The University of Oklahoma

Contribution Strategy and Health Insurance Options Committee

Final Report

September 6, 2007

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Executive Summary

Health insurance benefits are a key component of the total compensation package needed to attract and retain the diverse workforce the University requires. Over the last five years, The University of Oklahoma (OU) and its employees have experienced significant increases in the cost of medical insurance coverage, coupled with some reductions in the level of benefits. The cost of individual medical premiums has doubled since 2001, and the cost of family coverage has increased by 177%. The large increases in cost for family coverage have contributed to a 60% decline in the number of employees electing to cover spouses or families in the OU-sponsored medical benefit plans.

At the recommendation of the University's Employment Benefits Committee (EBC), President David Boren appointed a committee to explore alternatives to stabilize the University's healthcare costs and continue to provide competitive and quality healthcare benefits. The Contributions Strategy and Health Insurance Options Committee appointed by the President included 16 experienced faculty and staff members. The appointments were made to include specific expertise in healthcare, public health, and university finances. The Committee's charge was to review and analyze the following issues: OU's healthcare plan options and benefit levels, funding and contribution strategies, competitive position, and the possible effects employee wellness programs and incentives might have on current healthcare trends. The Committee was also charged with recommending changes that best meet the needs of active employees, retirees, and the University.

The Committee met frequently from April through August to acquire and analyze information about the OU healthcare options and participants and learn about practices at peer institutions and local employers. The Committee was assisted by consultants from the Segal/Sibson benefits consulting firm.

After significant analysis and debate, the Committee concluded OU's current practice of paying 100% of the cost of employee-only coverage, while contributing nothing toward dependent coverage, is not a competitive practice. The current contribution strategy has resulted in OU premiums for employees covering a spouse or family being almost double the premiums charged by peer organizations and local employers with whom it competes for talent.

The data clearly establishes OU's current contribution strategy places the University at a disadvantage in attracting and retaining employees who need dependent healthcare coverage. Identifying alternative contribution strategies that provide affordable, high-quality healthcare options for all employees led the Committee to consider many different approaches. The Committee determined any recommended contribution strategy must satisfy "guiding principles" that included ensuring healthcare premiums were affordable for all segments of the diverse university community and would not place a hardship on lower-paid employees.

The Committee determined additional University contributions in 2008 and in the future are needed to provide more affordable health insurance premiums for employees and their dependents and to ensure the University offers a competitive level of benefits. The Committee also concluded significant progress in lowering dependent contributions would also require the introduction of contributions by most employees toward the cost of their employee-only coverage. The contribution strategy recommended by the Committee would require some reasonable level of employee contributions toward employee-only coverage for most employees. Employees with family incomes at or less than 200% of the federal poverty level would be eligible for no-cost individual coverage and reduced premiums for dependent coverage. Other employees would be subject to premium contributions based on OU compensation, with higher paid employees subject to larger premiums. The proposed contribution strategy would establish employee premiums based on compensation tiers. Four compensation tiers are proposed: employees with compensation above $60,000/year (top quartile), employees with compensation between $42,000 to $59,999/year (third quartile), employees with compensation under $42,000/year (below median university salary), and employees with family income at or less than 200% of the federal poverty level.

The Committee recognizes the recommended change in contribution strategy for active employees represents a major shift from the approach in place at OU for many years. However, the current strategy is no longer competitive and cannot be sustained.

Following is a summary of the Committees' recommendations. The background and analysis that support the recommendations is included in the subsequent report.

Summary of Recommendations

1. The Committee recommends the University issue a Request for Proposal (RFP) every 3 to 4 years to identify the healthcare vendors providing the best value for plan participants and the University. The recommended cycle would enable OU to develop an ongoing partnership and credible experience with the chosen vendor(s), while ensuring competitive pricing and services and minimizing disruption for plan participants. In keeping with this recommendation, the University should issue an RFP in time to allow evaluation of potential health insurance providers for coverage beginning January 1, 2009.

2. The Committee recommends OU continue to seek the best possible health insurance options as an independent purchaser. As one of the two largest higher education institutions in the state, OU gains no significant leverage through joining a higher education coalition to purchase health

insurance. The limited potential benefits of such a coalition are outweighed by the restrictions such an arrangement would impose.

3. The Committee recommends the University develop and adequately fund health and wellness initiatives aimed at encouraging healthier lifestyles and behaviors of plan participants. Initially, medical plan benefits should be expanded to provide smoking cessation benefits that include nicotine replacement therapy and behavioral modification. Additional focus should be placed on weight loss and walking programs and health risk assessments, with incentives designed to encourage participation.

4. The Committee recommends the University implement a premium contribution strategy that offers employees with dependents more affordable healthcare options, and at the same time, introduces moderate employee contributions toward the cost of their individual coverage. A four-tier, compensation-based contribution structure is proposed. Three of the tiers will be based on OU compensation only, while the fourth tier will allow low-income employees to qualify for the lowest premiums based on family size and family income. Included in the recommended 2008 premium structure is additional University funding for healthcare benefits, and the Committee urges continued higher level of University funding needed to sustain healthcare benefits at a competitive level.

5. The Committee recommends for the plan year starting in January 2008 the elimination of the High Option HMO and limited plan design changes to the Aetna HealthFund, Open Access PPO, and the Low Option HMO.

6. The Committee recommends employees hired on or after January 1, 2008, have a reduced or unsubsidized retiree medical benefit and not be eligible for the current retiree medical benefit program. The retiree medical benefit and contribution structure for current retirees should remain unchanged at this time. Active employees currently eligible to retire should also be eligible to participate in the same retiree medical benefit and contribution structure as current retirees upon their retirement from the University. For other employees, the Committee recommends service-based employer contributions toward the cost of future retiree medical coverage be investigated.

7. Because of the significant and growing costs associated with the University's post-retirement benefit obligation and the complexity of the analysis of funding requirements and options, the Committee further recommends it continue its work to conduct a further study of these issues.

OU Contribution Strategy and Health Insurance Options Committee

Background

The University, like virtually all employers in the public and private sectors across the country, is faced with managing the effects of staggering employee healthcare cost increases. Since 2001, premiums for employee-only medical coverage have more than doubled, increasing the University's average cost per covered employee from $2,040 in 2001 to $4,236 in 2007. Premiums for employee and dependent coverage have increased substantially as well, rising from an average cost of $3,360 per year in 2001 to $9,336 per year in 2007.

During this time, the University has paid the full cost for employee-only coverage premiums, meaning, those enrolled in employee-only medical coverage are not required to make a contribution toward their medical benefit premiums from their regular paychecks. Employees who elect the University's family coverage must pay the full premium to enroll their dependents. Because of the high costs to enroll dependents in the University's health insurance plans, many employees chose to seek coverage elsewhere, or in some cases, go without coverage for their dependents.

Employees' out-of-pocket costs for medical benefits also have increased. Plan deductibles and the share of costs participants are required to pay at the point of care (e.g., co-payments for doctor's office visits and prescription drugs) have risen steadily over the past few years. These increases have affected employees in different ways – healthy employees who use plan benefits infrequently may not have experienced a significant increase in their expenses. However, those who are more frequent users of plan benefits due to illness, a chronic health condition, or a health "event" such as surgery, have felt the effects of higher out-of-pocket expense requirements.

The low participation rate within the family coverage tier has had an adverse selection impact on the University's health plan, meaning that because of the high premium cost, only those families who have more costly medical expenses tend to enroll in the plan. An increase in family enrollees, which is one of the objectives of the Committee's recommendation, could result in a healthier mix of participants with the addition of more dependent children, thus lowering the average cost per member.

Additionally, the high cost of dependent medical coverage is becoming an increasing barrier to the attraction of new employees who desire to obtain medical insurance coverage for their dependents.

Committee Charge

In response to the University's critical challenge to ensure employees have access to affordable, quality healthcare, President Boren announced in April the appointment of the OU Contribution Strategy and Health Insurance Options Committee, made up of experienced faculty and staff. The Committee was charged with:

- developing a fundamental understanding of the factors that are driving these healthcare cost increases;
- conducting a comprehensive review of the University's healthcare plans and alternative healthcare strategies; and
- recommending changes that best meet the needs of active employees, retirees, and the University.

Committee Deliberations and Process

The Committee began its deliberations in April 2007 and met every two to three weeks through August 2007. The Committee was assisted by consultants from Segal/Sibson consulting and HR staff in gathering and analyzing data and modeling aspects of alternative plan design and contribution strategies considered. The Committee met with representatives of Aetna and discussed Aetna services, health management initiatives and OU employee plan utilization. The Committee requested and received information from the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) about immediate and short-term benefit and administrative changes planned by that agency. Between meetings, members worked individually to gather information and perspectives through literature review and discussions with other employees, and they considered feedback submitted through the HealthOptions website.

The Committee sent a letter to all benefits-eligible employees announcing the appointment, charge, and membership of the Committee. In addition, the Committee established a website to provide updates on its progress. Faculty and staff were invited to submit comments, suggestions, and questions to the Committee through an email address that was established. Approximately 245 emails were received through August 31, 2007, and after identifying information was removed, all of these emails were submitted to and reviewed by each Committee member.

At its initial meeting, the Committee agreed it would focus on the review of issues that must be addressed expeditiously by the University. A separate review of healthcare policy issues and innovative strategies that may be effective in the future will be conducted. Dr. Gary Raskob and Dr. Robert Dauffenbach were asked to develop a proposal for the future study after the completion of the Committee's initial review.

Issues to be Reviewed

The Committee agreed to address the following questions within the scope of its initial review:

1. How do OU employee and family health insurance coverage options and other benefit programs compare with the programs of similar major universities?

2. Is OU's current health insurance program creating disadvantages in attracting and retaining faculty and staff, particularly those who have dependents requiring health insurance coverage?

3. How should OU approach the task of obtaining a third-party administrator (such as Aetna, HealthChoice, etc.) for its health insurance program? How frequently should OU submit an RFP to the market for bid?

4. Can OU realize savings in its health insurance program by joining in purchasing coalitions with other Oklahoma higher education institutions?

5. Should healthy behavior by plan participants and personal accountability be encouraged through incentives in the insurance premium structure?

6. What contribution model(s) should be used to determine premium contributions from the University, from employees, and by employees for their dependents?

7. Based upon comparisons to other major universities, should OU change age or service requirements to qualify for retiree medical coverage in the future?

Guiding Principles

Before beginning the development of its recommendations, the Committee felt all recommendations and discussion should be measured against the following "guiding principles" that were developed after significant discussion over two meetings:

- OU wants to be socially responsible with its contribution strategy.
- OU wants to address the root-cause drivers of healthcare costs by providing appropriate support to facilitate healthier behaviors.
- In OU's efforts to attract and retain its required talent and achieve appropriate employee diversity, its benefit programs need to be affordable to all segments of OU's population.
- Retiree health benefits need to be tied more closely to a total reward strategy and be more reflective of the years of service provided to OU.

- The health plan should be affordable to all benefits-eligible employees, without creating a hardship for the lower-paid employees.
- Benefits should provide reasonably comprehensive security for OU's employees.

Committee Analysis, Findings, and Recommendations

Question: How do OU employee and family health insurance coverage options and other benefit programs compare with the programs of similar major universities?

Committee Response: The Committee engaged Segal/Sibson to conduct a comparison of OU benefit plans with the plans of 14 peer higher education institutions and 5 local employers. This review was needed to establish how OU's benefit plan options, costs, and contribution strategies compared with those offered by organizations we might compete with for employee talent. In addition, this information would help establish whether the current benefit options and employee/employer contributions might present some barriers to attracting and retaining the talent needed in the future.

The comparator higher education peer institutions were selected by the Committee because of their similarity to OU in either geography, mission, or breadth of academic and medical programs offered. The local employers selected represent major employers in Norman and Oklahoma City. While the comparator group selected does not represent the entire universe of organizations with which we compete for talent, the Committee felt the results of a comparison with this group would be a strong reflection of OU's competitive position. The comparator group used in this benchmarking study included: University of Alabama – Birmingham, University of Arkansas, University of Colorado, University of Illinois, Iowa State University, University of Iowa, University of Kansas, University of Missouri, University of Nebraska, The Ohio State University, Oklahoma State University, Texas A & M University, University of Texas, Chickasaw Nation, Integris Health, York International, Dell Computer, and State of Oklahoma. The type of information gathered in the benchmarking study is identified in Appendix F.

Key findings from the comparison are summarized below:

- OU's medical benefit options (HMO, PPO, and CDHP) offered are commonly offered by the comparator group.
- OU medical benefits are competitive with other organizations surveyed.
- OU appears to be contributing as much in total toward employee medical coverage as other peer institutions, but the allocation between spending on employee and dependent coverage is significantly different than the peer group.
- OU is unique among the surveyed group in providing free employee-only medical, dental, and retiree medical insurance coverage.

- 8 of 14 peer institutions require employee premium contributions for every medical coverage option offered; of the 6 peer institutions that offer free single coverage, the free plan is generally the lowest priced option.
- Among the comparison group, only OU and OSU provide no contribution toward the cost of dependent coverage.
- The average employee contribution for PPO coverage reported by the peer group is $68/month; OU does not currently require an employee contribution.
- The average employee contribution for PPO family coverage reported by the peer group was $380/month; OU currently requires a $778/month employee contribution for family coverage.

Question: Is OU's current health insurance program creating disadvantages in attracting and retaining faculty and staff, particularly those who have dependents requiring health insurance coverage?

The benchmarking study confirmed OU's current contribution strategy has resulted in the cost of spouse and family coverage being significantly higher than peer institutions and many local employers. There were many examples provided to the Committee by faculty and staff hiring managers that indicate the high cost for spouse or family coverage is a factor that impacts our recruiting for candidates with families. It was noted OU has far fewer employees covering dependents than other colleges and universities. At OU, only 25% of employees have dependents enrolled in the University's health insurance plans. Segal's database shows at other colleges and universities, 52% of employees cover dependents. Since 2001, the cost of covering dependents at OU has increased by 177%. While the number of employees who elected to cover a spouse or children has remained relatively unchanged during this period, the number of employees electing family coverage has dropped from 1,492 in 2003 to 605 in 2007.

Question: How should OU approach the task of obtaining a third-party administrator (such as Aetna, HealthChoice, etc.) for its health insurance program? How frequently should OU submit an RFP to the market for bid?

In the last five years, the University has made three changes in the provider used to administer medical insurance benefits. While each of the changes was motivated by the goal of obtaining the best value for employees and the University, any change is potentially disruptive for employees and their covered dependents. After review, the Committee recommends OU survey the market every 3-4 years to ensure the University and its employees are receiving the best value available. A Request for Proposal (RFP) should be issued every 3-4 years to identify healthcare providers capable of providing the appropriate balance of price, quality, network access, health management, and other services. The 3-4 year period is also needed for OU to leverage power to establish service

expectations and to develop credible experience and a partnership with the healthcare service provider selected. Chasing the "best deal" on an annual basis does not help ensure competitive pricing and services.

The RFP process at OU is lengthy, due in part to the complexity of analyzing the financial and medical services aspects of proposals submitted. Keeping the University community apprised of the evaluation process and results, and obtaining employee and retiree feedback, also extends the time required to complete the RFP process.

Recommendation: The Committee recommends the University should issue a Request for Proposal (RFP) every 3 to 4 years to identify the healthcare vendors who provide the best value for plan participants and the University. The recommended cycle would enable OU to develop an ongoing partnership and credible experience with the chosen vendor(s), while ensuring competitive pricing and services and minimizing disruption for plan participants. In keeping with this recommendation, the University should issue an RFP in time to allow evaluation of potential health insurance providers for coverage beginning January 1, 2009.

Question: Can OU realize savings in its health insurance program by joining in purchasing coalitions with other Oklahoma higher education institutions?

The idea of OU joining other higher education institutions in Oklahoma to form a coalition to purchase health insurance has been investigated. The locations, size and needs of the state's higher education institutions are very diverse. This makes finding an insurance option that meets everyone's needs very difficult. A healthcare purchasing coalition would become unstable if a member withdrew to pursue a "better deal" on their own. Because of its size, OU is able to achieve purchasing leverage on its own. OU participation in a healthcare purchasing coalition with other Oklahoma colleges and universities is not supported because of the constraints to flexibility of plan design and administrative complexity associated with such participation.

Recommendation: The Committee recommends OU continue to seek the best possible health insurance options as an independent purchaser. As one of the two largest higher education institutions in the state, OU gains no significant leverage through joining a higher education coalition to purchase health insurance. The limited potential benefits of such a coalition are outweighed by the restrictions such an arrangement would impose.

Question: Should healthy behavior by plan participants and personal accountability be encouraged through incentives in the insurance premium structure?

Employers at the national level, including institutions such as Purdue University, University of Michigan, and University of Iowa, are taking a close look at the employee health and wellness side of the equation. They are exploring to what extent their employees' health status and lifestyle choices affect not only their healthcare costs, but also the overall productivity and well-being of their employee communities.

Understanding an employee population's health risk factors is a critical input for this review. Risk factors are conditions and behaviors that increase your chances of developing a more serious disease. For example, obesity can lead to heart disease, type 2 diabetes, stroke, and some cancers.

The most common employee health risk factors include:

- Smoking
- Obesity
- High blood pressure
- Sedentary lifestyle
- High lipids/cholesterol
- Stress/anxiety/depression

To begin to moderate these employee health risks, many employers are building health management programs and incentives into their healthcare strategies, including employee prevention and wellness programs or disease management programs. This approach is beginning to recognize real results. For example, a recent study on the economic return of employer health promotion initiatives indicated over a 3-4 year period, employers reduced healthcare costs by 26%, and in addition, reduced employee absenteeism by 27%.[1]

Given this emerging data, the Committee is clearly interested in exploring the possible outcomes employee health management programs might have for the University.

Recommendation: The Committee recommends the University develop and adequately fund health and wellness initiatives aimed at encouraging healthier lifestyles and behaviors of plan participants. Initially, medical plan benefits should be expanded to provide smoking cessation benefits that include nicotine replacement therapy and behavioral modification. Additional focus should be placed on weight loss and walking programs and health risk assessments, with incentives designed to encourage participation.

[1] Larry Chapman, "Art of Health Promotion," July/August 2005.

Question: What contribution model(s) should be used to determine premium contributions from the University, from employees, and by employees for their dependents?

The Committee examined many contribution models before developing the recommended approach. Segal developed models to project the financial and enrollment impacts of several different approaches to make dependent coverage more affordable at OU. The Committee carefully evaluated each model and paid particular attention to the following issues:

- Is the approach consistent with the ”Guiding Principles” established?
- Can it be communicated and implemented effectively?
- Does it seek to balance the interests and needs of our diverse University community?
- Is it fiscally responsible and sustainable?

The Committee concluded making a significant impact on dependent contribution rates will require a major change in the University contribution philosophy. The current contribution approach of paying 100% of an employee's premium for single coverage and making no contribution toward dependent coverage is not competitive and puts the University at a distinct disadvantage in the attraction and retention of employees who need dependent coverage. To get contribution rates closer to the benchmarks of the peer group not only will require additional University contributions toward medical insurance benefits, but also will require the introduction of employee contributions. However, the Committee was especially concerned about the impact of introducing contribution requirements for single coverage, especially on lower-paid employees. The Committee examined several methods for varying the premium based on the compensation of employees, including models that defined different compensation bands at varying percentiles of compensation. The Committee acknowledges compensation-based contributions may introduce some inequities, since only OU compensation is considered in determining the contribution tier assigned. However, the Committee felt the primary concern of keeping the cost of medical coverage more affordable for lower-paid employees overrides the administrative complications associated with a compensation-based contribution structure.

After much deliberation, the Committee determined a four-tier, compensation-based contribution structure most closely met its priorities and objectives. Three tiers would be based on OU compensation: employees in the bottom 50% of pay (currently those making under $42,000/yr), those in the 3rd quartile of compensation (currently making between $42,001-$59,999), and those in the top quartile of compensation (making more than $60,000/yr). The fourth tier will provide the lowest premiums and will be available to employees whose family income is at or less than 200% of the federal poverty level. Current federal poverty levels are shown in Appendix B. Quartile levels will be adjusted in the future to reflect changes in University compensation.

Recommendation: The Committee recommends the University implement a premium contribution strategy that offers employees with dependents more affordable healthcare options, and at the same time, introduces moderate employee contributions toward the cost of their individual coverage. A four-tier, compensation-based contribution structure is proposed. Three of the tiers will be based on OU compensation only, while the fourth tier will allow low-income employees to qualify for the lowest premiums based on family size and family income. An example of the recommended four-tier contribution model with estimated 2008 rates is attached as Exhibit A. Included in the recommended 2008 premium structure is additional University funding for healthcare benefits, and the Committee urges continued higher level of University funding needed to sustain healthcare benefits at a competitive level.

Question: Based upon comparisons to other major universities, should OU change age or service requirements to qualify for retiree medical coverage in the future?

How organizations are dealing with retiree medical plans is in a state of transition, which makes comparisons difficult. Many universities have made recent changes in their retiree medical benefits and eligibility, and others are contemplating changes in the near future. In addition to the escalating costs of providing retiree medical benefits, a recent change in accounting rules is spurring a closer look at these benefits by employers. The Governmental Accounting Standards Board (GASB) recently implemented accounting rules that require public organizations to disclose in their financial statements, for the first time, obligations associated with post-retirement benefits. In the past, this obligation was not routinely measured and reported, as most organizations operated on a "pay as you go" basis. OU recently completed an actuarial study that estimates its post-retirement benefit obligation at $493 million.

The comparison of retiree medical benefits and service requirements to qualify for those benefits is very complex. The complexity is associated with the fact that many universities provide different levels of benefits dependent on the employee's date of retirement. This "grandfathering" of certain groups of retirees when level of benefits or contributions are changed is quite common and recognizes those retired or close to retirement have little opportunity to prepare financially for the impact of plan changes that increase costs.

The comparison study did identify some differences between OU's retiree medical plan and our peer institutions. OU's approach of paying 100% of the premium for the retiree and not contributing toward the premium of a spouse is not common. Most organizations require some retiree contribution, and some provide a subsidy for covered dependents. In addition, OU allows employees to qualify for full University payment of the retiree's medical premium with as little as ten (10) years service upon reaching age 62.

In view of the competitive analysis and the large post-retirement benefit obligation projected for the University, the Committee identified several broad approaches that should be investigated further. The Committee recognizes there are several segments of the current employee and retirement communities with different needs, resources, and priorities that must be addressed. As a result, the Committee feels the solutions proposed probably should be different for these various segments.

In our discussions, the following potential segments were identified:

- Current retirees
- Active, but currently eligible to retire
- Active employees that are near eligibility to retire (criteria to be developed after further study)
- Other active employees
- Future employees – those not employed as of some cutoff date

Current retirees and those already qualified for University retirement are least able to prepare for any significant changes in benefits or required contributions. The Committee feels there should be no changes made to the benefits or contribution strategy for this segment at this time. The “at this time” qualifier is added, not to alarm this group about some pending surprise, but to acknowledge the national health care scene is in turmoil and future benefits and costs are not predictable.

The Committee also acknowledges there is a group of employees who are approaching eligibility for retirement who should be “grandfathered” into the group that includes current retirees and those active employees currently eligible to retire. However, further study and analysis is required to establish the basis for setting eligibility criteria and assessing the impact of potential changes for this group.

The Committee reached consensus current active employees should continue to be eligible for employer contribution toward the cost of their retiree medical benefits. However, the employer contribution should be based on University service so that longer-service employees receive a greater benefit. For future employees hired on or after January 1, 2008, the Committee concluded this group should have a reduced or unsubsidized retiree medical benefit and not be eligible for the current retiree medical benefit program

The Committee recognizes additional study of this important topic is required before specific strategies that impact current employees and retirees can be made. Additional actuarial projections and modeling is needed to understand the financial and employee impacts of various options available to manage this issue.

Recommendation: The Committee recommends employees hired on or after January 1, 2008, have a reduced or unsubsidized retiree medical benefit and not be eligible for the current retiree medical benefit program. The retiree medical benefit and contribution structure for current retirees should remain unchanged at this time. Active employees currently eligible to retire should be eligible to participate in the same retiree medical benefit and contribution structure as current retirees upon their retirement from the University. For other employees, the Committee recommends service-based employer contributions toward the cost of future retiree medical coverage be investigated. Because of the significant and growing costs associated with the University's post-retirement benefit obligation and the complexity of the analysis of funding requirements and options, the Committee further recommends it continue its work to conduct a further study of these issues.

Closing Comments:

When we accepted the charge assigned by President Boren earlier this year, Committee members recognized the complexity of the issues we were asked to analyze and understood the University community would be keenly interested in our work. We were pleased to find all Committee members took their appointment seriously and were committed to recommending changes in OU health insurance programs that best meet the needs of active employees, retirees, and the University. We understand the importance of healthcare benefits to current, former, and future employees of OU.

We achieved consensus on the recommendations after vigorous and open discussion and debate, reflecting many viewpoints. The input from other members of the OU family received full consideration in our deliberations.

There are clearly some areas highlighted in our recommendations where the University and its employees can take actions that will impact the quality, cost, and access to healthcare. However, we also understand there are some constraints and limitations imposed by our national healthcare system we cannot impact. When considering our recommendations, it is important to view them in the context of a national healthcare system that faces critical challenges that include rapidly increasing costs that drive ever-increasing insurance rates.

We'd like to thank President Boren for having the confidence in the Committee members to review these issues of such great importance to the University. We look forward to our continuing work which will address future retiree medical benefits and additional wellness and prevention initiatives.

Contribution Strategy and Health Insurance Options Committee

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Acknowledgements

The Committee would like to acknowledge and thank the following individuals who directly provided data, analysis, and support that enabled the Committee to work efficiently and produce a high volume of quality work within a compressed timeframe.

- Consultants for Segal/Sibson
    - Mitch Bramstaedt
    - Steve Cyboran
    - Ruth Donahue
- Stephanie Spencer, Benefits Administrator, Health Sciences Center
- Staff from the OU Benefits offices in Norman and the Health Sciences Center
- Gayle Lipscomb and Donna Emrick from the Office of the Dean, College of Medicine
- Terri Sarsycki, HR Administrator, Norman campus

Special thanks to Nick Kelly, Assistant Human Resources Director – Employee Benefits, who provided significant staff support to the Committee

Appendix A

Recommended Four-Tier Contribution Structure for 2008 Active Employees

	Low Income Tier			Under $42,000			$42,000 to $59,999			$60,000 and Over		
	2007 Current	2008 Proposed	Difference	2007 Current	2008 Proposed	Difference	2007 Current	2008 Proposed	Difference	2007 Current	2008 Proposed	Difference
Open Access												
Employee Only	$ -	$ -	$ -	$ -	$ 35	$ 35	$ -	$ 50	$ 50	$ -	$ 75	$ 75
Employee & Spouse	500	209	(290)	500	257	(243)	500	311	(188)	500	369	(131)
Employee & Child(ren)	258	151	(108)	258	178	(81)	258	218	(40)	258	264	5
Employee & Family	778	274	(505)	778	344	(435)	778	414	(365)	778	484	(295)
HMO Low Option												
Employee Only	$ (29)	$ -	$ 29	$ (29)	$ 5	$ 34	$ (29)	$ 20	$ 49	$ (29)	$ 45	$ 74
Employee & Spouse	412	102	(310)	412	164	(248)	412	219	(193)	412	276	(136)
Employee & Child(ren)	194	65	(129)	194	107	(87)	194	148	(47)	194	193	(1)
Employee & Family	668	141	(527)	668	226	(442)	668	296	(372)	668	366	(302)
Aetna Health Fund												
Employee Only	$ (44)	$ -	$ 44	$ (44)	$ 15	$ 59	$ (44)	$ 30	$ 74	$ (44)	$ 55	$ 99
Employee & Spouse	381	161	(220)	381	209	(173)	381	263	(118)	381	321	(61)
Employee & Child(ren)	170	113	(58)	170	140	(31)	170	180	9	170	226	55
Employee & Family	627	215	(412)	627	285	(342)	627	355	(272)	627	425	(202)
Opt Outs	$ (50)	$ (50)	$ -	$ (50)	$ (50)	$ -	$ (50)	$ (50)	$ -	$ (50)	$ (50)	$ -

Federal Poverty Levels for Low Income Tier - 2007

Persons in Family or Household	HHS Poverty Guidelines (48 Contiguous States and DC)	Qualify for OU Low-Income Tier (200% of HHS Poverty Guidelines)
1	$10,210	$20,420
2	$13,690	$27,380
3	$17,170	$34,340
4	$20,650	$41,300
5	$24,130	$48,260
6	$27,610	$55,220
7	$31,090	$62,180
8	$34,570	$69,140
For each additional person, add:	3,480	$6,960

SOURCE: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147-3148

Appendix C

Recommended Contribution Structure for Retirees - 2008

	2007 Current	2008 Proposed	Difference	Change
Open Access				
Employee Only	$ -	$ -	$ -	N/A
Employee & Spouse	661	704	44	7%
Employee & Child(ren)	333	355	22	7%
Employee & Family	1,042	1,111	69	7%
HMO Low Option				
Employee Only	$ -	$ -	$ -	N/A
Employee & Spouse	606	633	26	4%
Employee & Child(ren)	284	297	12	4%
Employee & Family	948	989	41	4%
Aetna Health Fund				
Employee Only	$ -	$ -	$ -	N/A
Employee & Spouse	569	668	98	17%
Employee & Child(ren)	287	336	49	17%
Employee & Family	898	1,053	155	17%
Indemnity (Medicare Retirees)				
Employee Only	$ -	$ -	$ -	N/A
Employee & Spouse	309	354	45	15%
Employee & Child(ren)	333	381	48	15%
Employee & Family	642	735	93	15%

Appendix D

Comparison of Employee and OU Contributions for 2007 and 2008

	Low Income Tier				Under $42,000				$42,000 to $59,999				$60,000 and Over			
	2007 Premium	EE Cont	OU Cont	% OU Cont	2007 Premium	EE Cont	OU Cont	% OU Cont	2007 Premium	EE Cont	OU Cont	% OU Cont	2007 Premium	EE Cont	OU Cont	% OU Cont
Open Access																
Employee Only	$ 358	$ -	$ 358	100%	$ 358	$ -	$ 358	100%	$ 358	$ -	$ 358	100%	$ 358	$ -	$ 358	100%
Employee & Spouse	858	500	358	42%	858	500	358	42%	858	500	358	42%	858	500	358	42%
Employee & Child(ren)	617	258	358	58%	617	258	358	58%	617	258	358	58%	617	258	358	58%
Employee & Family	1,137	778	358	32%	1,137	778	358	32%	1,137	778	358	32%	1,137	778	358	32%
HMO Low Option																
Employee Only	$ 329	$ (29)	$ 358	109%	$ 329	$ (29)	$ 358	109%	$ 329	$ (29)	$ 358	109%	$ 329	$ (29)	$ 358	109%
Employee & Spouse	770	412	358	47%	770	412	358	47%	770	412	358	47%	770	412	358	47%
Employee & Child(ren)	553	194	358	65%	553	194	358	65%	553	194	358	65%	553	194	358	65%
Employee & Family	1,027	668	358	35%	1,027	668	358	35%	1,027	668	358	35%	1,027	668	358	35%
HMO High Option																
Employee Only	$ 480	$ 122	$ 358	75%	$ 480	$ 122	$ 358	75%	$ 480	$ 122	$ 358	75%	$ 480	$ 122	$ 358	75%
Employee & Spouse	967	609	358	37%	967	609	358	37%	967	609	358	37%	967	$ 609	358	37%
Employee & Child(ren)	823	465	358	44%	823	465	358	44%	823	465	358	44%	823	$ 465	358	44%
Employee & Family	1,351	993	358	27%	1,351	993	358	27%	1,351	993	358	27%	1,351	$ 993	358	27%
Aetna Health Fund																
Employee Only	$ 315	$ (44)	$ 358	114%	$ 315	$ (44)	$ 358	114%	$ 315	$ (44)	$ 358	114%	$ 315	$ (44)	$ 358	114%
Employee & Spouse	740	381	358	48%	740	381	358	48%	740	381	358	48%	740	381	358	48%
Employee & Child(ren)	529	170	358	68%	529	170	358	68%	529	170	358	68%	529	170	358	68%
Employee & Family	985	627	358	36%	985	627	358	36%	985	627	358	36%	985	627	358	36%
Opt Outs	-	(50)	50		-	(50)	50		-	(50)	50		-	(50)	50	

	Low Income Tier				Under $42,000				$42,000 to $59,999				$60,000 and Over			
	2008 Estimated Premium	EE Cont	OU Cont	% OU Cont	2008 Estimated Premium	EE Cont	OU Cont	% OU Cont	2008 Estimated Premium	EE Cont	OU Cont	% OU Cont	2008 Estimated Premium	EE Cont	OU Cont	% OU Cont
Open Access																
Employee Only	$ 382	$ -	$ 382	100%	$ 382	$ 35	$ 347	91%	$ 382	$ 50	$ 332	87%	$ 382	$ 75	$ 307	80%
Employee & Spouse	916	209	707	77%	916	257	659	72%	916	311	605	66%	916	369	547	60%
Employee & Child(ren)	725	151	574	79%	725	178	548	76%	725	218	507	70%	725	264	461	64%
Employee & Family	1,126	274	852	76%	1,126	344	782	69%	1,126	414	712	63%	1,126	484	642	57%
HMO Low Option																
Employee Only	$ 337	$ -	$ 337	100%	$ 337	$ 5	$ 332	98%	$ 337	$ 20	$ 317	94%	$ 337	$ 45	$ 292	87%
Employee & Spouse	808	102	707	87%	808	164	644	80%	808	219	590	73%	808	276	532	66%
Employee & Child(ren)	640	65	574	90%	640	107	533	83%	640	148	492	77%	640	193	446	70%
Employee & Family	993	141	852	86%	993	226	767	77%	993	296	697	70%	993	366	627	63%
Aetna Health Fund																
Employee Only	$ 362	$ -	$ 362	100%	$ 362	$ 15	$ 347	96%	$ 362	$ 30	$ 332	92%	$ 362	$ 55	$ 307	85%
Employee & Spouse	868	161	707	81%	868	209	659	76%	868	263	605	70%	868	321	547	63%
Employee & Child(ren)	687	113	574	84%	687	140	548	80%	687	180	507	74%	687	226	461	67%
Employee & Family	1,067	215	852	80%	1,067	285	782	73%	1,067	355	712	67%	1,067	425	642	60%
Opt Outs	-	(50)	50		-	(50)	50		-	(50)	50		-	(50)	50	

Appendix E

Cost Impact of Recommended Changes - 2008

(Thousands)	2007 OU Current	2008 OU Current	Difference	2008 Proposed	Difference
Contributions					
Employer Contributions					
Actives					
Single	$ 25,694	$ 27,511	$ 1,817	$ 22,400	$ (3,294)
Family	9,022	9,660	638	16,584	7,562
Total Actives	34,716	37,171	2,454	38,984	4,268
Retirees					
Single	4,005	4,428	423	4,416	411
Family	765	856	91	854	89
Total Retirees	4,770	5,284	514	5,271	501
Opt Outs	406	406	-	424	19
Total Employer Contributions	$ 39,892	$ 42,861	$ 2,968	$ 44,679	$ 4,787
Employee Contributions					
Actives					
Single	$ (204)	$ (350)	$ (146)	$ 2,594	$ 2,799
Family	10,883	11,554	671	8,130	(2,753)
Total Actives	10,679	11,204	526	10,725	46
Retirees					
Single	8	7	(1)	-	(8)
Family	878	978	100	976	98
Total Retirees	886	985	98	976	90
Total Employee Contributions	$ 11,565	$ 12,189	$ 624	$ 11,700	$ 136
Total Contributions	$ 51,457	$ 55,049	$ 3,592	$ 56,380	$ 4,923

Benchmarking Study: *Comparing OU's Offerings to the Market*

Comparator Institutions/Employers		**Programs Included in study** *(active employees and retirees)*	**Elements of Comparison**
University of Alabama, at Birmingham	Chickasaw Nation	Medical	Medical plan types (i.e., PPO, HMO, POS)
University of Arkansas	Dell	Prescription Drugs	Deductibles
University of Colorado	Integris Health	Dental	Co-payments
University of Illinois	State of Oklahoma	Life	Co-insurance
Iowa State University	York International	AD&D	Out-of-pocket maximums
The University of Iowa		Vision	Lifetime maximums
The University of Kansas		Disability	Employee contribution: • Employee only • Employee + spouse • Employee + child • Employee + family
University of Missouri		Wellness	
University of Nebraska		Other ancillary programs	
University of New Mexico			
Ohio State University			
Oklahoma State University			
Texas A&M University			
The University of Texas			

Gap Between OU's Current Contributions Strategies and Those of the Benchmark Institutions

(Thousands)	2007 OU Current	2007 Peer Institution Benchmark	Difference from OU Current	2006 CUPA Benchmark	Difference from OU Current
Contributions					
Employer Contributions					
Actives					
Single	$ 25,694	$ 20,648	$ (5,046)	$ 19,953	$ (5,741)
Family	9,022	13,056	4,034	14,510	5,488
Total Actives	34,716	33,704	(1,012)	34,463	(253)
Retirees					
Single	4,005	1,856	(2,149)	2,314	(1,692)
Family	765	975	210	981	216
Total Retirees	4,770	2,831	(1,939)	3,295	(1,475)
Opt Outs	406	406	-	303	(103)
Total Employer Contributions	$ 39,892	$ 36,941	$ (2,951)	$ 38,061	$ (1,831)
Employee Contributions					
Actives					
Single	$ (204)	$ 4,841	$ 5,046	$ 5,536	$ 5,741
Family	10,883	6,849	(4,034)	5,395	(5,488)
Total Actives	10,679	11,691	1,012	10,932	253
Retirees					
Single	8	2,157	2,149	1,699	1,692
Family	878	669	(210)	662	(216)
Total Retirees	886	2,826	1,939	2,362	1,475
Total Employee Contributions	$ 11,565	$ 14,516	$ 2,951	$ 13,293	$ 1,729
Total Contributions	$ 51,457	$ 51,457	$ -	$ 51,355	$ (103)

Active Employee Contribution Summary Compared to Benchmarks

	2007 OU Current	2007 Peer Institution Benchmark	Difference from OU Current	2006 CUPA Benchmark	Difference from OU Current
Open Access					
Employee Only	$ -	$ 67.94	$ 67.94	$ 80.00	$ 80.00
Employee & Spouse	499.69	262.78	(236.91)	246.84	(252.85)
Employee & Child(ren)	258.22	250.15	(8.07)	177.38	(80.84)
Employee & Family	778.38	380.31	(398.07)	327.00	(451.38)
HMO Low Option					
Employee Only	$ (29.09)	$ 59.89	$ 88.98	$ 64.00	$ 93.09
Employee & Spouse	411.67	229.51	(182.16)	189.05	(222.62)
Employee & Child(ren)	194.25	207.11	12.86	135.68	(58.57)
Employee & Family	668.12	345.84	(322.28)	252.00	(416.12)
HMO High Option					
Employee Only	$ 121.90	$ 59.89	$ (62.01)	$ 64.00	$ (57.90)
Employee & Spouse	608.94	229.51	(379.43)	180.39	(428.55)
Employee & Child(ren)	464.59	207.11	(257.48)	153.47	(311.12)
Employee & Family	992.97	345.84	(647.13)	252.00	(740.97)
Aetna Health Fund					
Employee Only	$ (43.64)	$ 31.50	$ 75.14	$ 42.00	$ 85.64
Employee & Spouse	381.38	144.91	(236.48)	138.15	(243.23)
Employee & Child(ren)	170.45	139.42	(31.03)	98.76	(71.69)
Employee & Family	626.94	179.34	(447.61)	184.00	(442.94)

Current Medical Insurance Enrollment Profile

	HSC	Norman	Total
Average Age	42.9	45.7	44.5
Average Salary	$48,265	$48,498	$48,398
% Dependent Coverage	24.5%	20.7%	22.3%
% Enrollment by Plan			
Managed Choice	62.2%	67.0%	64.8%
HMO Low	32.3%	27.9%	29.8%
HMO High	2.7%	2.5%	2.6%
AHF-PPO	2.8%	2.7%	2.8%