Retiree Health Working Group – Interim Summary

University of California

April 6, 2018

PRE-DECISIONAL INFORMATION

Important Notes on this Summary

This document represents a summary of materials, issues and choices discussed by the Retiree Health Working Group to explore potential strategies and develop options for UC leaders to consider to ensure the long-term financial viability of the retiree health benefits program. All modeled changes and savings are illustrative.

These materials were intended to communicate current information about the retiree health program, benefits and costs, and to **illustrate potential tactics in addressing both short and long-term cost management. The material included here is entirely for the purpose of prompting discussion, raising awareness and surfacing issues among the Working Group. It does not represent recommendations or decisions.**

Absent the Working Group discussions, the material is incomplete and caution should be used in forming opinions based on the material alone. The material should be considered in consultation with a member of the Retiree Working Group.

For simplicity, a number of details and caveats are not included with this summary.

Contents

This is an interim report covering the content of Working Group meetings January 16, February 3, February 27, and March 23. Additional meetings may revisit some of the topics summarized here, and additionally are expected to include discussions of:

- Alternative contribution designs
- Options for altering the spouse subsidy
- Savings through UCMC options (discussion initiated April 3)
- Effects of savings options on long-term costs and liabilities

Framework
General

Cost Reduction Alternatives by Type

Options for reducing the University cost of retiree health fall into several broad categories. The items discussed to date are noted below.

Program Cost Reduction	Benefit Type / Value	Contribution Share/Strategy
No cost-shift to members	**Increases to member cost-sharing**	**Changes to amount or distribution of UC/member contribution share**
• Medicare Exchange* • Medicare Advantage PPO* • Seniority Plus PPO displaces HMO in select regions • UCMC family rate enhancement	• Terminate High Option • Increase Medicare PPO cost-sharing • Terminate UC Care • Substitute HRA plan model for current UC Care plan model • Increase member Blue & Gold cost-sharing • Increase member Seniority Plus cost-sharing	• Introduce dental contributions • Increase contributions to non-Medicare over 65 retirees

*Absence of a cost-shift depends in part on how implemented

Medicare Plan Types

Medicare Integrated PPO

Traditional Medicare pays primary; group plan coordinates as secondary payer on amounts not paid by Medicare

UC Plans: High Option, Medicare PPO

Medicare Advantage HMO

Medicare pays fixed fee to plan; plan takes on risk and delivers coverage through HMO plan design /network

UC Plans: Health Net Seniority Plus, Kaiser Senior Advantage

Medicare Advantage PPO

Medicare pays fixed fee to plan; plan takes on risk and delivers coverage through PPO plan design/network

UC Plans: None

Medicare Exchange

Retirees select individual coverage from multiple options on the exchange; employer provides HRA contribution to fund premiums, employee maintains any excess

UC Plans: OneExchange (Via Benefits) outside CA

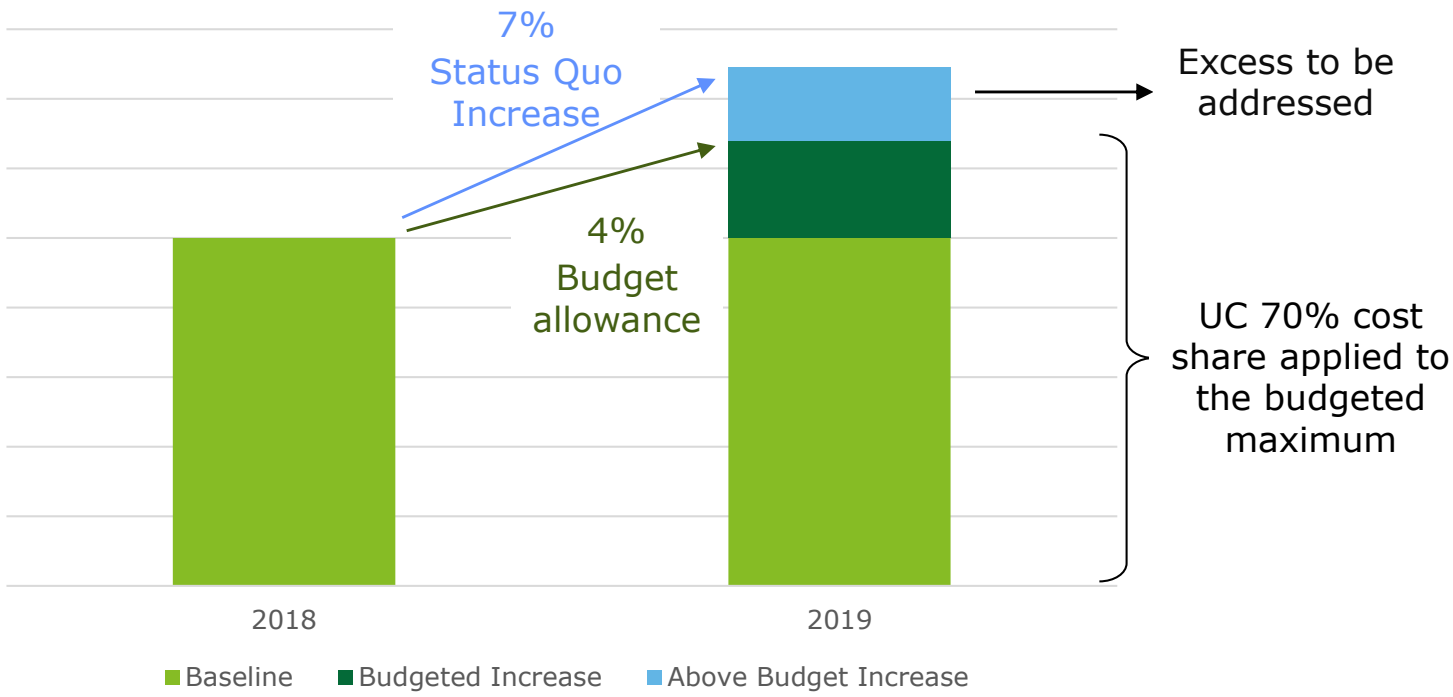
Framework

70/30 Share of Plan Premiums

The 70% Policy

- UC's commitment to maintain a minimum 70% aggregate share of retiree health premiums is established by Regental policy. After adoption of this policy UC worked its share of costs for medical plan premium down 3 percentage points each year until reaching the 70% level in 2018. This 70% share applies in aggregate and is not applied separately to each benefit plan.
    - In calculating the aggregate medical premiums, UC includes an estimated amount for the individual's Part B premiums. This raises the aggregate total and UC's 70% share.
- There are currently three exceptions to the 70/30 policy:
    - **Dental benefits**
        - Dental benefits have historically required no employee or retiree contributions. To date, the step-down to the 70% cost share has been applied only to medical benefits, and retiree dental remains 100% University-paid.
    - **Medical benefits for non-Medicare retirees age 65 and over**
        - The costs for this population have not been included in the calculation of the aggregate contribution share for retiree health. Retiree contributions have been tied to Pay Band 2, which protected this population from the step-down in UC share that has applied to other retirees.
    - **The "implicit subsidy" (explained later)**
        - The amount of the implicit subsidy is a component of UC's retiree health program cost. However, because non-Medicare retirees pay blended rates, this amount (~$96M) is not currently part of the 70% cost share calculation.

Budget and Contribution Share – Hypothetical Illustration



- To live within a budget allocation in any given year, if the aggregate retiree health cost increase exceeds the budget, the excess must be eliminated so that the denominator of the 70% calculation is within budget.
- The chart illustrates a circumstance where the retiree health costs increase by 7% but the available University budget increase is limited to 4%. To meet both the 70% commitment and the 4% budget, the aggregate cost must be reduced by the excess 3 percentage points.

Retiree Health Program Aggregate Cost

The table shows components of the retiree health program aggregate cost and 2018 maximum contribution policy

Components		Application in 2018 70/30 Policy
Benefits	Medical/Rx	Yes
	Medicare Part B	Yes
	Dental	**No**
Population	Retirees < 65	Yes
	NM over 65	**No**
	Medicare	Yes
	Spouses/Children	Yes
Subsidy	Explicit	Yes
	Implicit	**No**

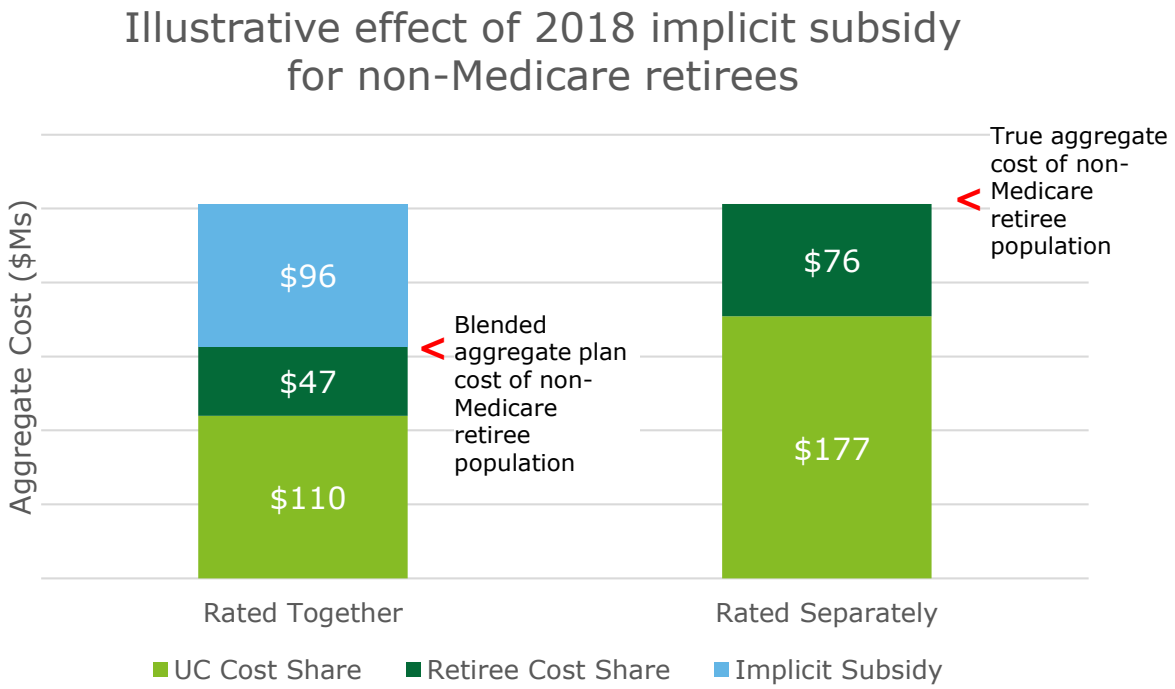
Implicit Subsidy – Definition and Effect

Definition

Non-Medicare retirees are included in a common pool with active employees to develop a single rate for all non-Medicare enrollees in each plan. The older average age and generally poorer health status of retirees makes them more expensive to cover. The blended rate is lower and more stable than a retiree-only rate.

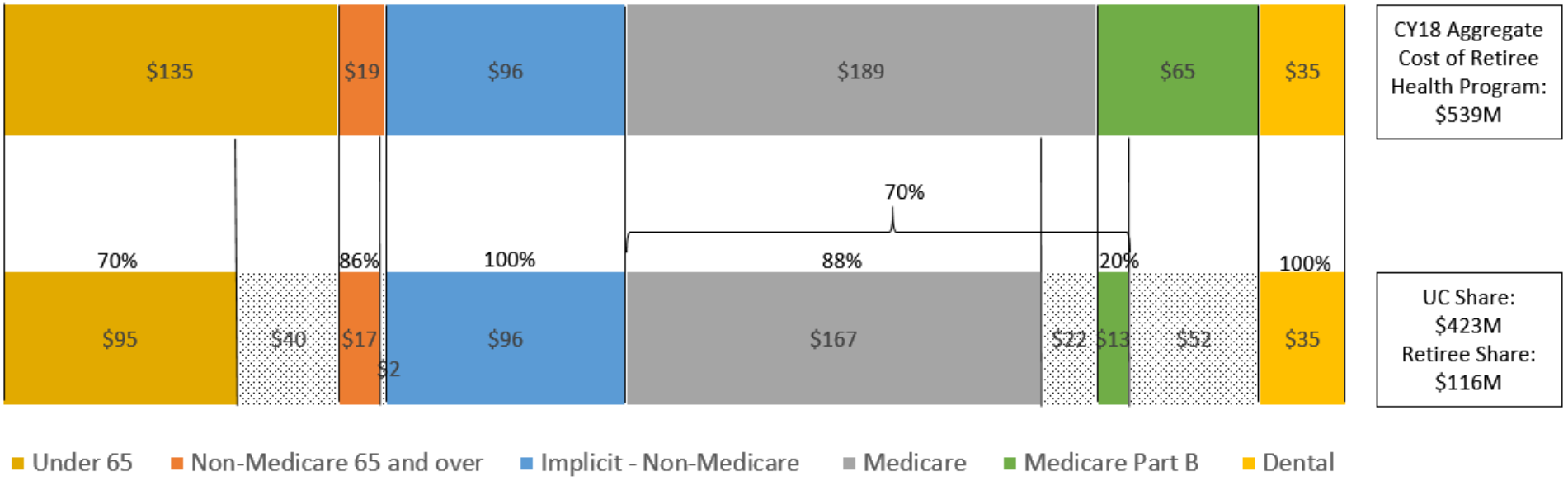
The difference between the combined rate produced by the blending method above, compared to what the rate would be if retirees were rated separately, is the **"implicit subsidy."** This is illustrated in the chart below. There is a small implicit subsidy for dental benefits, not shown.

For purposes of defining the University's future liability for retiree health benefits, the entire cost for retiree health, including the implicit subsidy, must be represented.



Retiree Health Program Aggregate Cost

The chart below illustrates CY2018 retiree health program aggregate cost components and UC's share by component



As illustrated, the current exceptions to the 70/30 policy – dental, non-Medicare retirees age 65 and over, and the implicit subsidy – result in UC paying more than its 70% minimum share. For CY18, UC is contributing 78% of aggregate retiree health program cost.

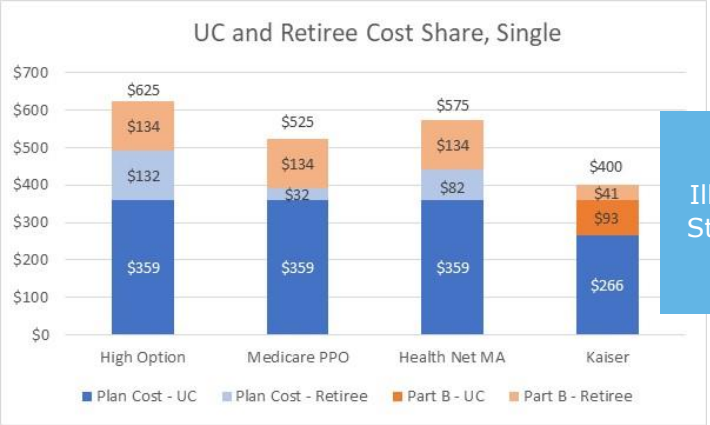
Generating UC Savings within the 70/30 Model

UC's commitment to the minimum 70% aggregate cost-share creates distinct dynamics in how plan changes can produce savings to the University.

- UC can save money through reducing the cost of an individual plan, or through the migration of retirees to lower-cost plans.
- In either case, the savings to the University is not based on the individual plan change in isolation, but on the effect the change has on reducing the aggregate plan premiums, which in turn and in proportion lowers the University's 70% share.

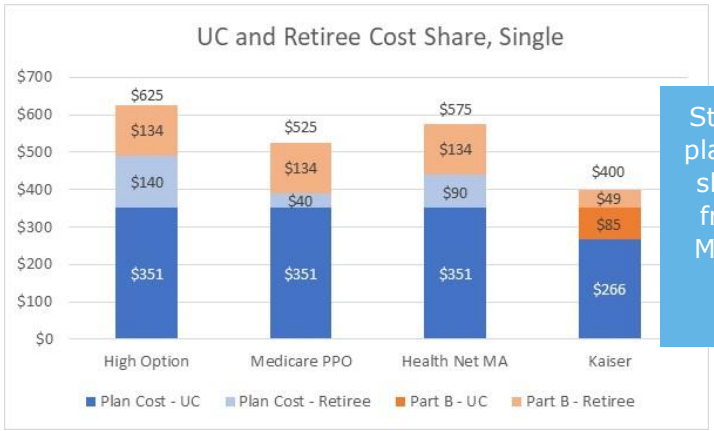
The following page shows illustrative examples of how this mechanism works in the examples of plan migration through voluntary movement or elimination of higher-cost plans. These examples are intended only to illustrate the process of defining savings, and are not fully modeled alternatives as addressed by the Working Group.

Illustration - Generating Savings in 70/30 Model



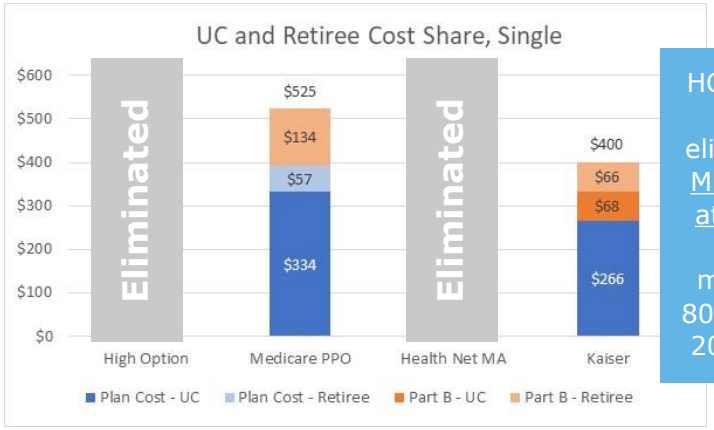
Illustrative Status Quo

	Per Member	Member Count	Plan Total (M)	Aggregate	UC 70% Share	Retiree 30% Share
High Option	$625	4,500	$33.8	**$246M**	**$172M**	**$74M**
Medicare PPO	$525	11,500	$72.5			
Health Net MA	$575	11,900	$82.1			
Kaiser MA	$400	12,100	$58.1			



Status quo plans; 10% shift each from HO, MPPO and HN to Kaiser

	Per Member	Member Count	Plan Total (M)	Aggregate	UC 70% Share	Retiree 30% Share
High Option	$625	4,050	$30.4	**$241M**	**$169M**	**$72M**
Medicare PPO	$525	10,350	$65.2			
Health Net MA	$575	10,710	$73.9			
Kaiser MA	$400	14,890	$71.5			



HO and HN MA eliminated; MPPO held at current cost; migration 80% to PPO 20% to KP

	Per Member	Member Count	Plan Total (M)	Aggregate	UC 70% Share	Retiree 30% Share
High Option		Eliminated		**$229M**	**$160M**	**$69M**
Medicare PPO	$525	24,620	$155.1			
Health Net MA		Eliminated				
Kaiser MA	$400	15,380	$73.8			

Contribution Share Options

Dental Benefits

Introduction of Dental Contributions

- Currently retirees make no contributions for dental coverage
- The table includes the projected impact on costs and retirees of introducing contributions at various levels up to a 30% maximum

Contribution %	Savings	Illustrative Retiree Impact: Monthly Single Contribution
10%	$3.8M	$4.51
20%	$7.5M	$9.50
30%	$11.1M	$14.63

- Impact is not linear because with the introduction of contributions some retirees are expected to opt out of dental coverage, which typically results in worse experience for those who remain enrolled in the plans

Comparison of Active and Retiree Dental Costs

- On average retiree dental costs are 23% higher than actives
  - This is principally driven by retirees having over twice the cost for major services compared to actives
- Active and retiree costs are similar for diagnostic and preventive services
- Retiree costs for basic services are 17% higher than actives mostly related to increased periodontal cost
- As expected retirees have relatively low orthodontic costs

Paid Period: January 1, 2017 - December 31, 2017

Type of Service	Procedure Codes	Actives PMPM		Retirees PMPM		Total PMPM	
D&P	Diagnostic (D0100 - D0999)	$7.51	22.2%	$7.83	18.8%	$7.58	21.3%
	Preventive (D1000 - D1999)	$7.51	22.2%	$7.86	18.9%	$7.59	21.3%
	Subtotal	**$15.02**	**44.3%**	**$15.70**	**37.6%**	**$15.17**	**42.6%**
Basic	Restorative (D2000 - D2499)	$4.48	13.2%	$3.72	8.9%	$4.32	12.1%
	Endodontics (D3000 - D3999)	$1.71	5.0%	$2.51	6.0%	$1.88	5.3%
	Periodontics (D4000 - D4999)	$3.09	9.1%	$5.19	12.5%	$3.55	10.0%
	Oral Surgery (D7000 - D7999)	$1.56	4.6%	$1.40	3.4%	$1.52	4.3%
	Miscellaneous (D9000 - D9999)*	$1.07	3.2%	$1.16	2.8%	$1.09	3.1%
	Subtotal	**$11.91**	**35.2%**	**$13.99**	**33.5%**	**$12.36**	**34.8%**
Major	Crowns & Inlays/Onlays (D2500 - D2999)	$3.60	10.6%	$7.27	17.4%	$4.40	12.4%
	Removable Prosthodontics (D5000 - D5999)	$0.21	0.6%	$0.85	2.0%	$0.35	1.0%
	Implant Services (D6000 - D6199)	$1.11	3.3%	$2.59	6.2%	$1.43	4.0%
	Fixed Prosthodontics (D6200 - D6999)	$0.45	1.3%	$1.10	2.6%	$0.59	1.7%
	Subtotal	**$5.37**	**15.9%**	**$11.81**	**28.3%**	**$6.77**	**19.0%**
Orthodontics	Orthodontia (D8000 - D8999)	$1.57	4.6%	$0.21	0.5%	$1.28	3.6%
	Subtotal	**$1.57**	**4.6%**	**$0.21**	**0.5%**	**$1.28**	**3.6%**
	Total	**$33.87**	**100.0%**	**$41.70**	**100.0%**	**$35.58**	**100.0%**

* Includes Anesthesia, Drugs and Adjunctive General Services

Contribution Share Options

Non-Medicare Retirees >65

Non-Medicare >65: Contribution Anomaly

Background

At the time of the OPEB task force, non-Medicare retirees >65 had a greater contribution share than Medicare retirees. In an effort to make their costs more comparable to Medicare retirees, they remained at Pay Band 2 contributions and were not included in the step-down of the UC contribution share.

After completion of the step-down process, non-Medicare retirees >65 have achieved much lower contributions than Medicare retirees, which was not the intent. As a next step in retiree health program management, one option is to implement an approach more consistent with the original principle of providing this group with contributions comparable to Medicare retirees.

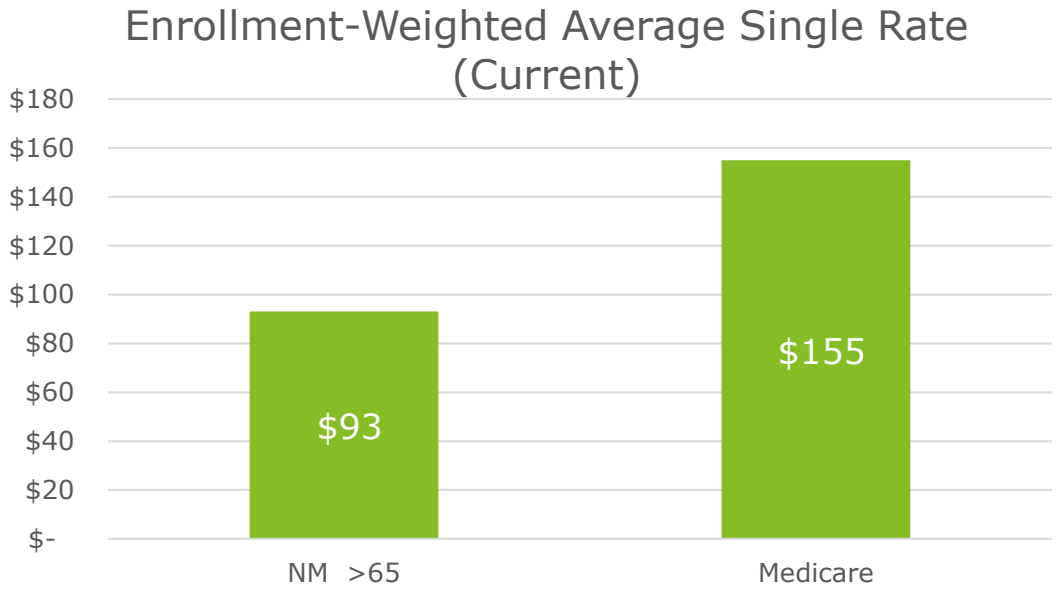
($ Millions)	Non-Medicare Retirees >65		Pre-Medicare and Medicare	
	$ Cost	Cost Share	$ Cost	Cost Share
Retiree	$2	14%	$114	30%
UC	$17	86%	$275	70%
Total	$19		$389	

1,765

non-Medicare retirees age 65 and over

Non-Medicare >65: Illustrative Contribution Change

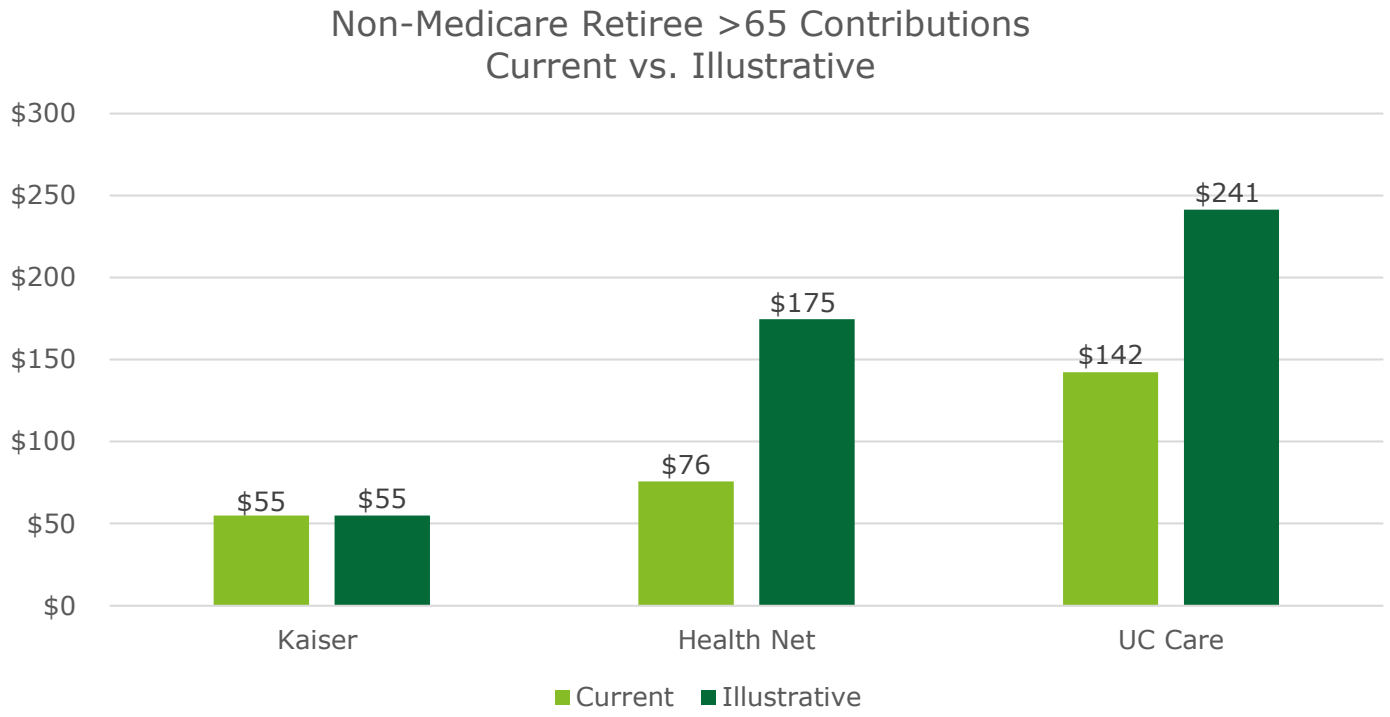
To illustrate potential UC savings from making a change, we modeled an increase to raise the average contribution cost for a non-Medicare >65 retiree to equal the average contribution for a UC Medicare retiree, including the Medicare retiree's Part B contributions. A proportional change is made for those retirees covering dependents.



Target: Increase contributions for non-Medicare Retirees >65 from $93 to $155 monthly

Non-Medicare >65: Illustrative Plan-Specific Contributions

Raising aggregate contributions for non-Medicare Retirees >65 as described on the previous page would have the plan-specific effects shown below:



Non-Medicare >65: Potential UC Savings

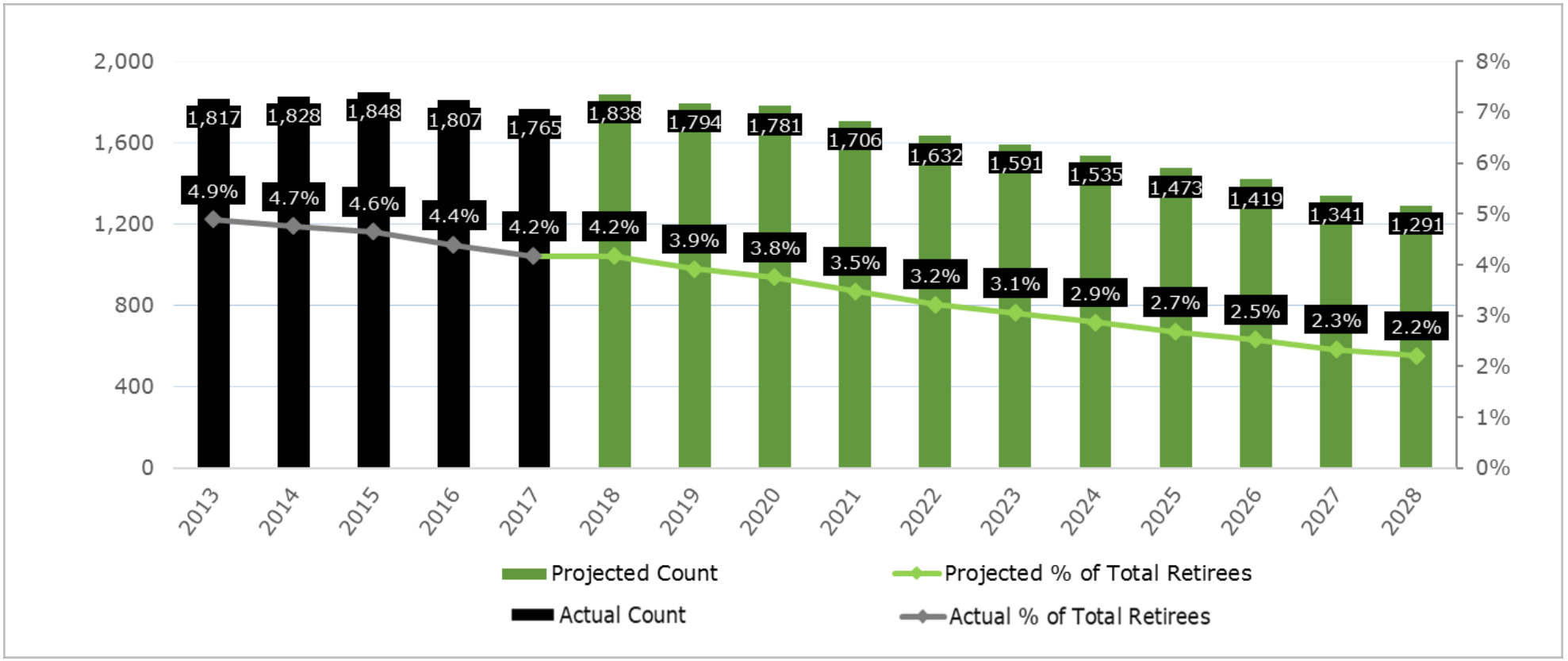
The table compares the current costs for UC non-Medicare retirees >65 compared to the illustrative contribution scenario. Even in the illustrative model, UC is absorbing more than 70% of the premium share.

Non-Medicare Retirees >65 (Millions)	Original Cost	Illustrative Cost	Difference
Retiree	$2	$4	+$2
UC	$17	$15	-$2
Total	$19	$19	$0

Non-Medicare Retirees >65	Original 2018 Cost Share %	Illustrative 2018 Cost Share %
Retiree	14%	23%
UC	86%	77%

Non-Medicare >65: Projected Enrollment and Life Expectancy

- The graph shows historical and projected non-Medicare >65 retiree enrollment counts and as a percentage of total retirees through 2028
- As of March 1, 2017, the average age of non-Medicare >65 retirees is 75.9 and their average future life expectancy is 14.7 years
- As expected, the proportion of non-Medicare retirees >65 has been decreasing as a greater proportion of retirees are Medicare eligible
- There is a projected enrollment increase in 2018 due to actives over age 75 assumed to retire immediately in 2018



Medicare Plan Options
Overview

Current Portfolio – Best Fit Profiles

High Option

Best Fit
- High premiums are affordable, expects 100% coverage for most non-Rx claims
- High utilization of drug benefit
- Prioritizes open choice of provider

Medicare PPO

Best Fit
- Prefers some plan design cost-share to higher contributions
- Prioritizes open choice of provider

Health Net MA

Best Fit
- Adapted to HMO model pre-Medicare
- Comfortable with limited provider selection
- Prefer simplicity of copays and single payer/no COB

Kaiser MA

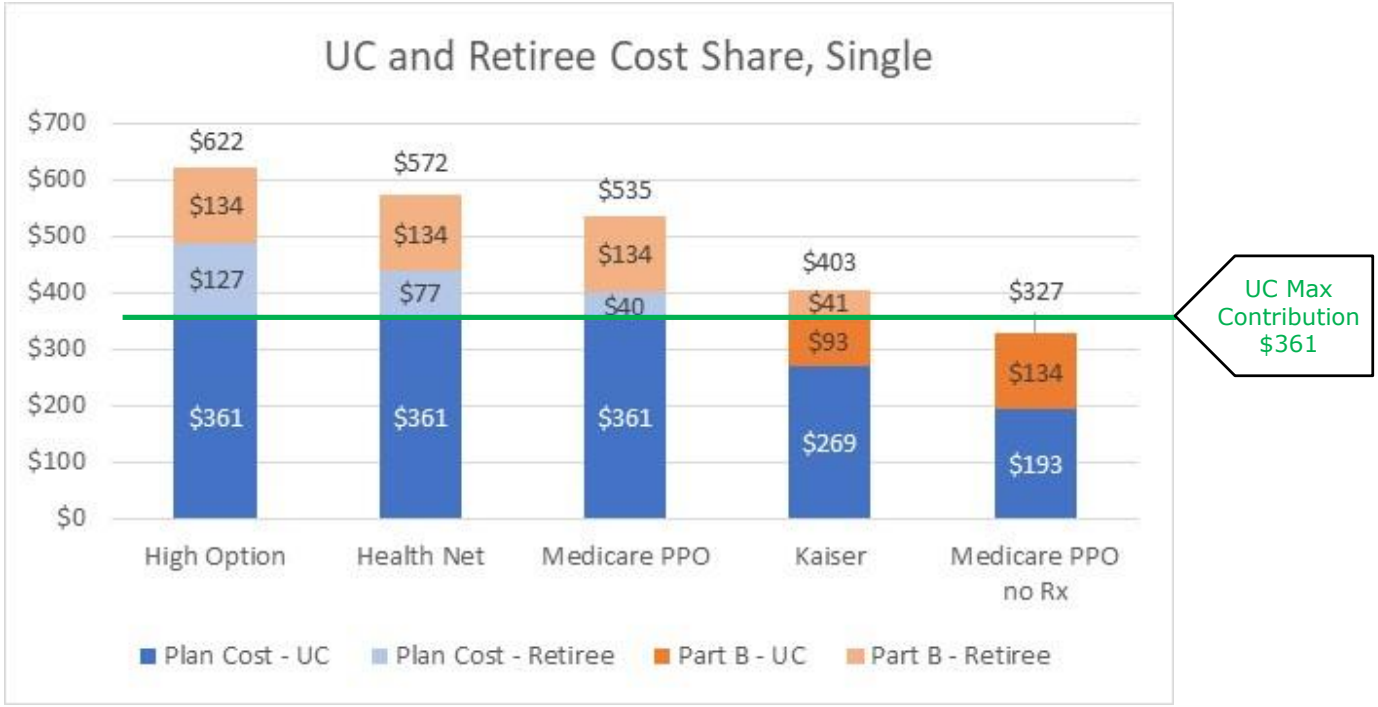
Best Fit
- Enrolled with Kaiser pre-Medicare
- Prioritizes low cost
- Comfortable using only KP providers
- Prefer simplicity of copays and single payer/no COB
- Prefer integrated Kaiser care model

Medicare Advantage PPO

Medicare Exchange inside CA

- UC offers the four Medicare options shown here within California, as well as the Medicare Exchange outside California
- For illustrative purposes we explore options in removing, changing, or adding to these plans through a Medicare Advantage PPO or Medicare Exchange within California.

Generating Savings from Plan Changes



Contribution chart shows single coverage

- For Medicare plans, due to the aggregate 70% and Part B policies, UC pays the same amount for enrollees in each plan (with exception of the "no Rx" plan which has minimal enrollment); thus shifting enrollment from high- to low-cost plans does not directly lower UC cost.
- Shifting enrollment to lower cost plans indirectly creates savings for UC by lowering the aggregate, enrollment-weighted premium against which its 70% share is calculated.
- Note that High Option and Medicare PPO are self-funded plans; UC will pay more or less than its Max Contribution depending on experience relative to the projected rate.

Medicare Plan Options

PPO Plans

Program Options: PPO Plans

Long-Term

High Option

- Highest-cost plan, one-third greater than average of other plans; drives up denominator of aggregate premium
- UC aggregate cost-share fixed by Regents
- 100% benefit is an integral plan feature
- Plan is self-funded
- **Alternative: Terminate High Option**

Medicare PPO

- High Option carry risk with them, raise cost of MPPO; contributions increase for current enrollees
- Plan is self-funded
- No provider disruption
- **Savings potential: limited**

MPPO benefit change

- Raise cost-sharing and/or change COB method
- Lowers aggregate cost and UC share
- Shifts costs to higher utilizers
- **Savings potential: moderate**

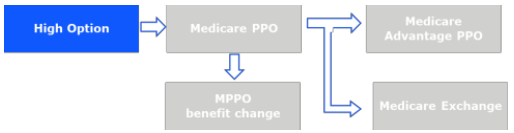
Medicare Advantage PPO

- Requires bid to firmly quantify savings potential
- Replicate or modify benefits
- Insured; risk shifts to administrator; risk control through care management
- Displaces traditional Medicare for retiree
- **Savings potential: good to moderate**

Medicare Exchange

- UC provides defined contribution (currently $3,000 per person per year) for retiree to pay plan directly
- Win/lose potential depending on individual Medicare plan choice
- **Savings potential: significant**

Eliminating High Option



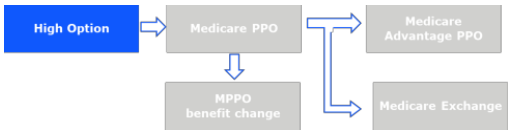
Perspective on High Option

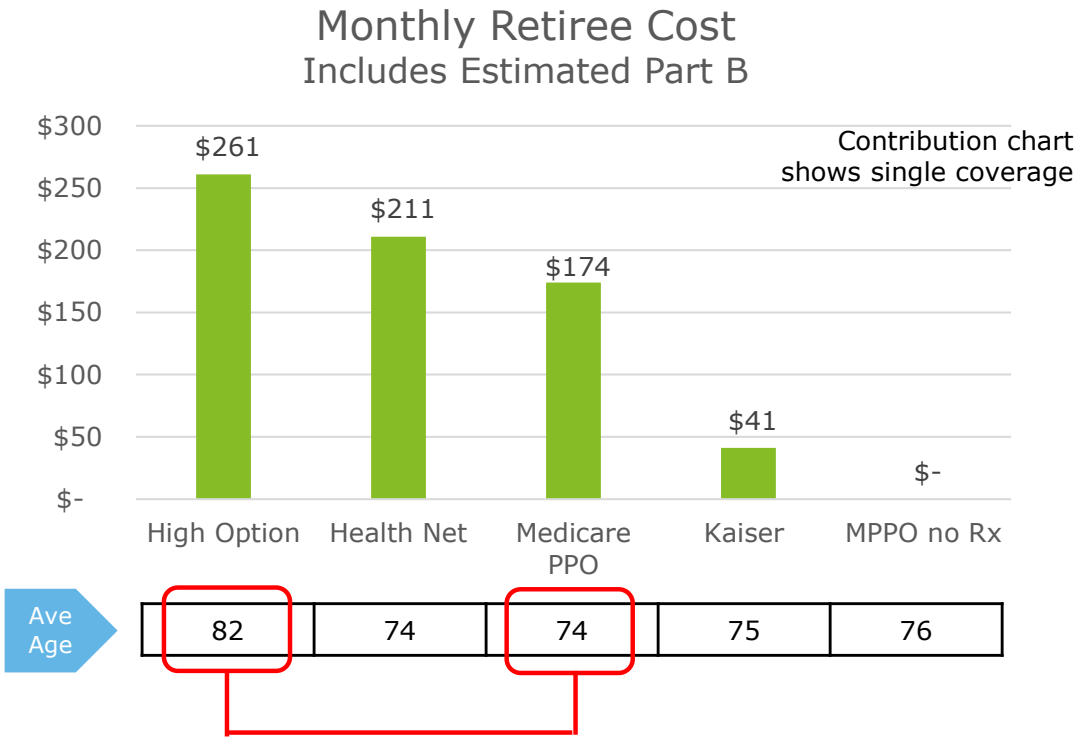
- Highest per-capita cost Medicare plan for UC
- Richest plan design with open provider access
- 10% of Medicare enrollment
- Highest average age among Medicare plans
- Must make positive enrollment choice to be in the High Option plan. All enrollees must be Medicare eligible.

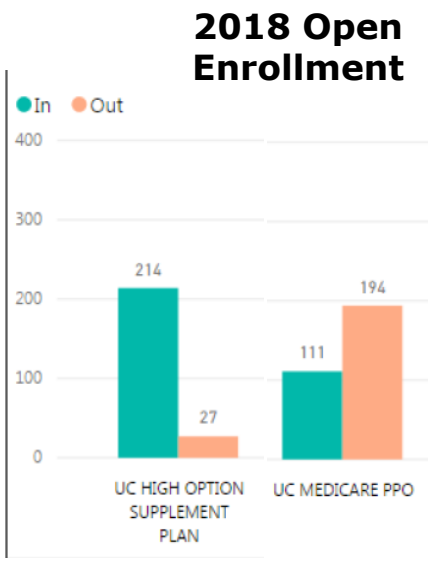
Considerations

- Eliminate High Option, reducing the aggregate Medicare premium from status quo, and correspondingly reducing the cost of UC's 70% share
- The aggregate premium differential between High Option and Medicare PPO for the High Option population is $4.8 million, which equates to 0.9% of the overall retiree health costs.

Eliminating High Option



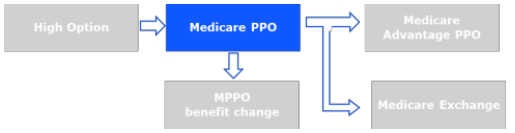




- Medicare plans are not risk-adjusted; majority of the difference in High Option v. PPO plan cost is the higher risk/cost of High Option members

- Because there is no default enrollment in High Option, retirees enter only by making a positive enrollment during open enrollment
- Despite this hurdle and the higher cost, High Option continues to attract new enrollees and experiences few disenrollments.

Benefit Design: High Option and Medicare PPO

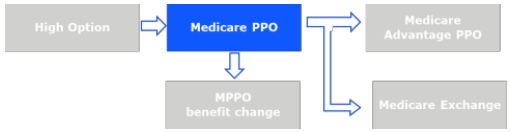


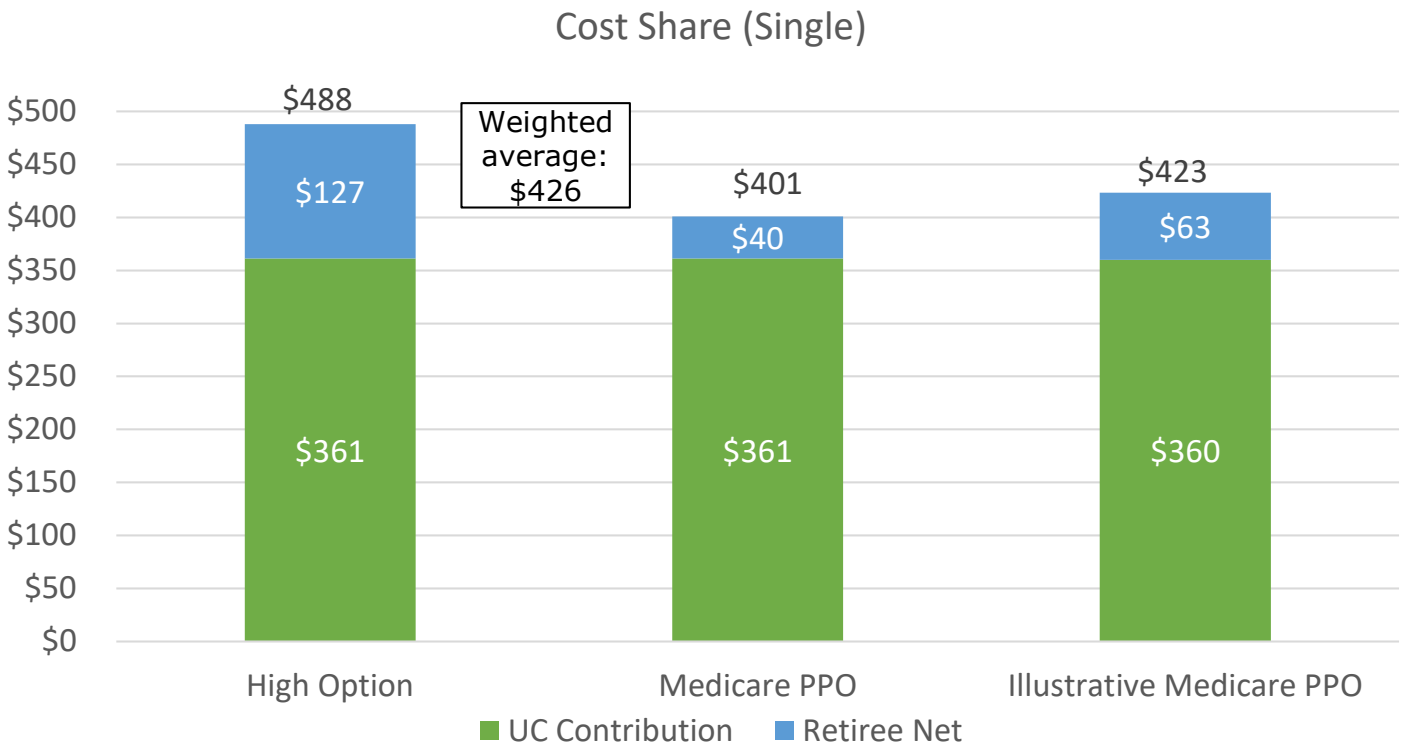
	High Option	Medicare PPO
Deductible		
Individual	$50/member	$100/member
Out-of-Pocket Maximum		
Medical (including deductible)	$1,050/member/year	$1,500/member/year
Prescription Drug	$1,000/member/year	$5,000* for 2018
Medicare Integration		
Integration Methdology	Coordination of Benefits/Supplement	Exclusion
Preventive Care and Office Visits		
Routine Exams	0%	0%
PCP Office Visits	0%	20%
Specialist Office Visit	0%	20%
Emergency Medical Care		
Emergency Room and Urgent Care	0%	20%
Hospital Care		
Inpatient	0%	20%
Outpatient Surgery	0%	20%
Outpatient Hospital	0%	20%
Prescription Drugs	*Deductible waived*	*Deductible waived*
Retail		
Generic	$10	$10
Brand Formulary	$30	$30
Brand Non-Formulary	$45	$45

Benefits for Medicare PPO are close in absolute value to those of High Option. A significant part of the difference in premium between the two plans is the higher age and risk of the population enrolled in High Option.

*Medicare True Out-of-Pocket Maximum

Removal of High Option: Impact to Retiree



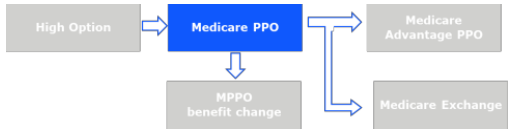


Elimination of High Option results in $23/month contribution increase for current MPPO members

Illustrative combines current Medicare PPO and High Option populations

- Both plans are self-funded. High Option members will carry their risk with them and raise the cost of Medicare PPO
- By eliminating High Option and assuming full migration into Medicare PPO, the rate for Medicare PPO increases from $401 to $423/month.
  - Retirees enrolled in High Option would contribute **$64/month less** toward coverage
  - Current Medicare PPO would contribute **$23/month more**

Removal of High Option: Impact to UC



The table compares the current Medicare costs for UC to the illustrative scenario where High Option is eliminated and no change is made to the Medicare PPO plan.

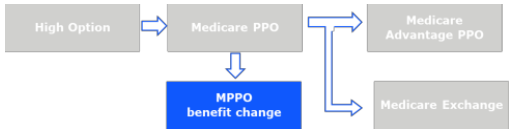
Medicare ($millions)	Original Cost	High Option Eliminated	Difference
Retiree	$73.6	$73.4	-$0.2
UC	$175.8	$175.6	-$0.2
Total	$249.4	$249.0	-$0.4

Savings as a % of UC Medicare plan costs:

0.1%

Since the plan designs for High Option and Medicare PPO are largely similar, migrating High Option members into Medicare PPO results in **only minor cost savings for UC**.

Medicare PPO: Plan Design Change



In order to illustrate the effect of certain plan design changes on the ability to reduce UC costs, we have modeled two plan designs, shown below, that would hold Medicare PPO premiums to the status quo level after the migration of the higher-cost High Option members into this plan.

Current Design

Deductible: $100/member
Medical OOP Max: $1,500 member
Coinsurance: 20%

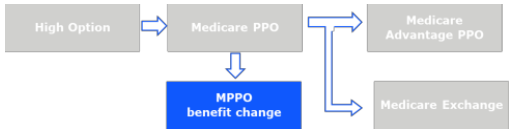
Sample Design 1

Deductible: $520/member
Medical OOP Max: $1,920 member
Retiree Coinsurance: 30%

Sample Design 2

Deductible: $450/member
Medical OOP Max: $1,850 member
Retiree Coinsurance: 40%

Medicare PPO: Effects of Plan Design Change



The table compares the current Medicare costs for UC to the illustrative scenario where High Option is eliminated and the Medicare PPO plan design is changed to keep premiums at the status quo level.

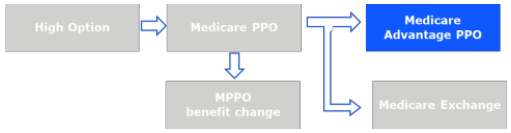
Medicare ($millions)	Original Cost	High Option Eliminated, MPPO Design Change	Difference
Retiree	$73.6	$72.2	-1.4
UC	$175.8	$172.5	-3.3
Total	$249.4	$244.7	-4.7

Savings as a % of UC Medicare plan costs:

2%

By bringing the new Medicare PPO rate (including High Option enrollees) back to its 2018 rate, UC saves $3.3 million.

Medicare Advantage PPO

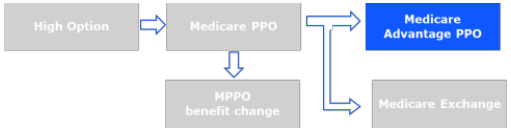


Overview

- Transition retirees from the Medicare PPO and High Option plans to a fully insured group Medicare Advantage PPO plan structure
- Requires a bid process to determine savings potential, product details and vendor
- Plan sponsors may replicate a current plan design or reduce benefits
- Medicare Advantage PPO plans typically reduce costs through two principal mechanisms:
  - Capture of incremental CMS revenues
  - Introduction of medical management as health plan manages its risk

Potential University Impact	Retiree Considerations
• Could deliver meaningful reduction to both "pay as you go" cost and GASB 75 liability • No change to administrative processes • Products fully insured • Current members can default into coverage	• With current contribution approach, lowering plan cost in one plan impacts what retirees pay in all plans • Plan designs may not be exact match • Medical management may be viewed as disruptive, particularly by older members • Potential disruption related to a few providers who do not accept Medicare

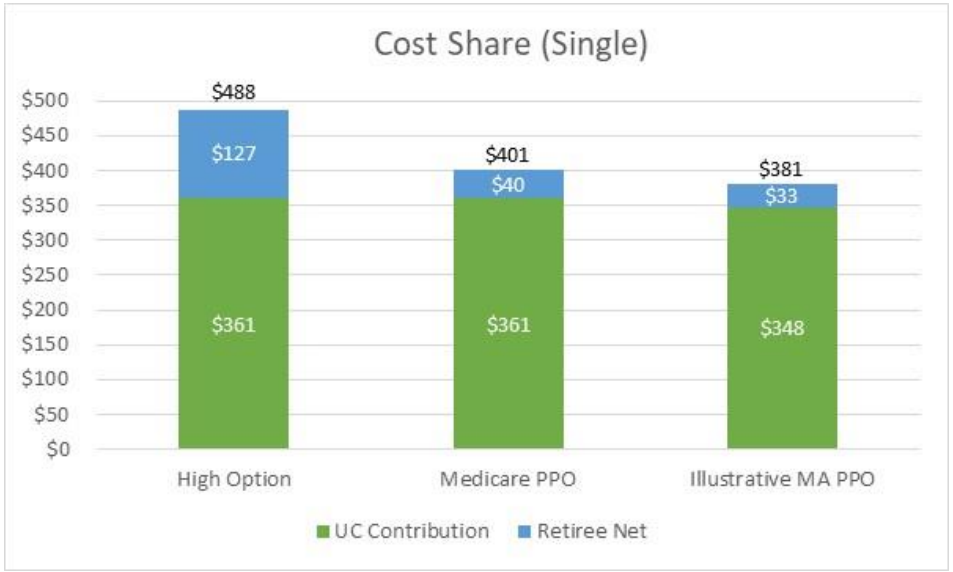
Medicare Advantage PPO – Illustrative Savings



The savings from introducing a fully-insured Medicare Advantage PPO plan in place of High Option and Medicare PPO is speculative until a bid is conducted. While some employers see exceptional savings, this depends on multiple factors, including demographics, location, and current plan performance.

For illustrative purposes, we estimated costs assuming a 10% reduction from the combined Medicare PPO/High Option rate, while replicating the current UC Medicare PPO plan benefits.

Medicare ($millions)	Original Cost	Illustrative Cost	Difference
Retiree	$73.6	$71.2	-$2.4
UC	$175.8	$169.6	-$6.2
Total	$249.4	$240.8	-$8.6



Medicare Plan Options

Medicare Advantage HMO Plan Design

Program Options: Health Net Medicare Advantage HMO

Long-Term

Health Net Seniority Plus

- Group Medicare Advantage Product
- Higher cost than MPPO
- Second largest enrollment
- **Alternative: Re-bid plan (in process)**

Alternative Medicare Advantage HMO

- 2019 Bid process in concluding phase
- **Savings potential: TBD**

Health Net HMO benefit change

- Raise cost-sharing
- Change prescription drug benefit to capture more Medicare reimbursements
- "Embedded MA PPO" to address UCMC reimbursements above Medicare
- **Savings potential: moderate**

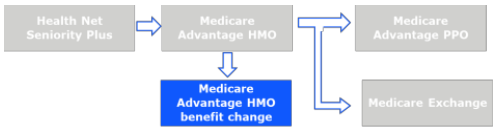
Medicare Advantage PPO

- Requires bid to firmly quantify savings potential
- Replicate or modify benefits
- Insured; risk shifts to administrator; risk control through care management
- Displaces traditional Medicare for retiree
- **Savings potential: good to moderate**

Medicare Exchange

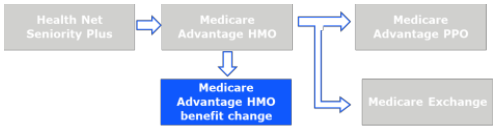
- UC provides defined contribution (currently $3,000 per person per year) for retiree to pay plan directly
- Win/lose potential depending on individual Medicare plan choice
- **Savings potential: significant**

Health Net Seniority Plus – Sample Options



Change Benefits	Change Benefits, Secure Improved CMS Reinsurance	Substitute County-Specific Health Net MA PPO
• Increase copays; straight reduction to premium • *UC savings comes from cost shift to retirees*	• Increase Rx out-of-pocket max and specialty Rx cost sharing; ~5% of members affected • Results in increased CMS reimbursements to plan • *UC savings comes from CMS and retiree at an approximately **6:4 ratio***	• Replace MA HMO with MA PPO in select counties • Substitutes Medicare reimbursement for certain HMO reimbursements currently above Medicare • *UC savings comes from reduced plan payments to certain providers, including UCDMC and Cottage Hospital*
Example modeled: • Increase hospital admission copay from $250 to $500	**Example modeled:** • Increase Rx OOP Max from $2,000 to $3,000, specialty cost share from $25 to 25%	**Example modeled:** • Convert Sacramento/Yolo and Santa Barbara Counties to Health Net MA PPO with equivalent benefits

Introduce Health Net MA PPO in select counties



Substituting Health Net's Medicare Advantage PPO in place of the Seniority Plus HMO in Santa Barbara and Sacramento/Yolo Counties has the following effects.

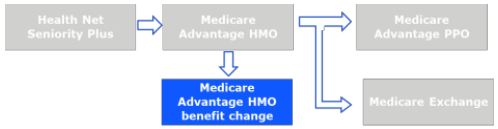
1. Reimbursement based on Medicare allowable fee schedule; UCMC reimbursement no higher then Medicare
2. Access to any provider that accepts Medicare
3. May be able to maintain current Health Net Seniority Plus plan design
4. No primary care physician assignment or specialist referral required
5. Potential equity and communications concerns given that HMO and PPO products will differ by county

Results in estimated UC savings of $1.4M

Note: MA HMO will not be available in these counties

Pending Health Net leadership approval

Health Net Seniority Plus – Plan Changes



There are options for reducing the cost of Seniority Plus through benefit reductions and other program changes. Several are shown below.

Scenario	UC Cost ($M)	UC Savings ($M)	Monthly Retiree Contribution (Single)	Change in Retiree Contribution (Single)
Status Quo	$175.8	N/A	$76.66	N/A
Increase Inpatient Hospital from $250 to $500	$175.4	$0.4	$74.06	($2.60)
Increase Rx OOP max/specialty copay to capture more Medicare reinsurance	$174.3	$1.5	$65.56	($11.10)
Introduce Medicare Advantage PPO in select counties	$174.4	$1.4	$66.63	($10.03)

Full Replacement - Medicare Advantage PPO

Medicare Advantage PPO – Full Replacement

- Replace Health Net Seniority Plus, High Option, and Medicare PPO with a full replacement Medicare Advantage PPO option
- Savings can be significant, though highly variable and unknown prior to a bid process; based on same illustrated modeling as above, full replacement would generate savings of ~$12M+ or 2% of total retiree costs
- Fee-for-service PPO based on Medicare allowable fee schedule; no higher UCMC reimbursement

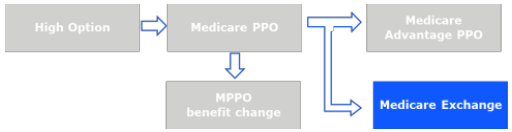
Impact on Retirees

- May result in benefit changes
- Medical management may not be viewed as favorable for older members

Medicare Plan Options

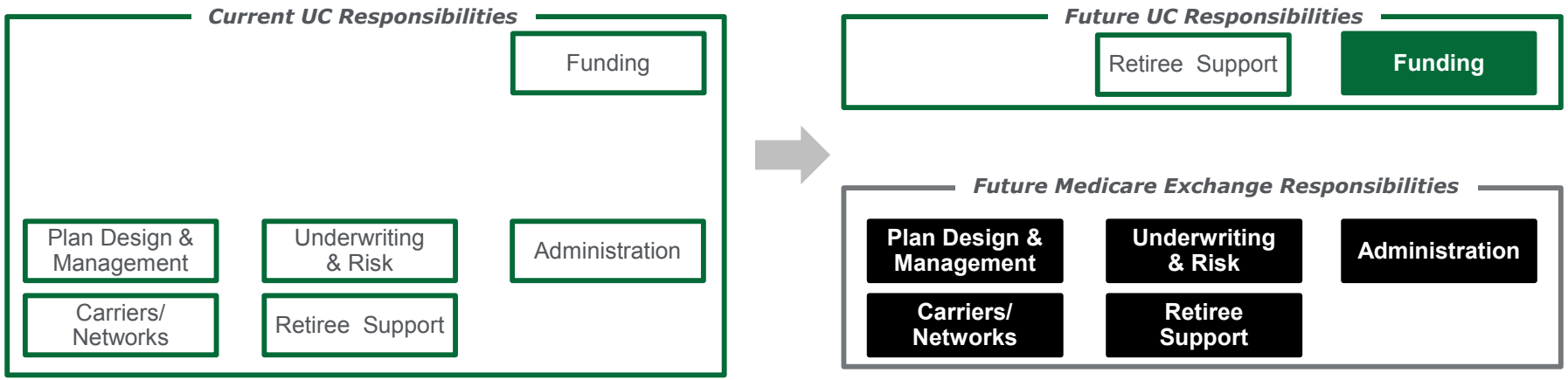
Medicare Exchange in California

Medicare Exchange inside California

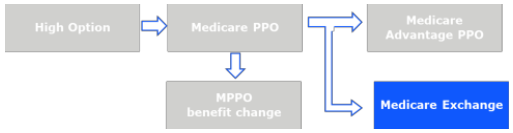


Overview

- Terminate group plans and introduce a UC-sponsored Health Reimbursement Arrangement (HRA), retirees can use to buy individual coverage through Medicare Exchange
  - Converts UC to defined-contribution model, removes 70% aggregate premium share as basis for UC costs
- Exchange contracts with carriers as a broker for individual insured Medicare Advantage, Medicare supplement, and Medicare prescription drug plans; UC would presumably use same Exchange administrator inside and outside California
- Exchange supports retiree education, decision making, and enrollment through licensed agents
- Not recommended as a choice offering due to potential risk selection issues – apply to all or based on retirement date
- Outside California, most UC members could find higher-value options (cost and benefits)



Medicare Exchange inside California



Pros	Cons
Effect on Retirees	
• Provides retirees with a greater range of plans options, including both supplement and Medicare Advantage products • Individual market may offer greater value where members can better match plans with their needs • Separate plans may be selected for the retiree and his/her spouse based on specific needs/preferences of each • Currently, the UC HRA contribution fully pays the individual Medicare plan premiums for ~90% of retirees outside California	• Retirees take on increased responsibility for decisions and actions (aided by exchange vendor) • Individual Medicare plans generally have higher cost sharing than group plans • Medicare Advantage plan designs may vary by county • Medical underwriting may apply in certain circumstances when moving into or across Supplement Plans
Effect on UC	
• Assuming $3,000 per Medicare member annual HRA amount, UC is projected to save ~$50M in pay-as-you-go costs based on 2017 contributions and Medicare enrollment ○ UC HRA amount for retirees outside of California has remained at $3,000 per member for 2014-2018	• Requires substantial consultation with stakeholder groups • Change management and communication needs will be significant • Vendor performance will reflect on UC

Medicare Exchange – Summary Modeling

WillisTowersWatson/Via Benefits, UC's Medicare Exchange administrator outside of California, provided the following summary of potential results for UC's California Medicare population, based on the same $3,000 UC HRA contribution currently provided outside California.

Cohorts	Modeled Members	Total Annual Rate	Modeled annual Employer contribution	Modeled reduction in Employer Subsidy	Annual HRA + Cat Rx Fund	Potential % Winners	Potential average annual savings to retiree group
Seniority Plus	8,893	$5,256	$4,336	29%	$3,060	98%	$1,938
UC High Option	3,454	$5,856	$4,336	29%	$3,060	94%	$2,708
UC Medicare PPO	7,049	$4,812	$4,336	29%	$3,060	99%	$2,642
UC Medicare PPO no RX	276	$2,316	$2,316	-30%	$3,000	99%	$2,773
Kaiser	9,527	$3,225	$3,225	5%	$3,060	90%	$1,360

Medicare Exchange – Retiree Premium Effect

		Retiree Savings (Cost) vs. Current Plan			
UC Plan	**Use Level**	**HiF**	**N**	**F**	**MAPD**
High Option	Low	$2,912	$1,881	$1,128	$4,440
	Average	1,118	940	478	2,719
	High	(1,123)	(719)	(893)	(86)
Medicare PPO	Low	2,200	1,338	701	3,577
	Average	1,295	1,294	955	2,736
	High	(196)	354	312	689
Seniority Plus	Low	2,525	1,692	1,084	3,422
	Average	1,249	1,263	944	1,431
	High	(195)	416	381	(2,044)
Kaiser	Low	1,662	750	83	2,371
	Average	727	574	145	979
	High	(707)	(19)	(221)	(2,423)

Low utilizer = average lowest 20%; high = average of highest 20%; average = average of all. Based on national Medicare cost distribution data. Savings modeled by WillisTowersWatson/Via Benefits.

Medicare Exchange – UC Savings

The University's savings from implementing Medicare Exchange as the sole option for Medicare coverage derives from substituting a defined HRA contribution for its 70% share of aggregate premiums. Using the current $3,000 HRA contribution outside California as the basis for illustrative modeling, UC's savings would be as shown below.

Members	Current Annual Contribution	HRA Annual Contribution	UC Savings*
40,414	$4,350	$3,000	$54.6M

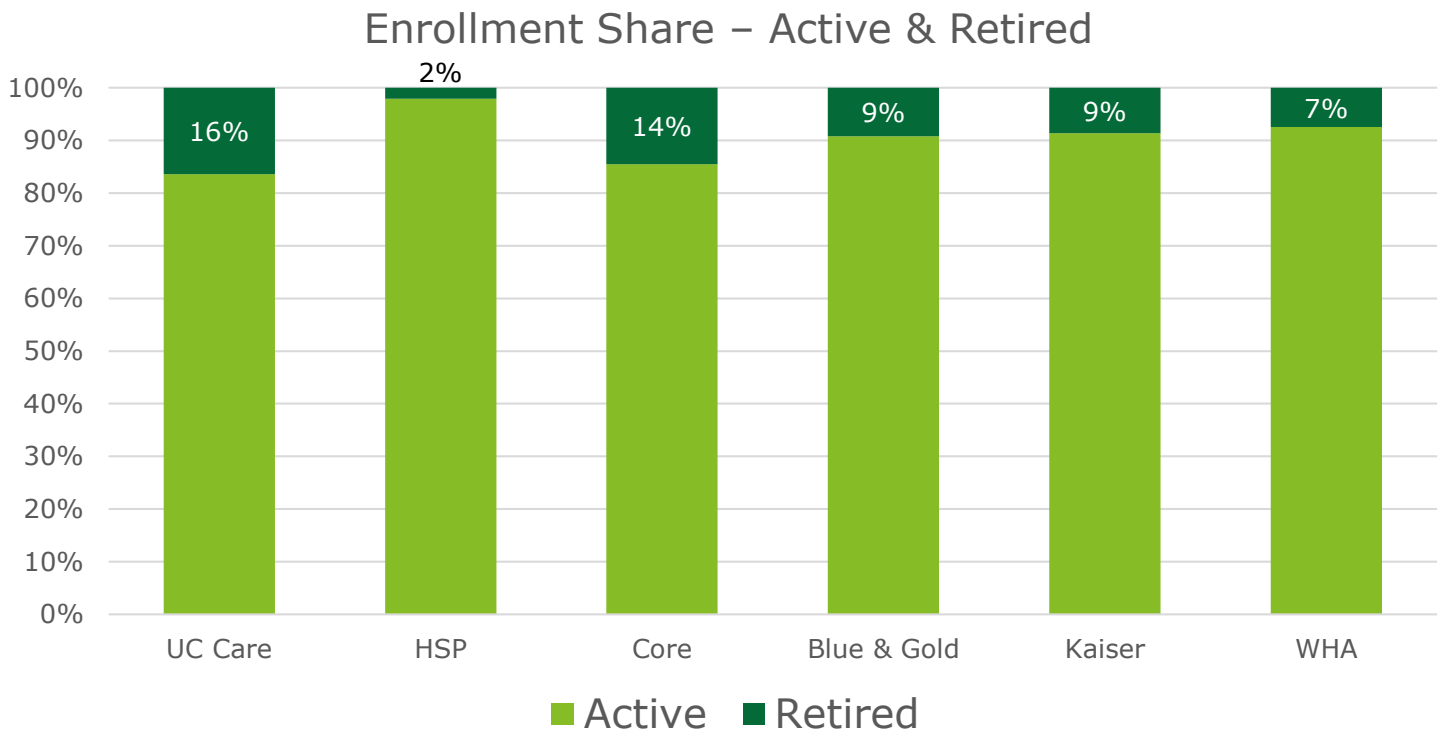
*Accounts for a small enrollment in Medicare PPO no Rx, and the cost of a UC supplement for catastrophic Rx coverage for all.

Savings as a % of UC Medicare plan costs:

31%

Non-Medicare Plan Options
Context

Active v. Retiree Enrollment



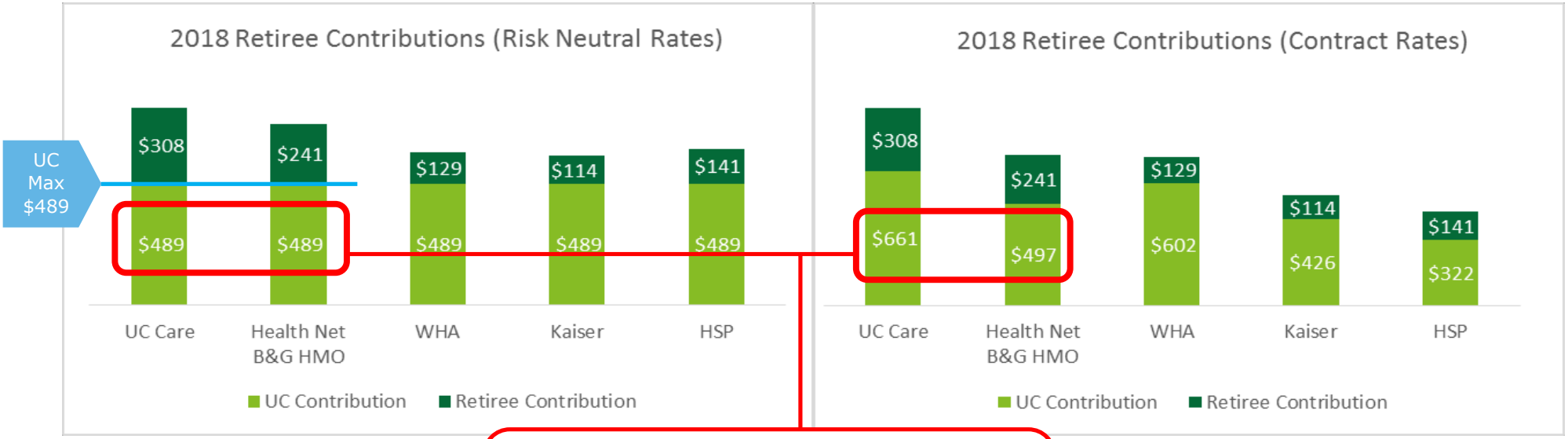
Overall Share of Retiree non-Medicare Enrollment:

10%

- Retiree enrollment represents a variable but generally small share of enrollment in the non-Medicare plans
- The negligible HSP enrollment is partly due to the policy that allows only active employees to newly enroll in the plan; HSP enrollees can remain enrolled after retirement, but cannot enroll for the first time while retired

Contributions and Cost – Retirees Under 65 (Single)

- Unlike Medicare, risk adjustment is applied to non-Medicare plans.
- The UC Max defines only the retiree contribution; **the University pays more when retirees enroll in a higher-cost plan**.
- For the UC Care plan locations pay $172/month more than the UC Max (single coverage), and $235 more than Kaiser, and $339 more than HSP.



Despite applying the same "UC Max" to both plans to determine contributions, UC pays substantially more for UC Care than Blue & Gold premiums

Current Portfolio – Best Fit Profiles

UC Care

Best Fit
- Can afford high premiums
- Want simplicity of fixed copays combined with open provider choice, no referral requirements, modest cost-sharing

HSP

Best Fit
- Want low premiums plus open access
- Have time & health to accumulate HSA savings
- Comfortable with account model
- Can bear risk of high cost-share

Core

Best Fit
- Good health, value of free plan exceeds risk of higher HSP contributions
- Can bear risk of high cost-share

HRA-PPO

Not currently offered

- UC offers the six plan options shown here for actives and non-Medicare retirees
- For illustrative purposes we explore options in removing UC Care or replacing it with an HRA model plan, and applying benefit changes to Blue & Gold

Blue & Gold

Best Fit
- Want community providers
- Willing to trade restricted provider choice for lower premiums
- Want fixed copays

WHA

Best Fit
- Davis/Sacramento
- Access community providers for Kaiser-level contribution
- Willing to trade restricted provider choice for lower premiums

Kaiser

Best Fit
- Want best financial protection: low premium and low cost-share
- Comfortable with only KP providers
- Prefer integrated care model

Non-Medicare Plan Options

PPO Plans

Addressing UC Care as Highest-Cost Plan

Current status

- UC Care has successfully increased member channeling to UCMCs.
- UC Care consistently attracts the highest-risk population, costs more than $2,700 more per year than Blue & Gold (2018 rates), and its cost trajectory is significantly higher than other plans.
- UC Care did not bend the cost trajectory compared to standard PPO plans.
- UC Care enrollment has nonetheless remained fairly consistent; UC members have not embraced high deductible, coinsurance-based plans.

Alternatives

- Based on current cost and claim experience, most active UC Care enrollees would be financially better off in the Health Savings Plan (HSP) or Core.
    - Higher cost-share offset by lower contributions for most.
- Introducing an HRA-PPO plan may split the difference: Offering richer benefits than HSP and lower costs than UC Care, while preserving UCMC channeling

HSA-HRA Quick Comparison

Both HSA and HRA plans are fundamentally PPO plans with high deductibles and spending accounts to encourage cost-effective care-seeking. However, HSA plans are subject to regulations that restrict their design. Both plans offer distinct value propositions in UC's portfolio.

HSA Plan	HRA Plan
▪ Deductible, OOP Max and other features stipulated by regulations	▪ Employer has more discretion with plan design
▪ HSA account dollars are tax-free	▪ HRA account dollars are tax-free
▪ Employer and employee may contribute to HSA	▪ Only employer may contribute to HRA
▪ Assets belong to employee and are portable	▪ Assets are notional; employee forfeits when leaving UC other than through retirement
▪ HSA funds may be used for cost-sharing or saved for future time	▪ HRA funds may be used for cost-sharing or saved for future time
▪ Cannot place UCMC coverage before the required deductible; limited ability to channel	▪ Lower or no deductible may be applied to UCMCs to support channeling of care

- HRA market presence has declined compared to the HSA model, as the HSA model brings lower cost and more tax advantaged savings opportunities for individuals.
- Option for individual account contributions makes HSA more attractive to higher income individuals

Modeling the HRA Plan

- Modeling in this document:
  - Plan design, costs and contributions are **illustrative estimates only**.
  - Costs are projected using actuarial values of plan design, applied to a blend of UC Care and HSP claims experience, as well as blended risk scores of the two plans.
- Plan Designs
  - We targeted two cost points in modeling the HRA benefits: 1) equivalent to Blue & Gold; 2) the midpoint between Blue & Gold and HSP.
  - For simplicity, the only benefit variables in the two HRA alternatives are the deductible and out-of-pocket maximums. Other plan designs could be modeled to achieve the same cost point.
  - Fixed copays are optional within an HRA plan; however, we have taken the perspective that going forward, they would be used only with HMOs where providers are at risk.
- Enrollment
  - The savings scenarios presume the entire UC Care enrollment migrates to the modeled HRA plan.
  - Savings are also modeled for a scenario where UC Care is eliminated, no HRA plan is added, and all UC Care enrollment migrates to HSP.

HRA Plan Designs v. HSP

	HRA Design 1*			HRA Design 2**			HSP	
	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	INN	OON
Deductible	$500/ $750/ $1,000	$1,000/ $1,500/ $2,000	$1,500/ $2,250/ $3,000	$750/ $1,125/ $1,500	$1,500/ $2,250/ $3,000	$2,250/ $3,375/ $4,500	$1,350/ $2,700	$2,550/ $5,100
Account Contribution	$500/$750/$1,000			$500/$750/$1,000			$500/$1,000	
Net Deductible	$0	$500/ $750/ $1,000	$1,000/ $1,500/ $2,000	$250/ $375/ $500	$1,000/ $1,500/ $2,000	$1,750/ $2,625/ $3,500	$850/ $1,700	$2,050/ $4,100
Out-of-Pocket Max	$5,100/ $7,650/ $10,200	$6,600/ $9,900/ $13,200	$13,200/ $19,800/ $26,400	$6,000/ $9,000/ $12,000	$12,000/ $18,000/ $24,000	$18,000/ $27,000/ $36,000	$4,000/ $8,000	$6,400/ $16,000
Office visit	10%	20%	50%	10%	20%	50%	20%	40%
Inpatient	10%	20%	50%	10%	20%	50%	20%	40%

* Design 1 targets a cost ≅ Blue & Gold

** Design 2 targets a cost halfway between Blue & Gold and HSP

HRA Plan Designs v. UC Care

	HRA Design 1*			HRA Design 2**			UC Care		
	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Deductible	$500/ $750/ $1,000	$1,000/ $1,500/ $2,000	$1,500/ $2,250/ $3,000	$750/ $1,125/ $1,500	$1,500/ $2,250/ $3,000	$2,250/ $3,375/ $4,500	$0	$250/ $750	$500/ $1,500
Account Contribution	$500/$750/$1,000			$500/$750/$1,000			N/A		
Net Deductible	$0	$500/ $750/ $1,000	$1,000/ $1,500/ $2,000	$250/ $375/ $500	$1,000/ $1,500/ $2,000	$1,750/ $2,625/ $3,500	$0	$250/ $750	$500/ $1,500
Out-of-Pocket Max	$5,100/ $7,650/ $10,200	$6,600/ $9,900/ $13,200	$13,200/ $19,800/ $26,400	$6,000/ $9,000/ $12,000	$12,000/ $18,000/ $24,000	$18,000/ $27,000/ $36,000	$5,100/ $8,700	$6,600/ $13,200	$8,600/ $19,200
Office visit	10%	20%	50%	10%	20%	50%	$20	20%	50%
Inpatient	10%	20%	50%	10%	20%	50%	$250	20%	50%

* Design 1 targets a cost ≅ Blue & Gold

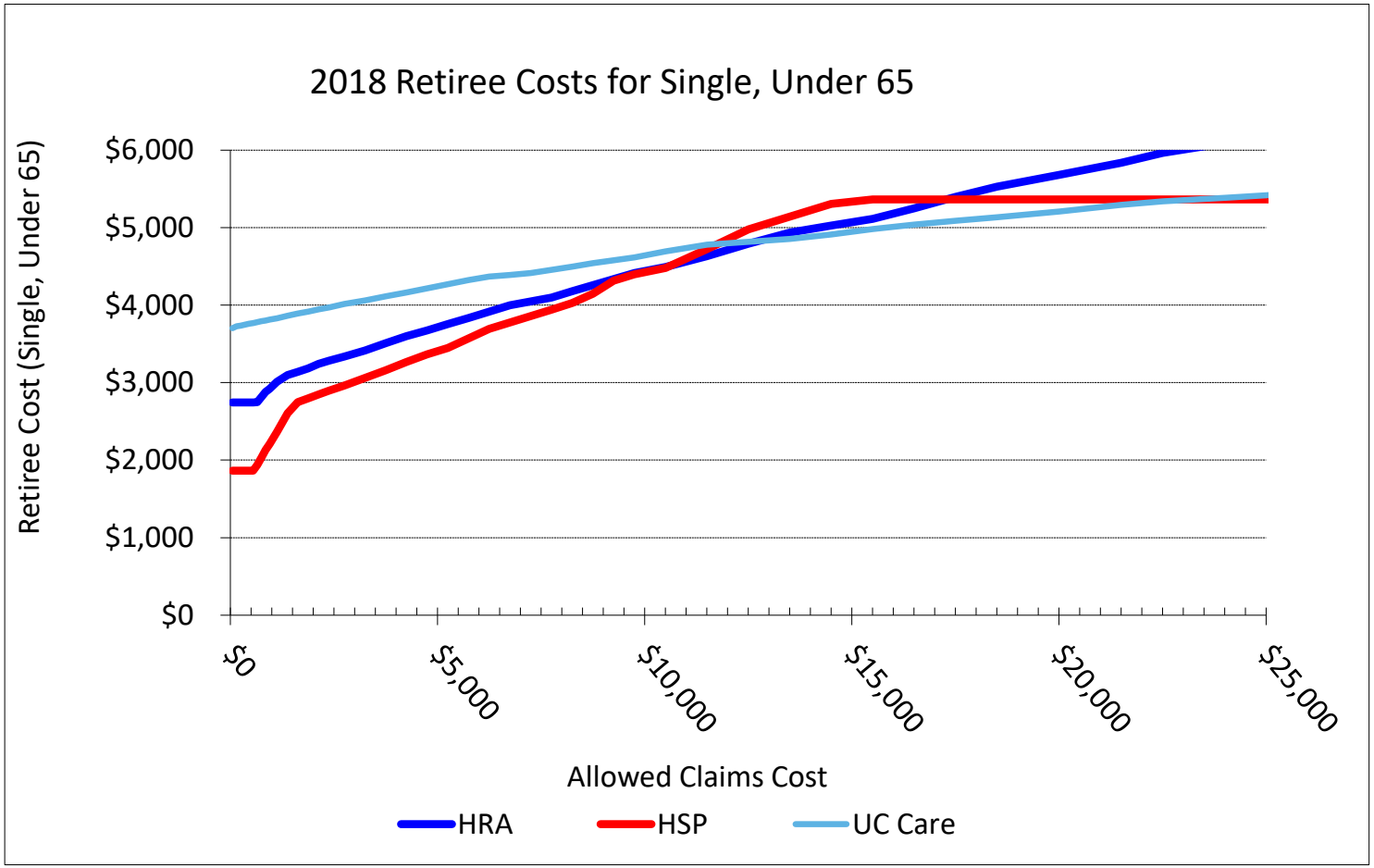
** Design 2 targets a cost halfway between Blue & Gold and HSP

Savings – UC View

	Aggregate Savings
Eliminate UCC – All migrate to HSP	$5.0M
Eliminate UCC – All migrate to HRA Design 1	$1.7M
Eliminate UCC – All migrate to HRA Design 2	$2.4M

- Aggregate savings include the UC savings for the non-Medicare over 65 population in the scenario where all migrate to HSP. In the other scenarios, there are no savings for non-Medicare >65 because UC would continue to pay the UC max for these individuals.
- Savings estimates are based on **risk-neutral premiums** to account for the migration of risk.

Employee Savings Potential – Contributions + Cost Share

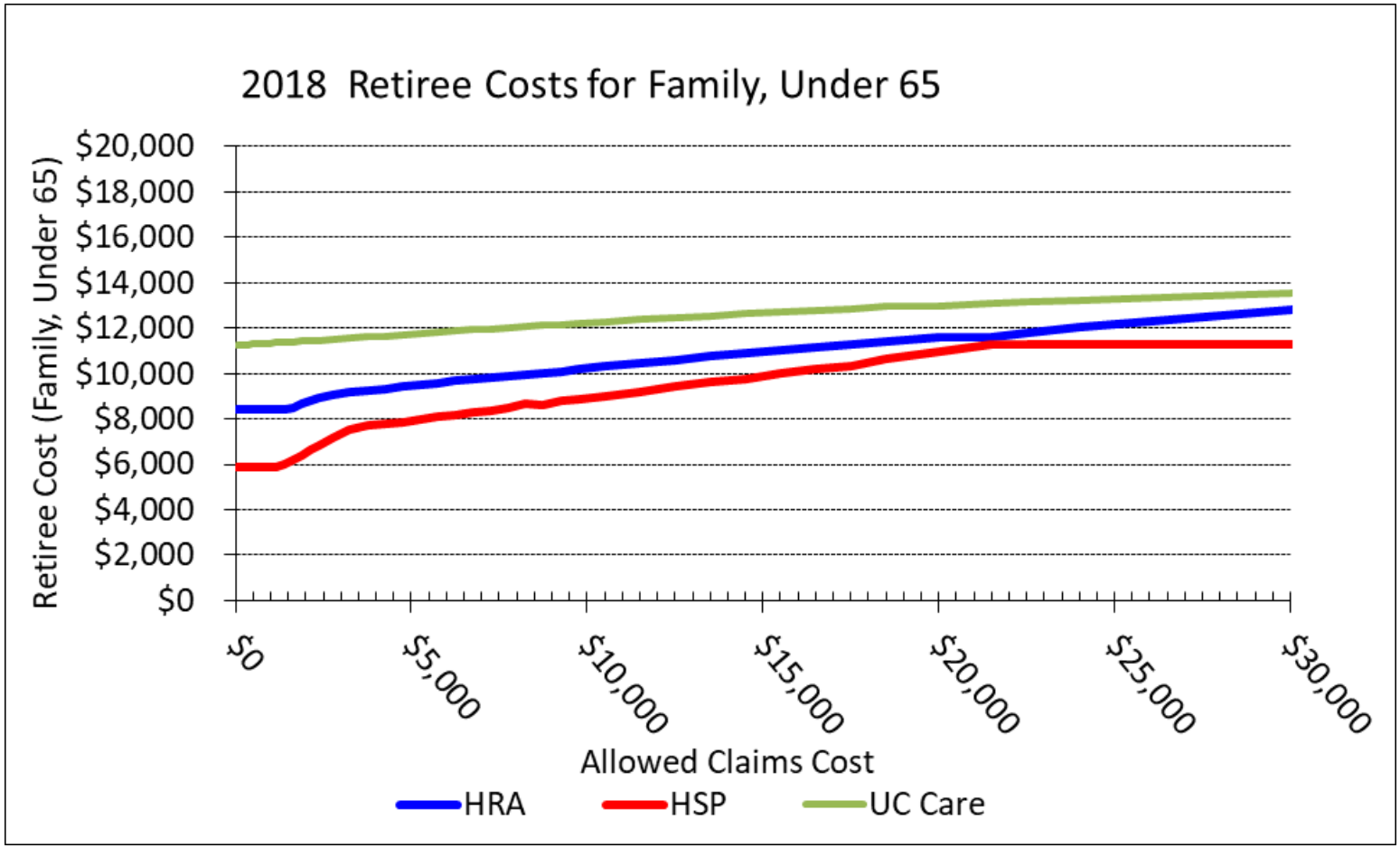


In this model, retirees incurring less than $12,500 in medical expense in a year would be better off in the HRA plan compared to UC Care.

For descriptive notes on the development of these charts, see the Appendix.

- The HRA plan charted here is the version at the price midpoint between Blue & Gold and HSP

Employee Savings Potential – Contributions + Cost Share



In this model, retiree families incurring less than $30,000 in medical expense in a year would be better off in the HRA plan compared to UC Care.

For descriptive notes on the development of this chart, see in the Appendix.

- The HRA plan charted here is the version at the price midpoint between Blue & Gold and HSP

Non-Medicare Plan Options

Blue & Gold Plan Design

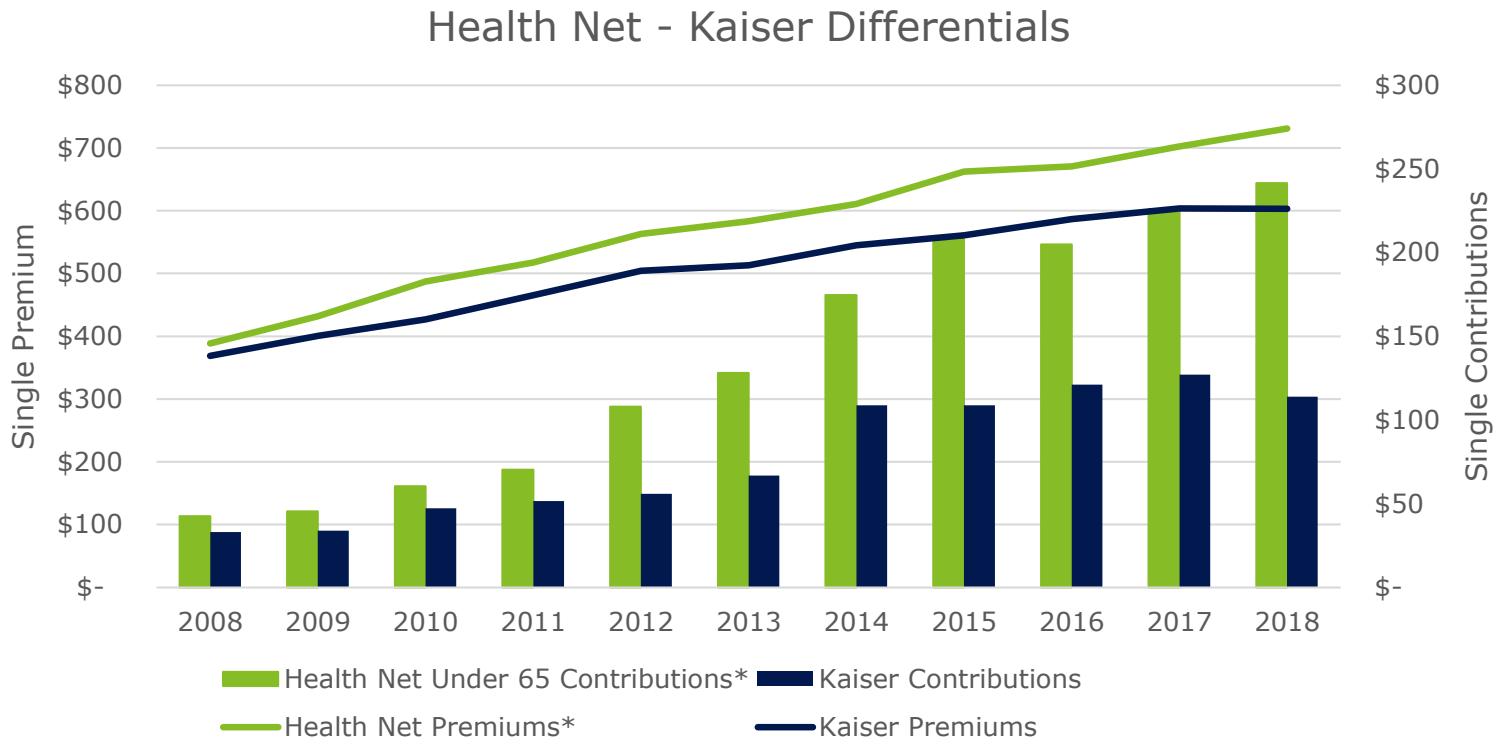
Divergence of Kaiser and Health Net

- UC has in practice maintained closely aligned plan designs between Health Net and Kaiser.
- Health Net premiums have continued to increase at a greater rate, despite HMO consolidation (2008), introduction of Blue & Gold (2011) and the UC Health collaboration (2016).
- While the premium percentage differential has been flat or slightly reduced, the percentage differential in contributions has more than doubled since 2008.

Option:

- Raise Blue & Gold copayments, moderating premium and shifting cost to those utilizing more services
- Copay differential with Kaiser may influence some higher-utilizers to migrate to Kaiser, better-balancing the risk profile of enrollees and increasing aggregate savings
- Areas without access to Kaiser may be a special consideration

Divergence of Kaiser and Health Net



*Health Net data shows Blue & Gold beginning 2011

Blue & Gold Illustrative Plan Design

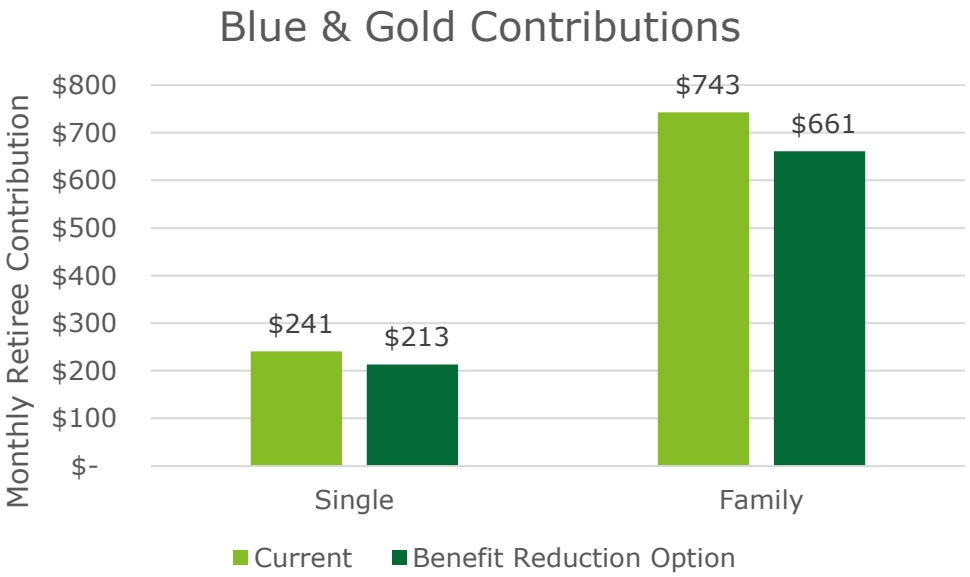
	Current Blue & Gold	Cost-Reduction Option
Out of pocket maximum	$1,000/$2,000/$3,000	$3,000/$6,000/$9,000
PCP/MHSA/Chiro Office Visit	$20	$40
Specialist Office Visit	$20	$75
Inpatient	$250	$500
Outpatient Surgery	$100	$300
Emergency Room/Urgent Care	$75/$20	$200/$100
Rx	$5/$25/$40/$20 – Retail $10/$50/$80 – Mail	$25/$50/$80/$100 – Retail $50/$100/$160 – Mail

- These benefit changes are estimated to place the cost reduction model within 15% of the Kaiser premium rate.

Blue & Gold: UC Savings and Contributions Effects

University Savings	Aggregate Savings
Blue & Gold Benefit reduction	$1.5M

Estimated savings comes from an actuarial model by Deloitte; this does not represent a quote or estimate from Health Net, which could be different. Savings does not include any indirect savings from potential migration of Blue & Gold enrollees to Kaiser.



The reduced benefits would create lower retiree contributions:

- Single: **$28/month**, $336/year
- Family: **$82/month**, $984/year

Due to the aggregate 70/30 policy, this reduction for B&G creates a slight increase in retiree contributions to other plans (~$9 for single).

Pre-funding
Investments

Pre-funding

- This material illustrates the additional contributions needed to pre-fund the plan under a 30-year level percentage of payroll funding scenario. A summary of the results are show in the table below:

Funding Policy Scenario	Additional $ Amount (millions)	Additional % of Payroll
Fully funding liability over 30 years as a level percentage of payroll	FYE2018: $400 FYE2032: $443	FYE2018: 3.7% FYE2032: 2.5%

- Potential source of monies for pre-funding could be a lower budget increase; for illustrative purposes we show the impact of redirecting the entire 4% budget target to pre-funding

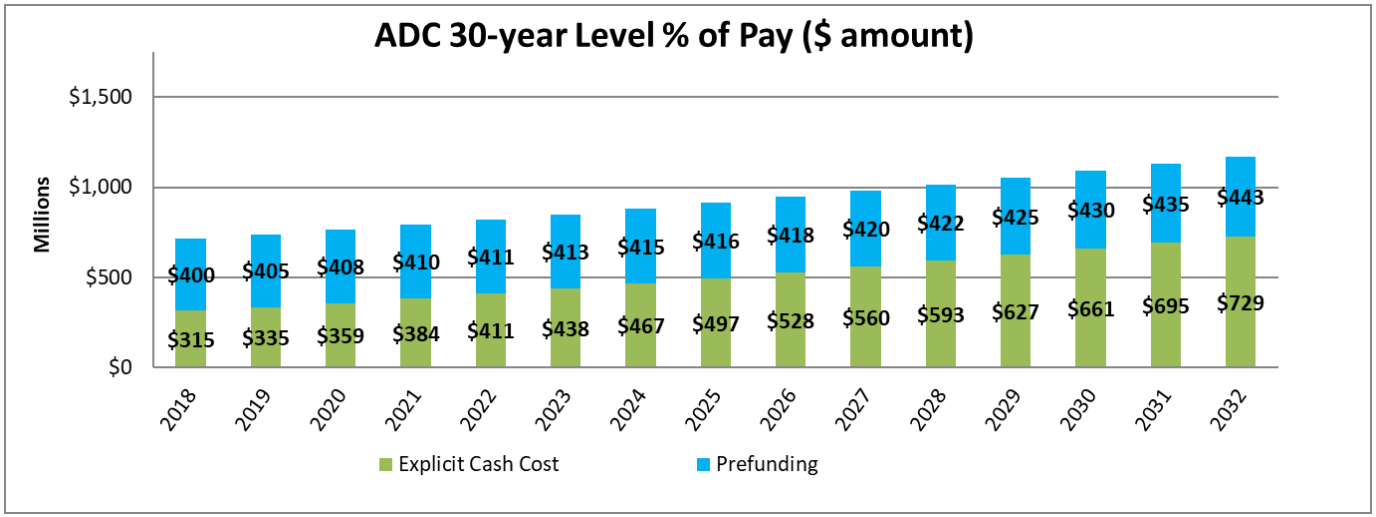
Redirect 4% budget target to pre-funding	FYE2018: $0 FYE2032: $272	FYE2018: 0.0% FYE2032: 1.5%

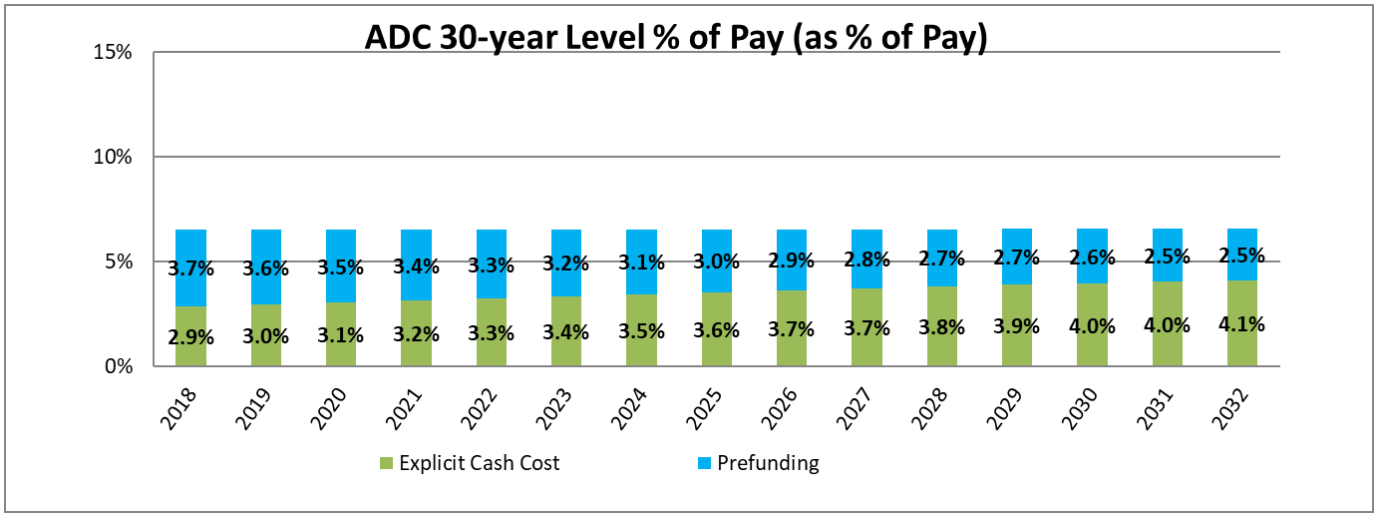
<u>Projection assumptions:</u>

- Annual 4% per capita cost increase
- No other future programmatic or contribution policy changes
- Total payroll projections provided by Segal (includes 0.7% assumed employee headcount growth)
- All other July 1, 2017 actuarial assumptions met
- All other data, assumptions, methods and plan provisions are based on the University of California Retiree Health Benefit Program Actuarial Valuation Report as of July 1, 2017

Actuarially Determined Contribution (ADC) – 30-year, Level % of Pay

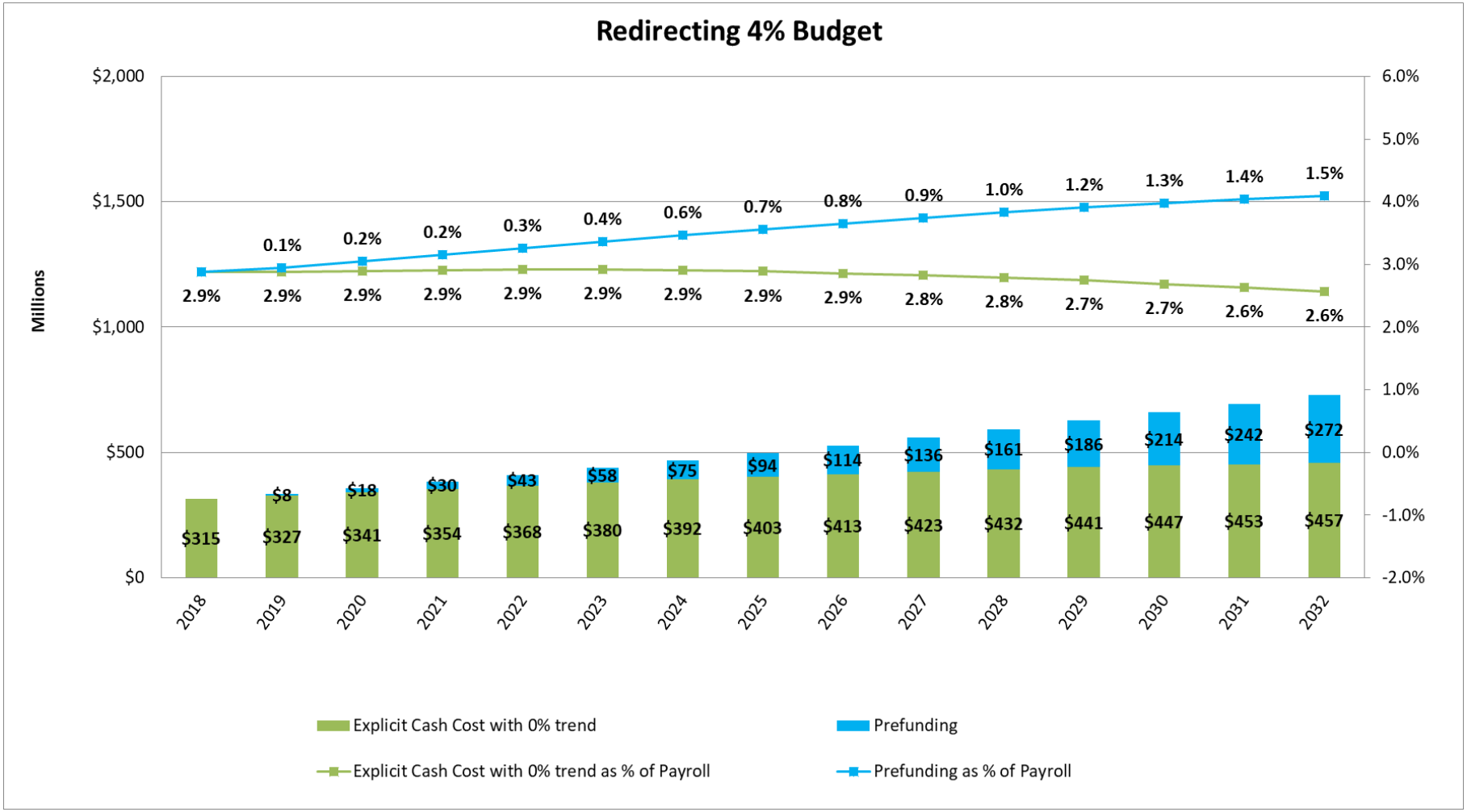
- To fully fund the plan over 30 years as a level percentage of payroll requires an annual contribution of ~6.5% of payroll, 3.7% more than the 2018 pay-as-you-go contribution
- The University's explicit cash cost projections are based on an annual 4% per capita cost increases





Illustrative – Redirecting 4% budget target

- Potential source of monies for pre-funding could be a lower budget increase; for illustrative purposes we show the impact of redirecting the entire 4% budget target to pre-funding (per capita explicit cash cost remains constant; cash costs increase due to retiree growth)
- By 2032, ~$272M or 1.5% of payroll could be redirected to pre-fund the plan



Summary of Savings Options

Items Modeled to Date

Summary – Potential Cost Savings

Increased Retiree Contributions	Potential UC Savings ($M)
Apply 10% contribution for dental benefits	**$3.8M**
Apply 20% contribution for dental benefits	**$7.5M**
Apply 30% contribution for dental benefits	**$11.1M**
Implement approximate contribution equivalency ($) between non-Medicare >65 and Medicare enrollees	**$2.0M**

Summary – Potential Cost Savings

Medicare	Potential UC Savings ($M)
Elimination of High Option	**$0.2**
Eliminate High Option; maintain MPPO rate	**$3.3**
Replace High Option and Medicare PPO with Medicare Advantage PPO*	**$6.2**
Increase Seniority Plus inpatient hospital copay from $250 to $500	**$0.4**
Increase Seniority Plus Rx out-of-pocket max/specialty copay to capture more Medicare reinsurance	**$1.5**
Introduce Health Net Medicare Advantage PPO in select counties	**$1.4**
Replace High Option, Medicare PPO and Seniority Plus with Medicare Advantage PPO*	**$12.1**
Full replacement Medicare Exchange in California	**$54.6M**

***Gray shading = magnitude of MA PPO savings is unknown without bid.** Illustrative figures assume combined Medicare PPO/High Option rate reduces by 10%; Kaiser continues

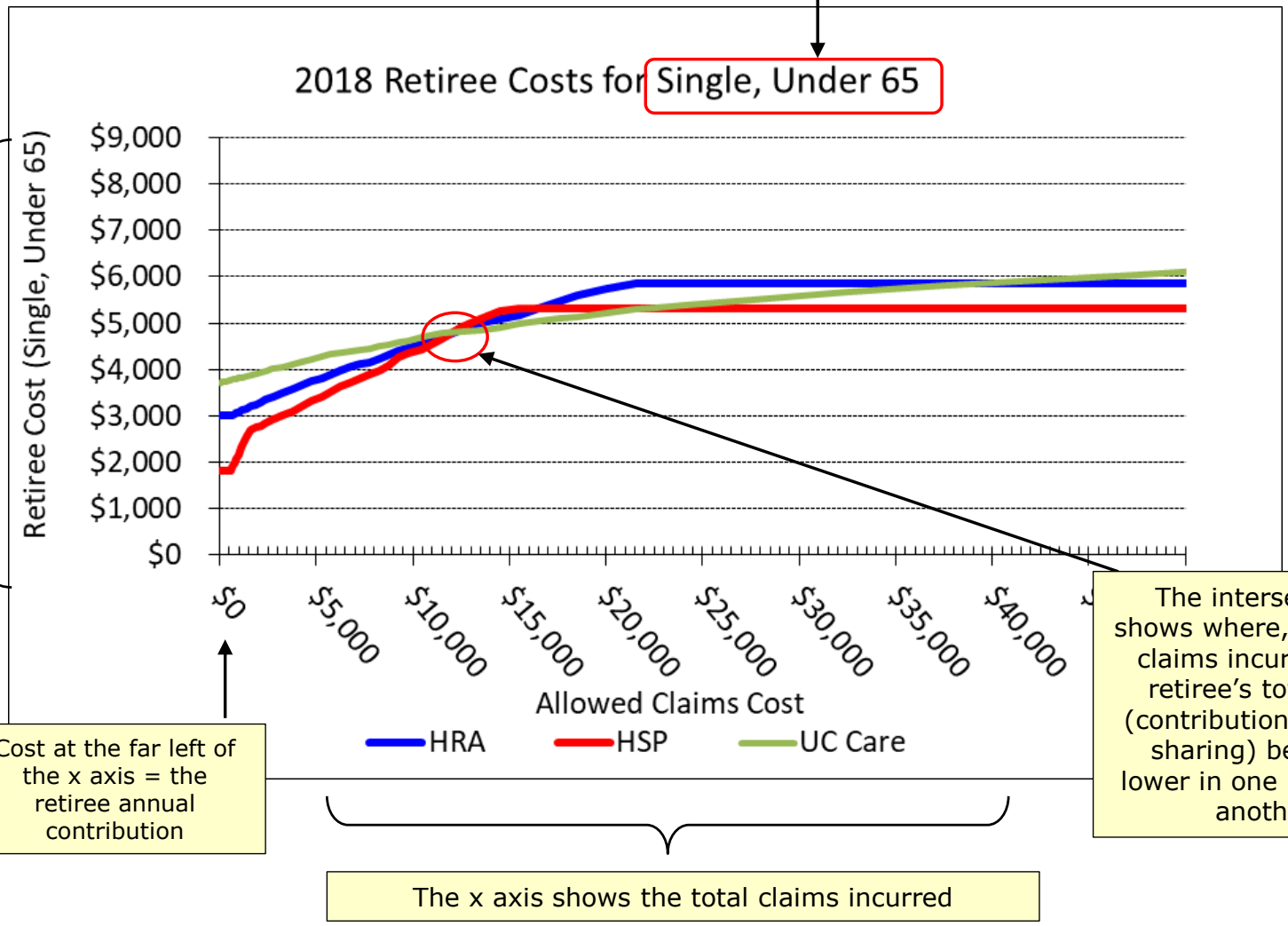
Summary – Potential Cost Savings

Non-Medicare	Potential UC Savings ($M)
Migrate UC Care enrollment to HSP	**$5.0M**
Migrate UC Care enrollment to HRA – B&G Equivalent Rate	**$1.7M**
Migrate UC Care enrollment to HRA – B&G/HSP Midpoint Rate	**$2.4M**
Increase Blue & Gold copayments substantially	**$1.5M**

Appendix

Guide to Cost Comparison Charts

Each chart is specific to a coverage tier and Age Range



The y axis shows total retiree costs – contributions plus claims cost-sharing

Cost at the far left of the x axis = the retiree annual contribution

The intersections shows where, based on claims incurred, the retiree's total cost (contributions + cost-sharing) becomes lower in one plan than another

The x axis shows the total claims incurred

This modeling assumes each UC Care enrollee uses Tiers 1, 2 and 3 in the same proportion as the overall plan population. Individuals who use only Tier 1 would have lower out-of-pocket cost.