage make it appear that employees with family coverage are bearing 26% and 30% of the burden for the POS and PPO plans respectively. But when the employee premium is compared with the normalized total premium, the share of families is 22.4% for the POS and 25.7% for the PPO. There is relative equality among these shares, which was perhaps the rationale for the structure we now have, even though the percentages applied to total premiums are anything but equal. (See Table 3 .)

Gallagher suggests we move toward an "incremental" method of calculating premiums. This method distinguishes between the premium paid for employee-only coverage and the

additional premium paid for any kind of dependent coverage. Thus, the employee-only rate is the base. The other three tiers of premiums contain two components: the employee-only component and the dependent component. The employee share of dependent coverage can be the same or different from that of dependent coverage. By this measure, employees with family coverage are currently paying 34% of dependent coverage under the POS plan and 40% under the PPO. By this measure, our current plan favors the employee-plus-children category. Bear in mind that the base rate for employee-only coverage is 18% for the POS and 20% for the PPO. All employees benefit by that rate but then pay a higher rate for dependent coverage. What appears relatively equal by one measure turns out unequal by another.

Table 3
Total Cost and Incremental Methods of Calculating Premiums

	EE share of total cost	Total Premium 2006-07	Current EE Premium	Normalized Premiums 2006-07	Current EE Premium % of Normal Premium	2006-07 EE % of Dependent Coverage	One Incremental Model	Normalized Premium	Employee Premium Based on Model	Difference from 2006-07
HMO								Plus 3%		
EE only	18.0%	$440.16	$79.23	$358.50	22.1%		20%	$369.26	$73.85	-$5.38
EE +1	23.0%	$727.23	$167.26	$734.93	22.8%	30.7%	26%	$756.98	$174.66	$7.40
EE+ childe	20.0%	$708.09	$141.62	$663.23	21.4%	23.3%	26%	$683.13	$155.46	$13.84
Family	26.0%	$880.33	$228.89	$1,021.73	22.4%	34.0%	26%	$1,052.38	$251.46	$22.57
PPO								Plus 13%		
EE only	20.0%	$523.77	$104.76	$429.54	24.4%		20%	$87.37	$97.08	-$7.68
EE +1	25.0%	$865.36	$216.34	$880.56	24.6%	32.7%	26%	$219.88	$229.59	$13.25
EE+ childe	22.0%	$842.59	$185.37	$794.65	23.3%	25.3%	26%	$194.64	$204.35	$18.98
Family	30.0%	$1,047.54	$314.26	$1,224.19	25.7%	40.0%	26%	$320.84	$330.54	$16.28

We recommend a shift to working from 1) total premiums that reflect "normal" ratios and 2) using the "incremental method" of determining premiums, using a base rate for employee-only coverage and another rate or rates for dependent coverage. We illustrate with one possible model for moving toward normalization, based on an employee-only rate of 20% and a rate for all dependent coverage of 26%. Compare the resulting premiums with those we are recommending above. Our recommendation (#6) assumes that both employer and employee an additional 5.8% to the premium pool. Our illustrative model (Table 3) assumes an increase in the college premium of 6.2% and an increase of total employee premiums of 4.1%. The extra college contribution would soften the transition and the extra burden on some tiers while permitted the employee-only tier to enjoy some relief. This is only one of at least a dozen and perhaps two dozen models we considered for moving toward normalization.

Here is an illustration of how a premium is calculated by this method. Suppose the total employee-only is $100 and the total family premium is $285. (Note that these totals reflect the normal ratio.) The dependent portion of the premium is 285-100 or $185. If then, as in the example above, the employee pays 20% of the employee-only premium and 26% of the dependent premium, the total employee share for family coverage would be (.20*100)+ (.26*185) or $20+$48=$68. The employer share is 285-68= $217.

We recommend that next year's committee consider this issue early in the year, well before decisions must be made , and consider moving toward a normalized model. Normalization would not solve the question of equity but it would help us approach the equity question with greater clarity. It would help us move toward the development of a rationale for our policy.[1]

Recommendation #9

The idea of increasing the college contribution to retirement originated with the AAUP several years ago. To make another move toward the goal of 10% would be particularly significant in a year when staff salary increases may not surpass our measure of past inflation. We backed away from a plan to normalize the premium tiers in part because we were told that keeping the increase in college contributions to medical insurance as low as possible would enhance the chances to move from a retirement contribution of 9.0% to 9.3%. This change would be beneficial for all employees in future years. It is thus more valuable and more important than the adjustments of premiums we were considering, but as we engaged in the long and complicated discussions summarized under Recommendation #8, we did not understand that the rate of contribution to TIAA-CREF might ride upon our decision. **This is our most important recommendation**.

Respectfully submitted,

Robert Lee
for the committee

[1] Don Heilman, area Vice President for Gallagher Benefit Services writes:
"We believe that it is important not only to receive enough revenue to fully support the overall costs of the underlying plan but to allocate those costs in a manner that reasonably reflects the costs of each enrollment tier. . . .The rates currently in place. . . reasonably reflect the overall costs. However, . . . based on statistical norms, the rate for single coverage is inflated, while the dependent tiers are understated. As such, this effectively results in single enrollees subsidizing the costs of dependents. What we have provided is what we view as reasonable rates that accomplish both of the above objectives: support the overall costs while using funding rates that reasonably reflect the underlying value of each enrollment tier. . . . In making you aware of the appropriate allocation of costs, [we want to help] you to arrive at a more informed, conscious decision as to your philosophy relative to cost sharing between Colorado College and employees in general, as well as by tier."