Health Care Task force 1990-1994

Bowling Green State University. Administrative Staff Council

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Pre-Microfilm Inventory

Collection: Bowling Green State University
Administrative Staff Council, UA-022

Location: Bowling Green, Ohio

Title of Series: Health Care Task Force

Inclusive Dates: 1990-1994

Format: Bound [ ] Loose [X]

Order: Alpha [ ] Chronological [X] Numerical [ ]

Index: Included [ ] Separate [ ] None [X]

Notes

1. Colored Paper
2. Colored Ink
3. Pencil
4. Photocopies
5. Highlighter
1. BGSU will assume a responsible and pro-active role within the Bowling Green medical community to assure that its employees will have access to quality cost effective health care. In order to achieve this goal BGSU will maintain an active dialogue with area health care providers and will support and actively participate in community health planning.

2. BGSU encourages the formation of and participation in alternate health care delivery systems, such as Preferred Provider Organizations (PPO) where it can be demonstrated that they can provide quality, cost effective health care services to BGSU employees.

3. BGSU will promote employee understanding of its Health Care Benefits Program and how it may be used in a cost effective manner. Employees will be encouraged to give serious consideration to alternate treatment settings that can provide quality cost effective health care.

4. BGSU will encourage its employees to accept an active role in their own health maintenance by developing healthy life styles, increasing safety consciousness, and practicing responsible management of chronic disease.

5. BGSU is committed to making Health Care Cost Management a University wide effort. This is a formally endorsed goal of the University and not just a program of any one group within the University. This is an overall BGSU effort to address a challenge of increasing magnitude.

6. BGSU will develop a comprehensive utilization review program. The University will study the patterns of health care services in the Bowling Green area. Emphasis will be on identifying cost practices which seem to be out of line, such as unnecessary testing, unusually long hospital confinements, and unreasonably high fees. Focused programs will be implemented to address the identified situations.
Administrative Staff Council Recommendations on the Health Care Task Force Proposal

Overall recommendations:
1. Health care coverage, cost to employee, and cost to the University should be the same for all employee groups.
2. Access to additional coverage (such as family dental care) should be the same for all employee groups.
3. There should be differential employee cost based on whether the employee takes single, dual, or family coverage.
4. Modest co-payments rather than benefit curtailment should be used as a cost reduction strategy.
5. The Plans described in appendix C of the Task Force Report include a plan cap of $1,000,000. We recommend that there be no cap, and that the University investigate the purchase of additional catastrophic insurance coverage.
6. The implementation date of the new plan is of concern because employees have been hired for the year under the current plan and have just completed 125 Plan registration.
7. The University contributions to the cost of each employee’s health care plan should be equally applied regardless of marital status (in cases when the married couple are both University employees).

Mental Health Coverage
1. While the Administrative Staff Council acknowledges that BGSU’s mental health coverage costs have risen above the industry norm, it is recommended that the coverage not swing too far in the opposite direction. Mental health coverage is as important as physical health coverage.
2. The per year limit covered by the plan for out-patient care should be raised from $1000 to $2000.
3. To assist in controlling costs, the University should have a “gatekeeper” who would assist employees in finding the most appropriate mental health care for their particular needs. A gatekeeper is defined as a mental health professional, paid by the University’s health care plan, who would be located off campus and who would provide confidential consultation.
4. The phase in period should accommodate patients already in treatment.
5. Mental health professionals on campus should have input into the mental health portion of the proposal.
Health Care Options (Task Force Recommendation 16)

1. The Administrative Staff Council recommends that there be no deductible at all to encourage employees to seek early treatment.

2. There should be a co-payment that has a low percentage but a high limit, so that employees have an incentive to limit the costs of most levels of care.

3. Whichever options are made available, there must be a thorough and timely education program to acquaint employees with the ramifications of each choice.

Preventative Care

1. The Administrative Staff Council applauds the task force recommendations on health promotion and information. We urge the inclusion of additional measures to encourage early detection of health problems; namely, the health care program should cover the costs of mammograms, pap tests, prostatic cancer detection tests, and colon cancer tests.

2. The University should have a Health Care Educator to work with staff in such wellness activities as smoking cessation, weight loss, nutrition, and fitness.
## BGSU Health Care Claims: 1985-86 - 1989-90

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<th>Fiscal Year</th>
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<th>% Increase over Prior Yr</th>
<th>% Increase over 1985-6</th>
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## BGSU Health Insurance Rates (Annual Rates 9/1/90 - 8/31/91)

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<th>Employee Contribution</th>
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OPB 11/1/90
The Insurance Committee has been charged this year with making recommendations for a revised insurance benefits package. It is felt that our plan currently is well designed to provide good benefits; the problem is cost. Thus the primary purpose of the revision is to limit the University's expenditures for health care. This can be done by actually reducing costs, shifting costs to employees, or some combination of these. Possible options include:

1. Reduce utilization of health care. This might involve employee education about health consumerism, wellness programs, or going from our current first dollar one hundred per cent plan to one with deductibles, co-payment or both.

2. Reduce costs without reducing utilization. Possible tactics include negotiation with local providers, some sort of preferred provider plan, an HMO plan, or again, employee education and/or co-payment.

3. Reduce enrollment in our plan. This would probably mean establishing premium participation for all employees, as well as for all dependents. This might reduce participation by those who have other insurance options, such as being covered by a plan provided by their spouse's employer.

4. Shift costs to employees, through premium participation, co-payment, deductibles, or some combination of these.

Because they not only shift, but also may serve to reduce costs, I anticipate that the recommended changes will include premium participation and co-payment, and probably deductibles as well. The goal will be to reduce unnecessary costs without jeopardizing needed health care.

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<th>BUDGET LOADS FOR HEALTH INSURANCE, AND PER CENT INCREASE</th>
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<td>(10%)</td>
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MEMORANDUM

TO: Galen Finn  
    Treasurer

FROM: Gregg DeCrane  
      Chair, ASC

DATE: January 11, 1991

RE: Health Care Information

Jim Morris attended the Administrative Staff Council meeting on January 10 and gave an excellent presentation along with a Q & A session dealing with health insurance and benefits in general. He distributed a handout (enclosed) which assisted members in understanding health care costs. During the Q & A session, a question arose as to the amount of money contributed to health care. Another question asked if there was a summary report available that would show health care contributions, costs and reserves for the health care year, which we understand runs September 1 to August 31. Jim indicated that you would be the one who could supply such information. I would appreciate whatever you could provide that would give ASC members a clear picture of the health care picture from a money in/money out perspective.

GD/bal
pc: Jim Morris
    [ASC Executive Committee]
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<tr>
<th>DATE</th>
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<tr>
<td>March 20, 1991</td>
<td>Meet with Insurance Committee to lay out sequence of events</td>
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<tr>
<td>April 2, 1991</td>
<td>Consultants to meet with Insurance Committee</td>
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<tr>
<td>April 4-5, 1991</td>
<td>Focus Group meetings with Faculty, Administrative and Classified Staff personnel</td>
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<tr>
<td>April 10, 1991</td>
<td>Follow-up meeting with Costeffex to discuss results of preliminary Focus Group meetings (Martin, Dalton, Morris, Finn)</td>
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<td>April 15, 1991</td>
<td>Martin to meet with Vice Presidents and other members of Ad Council</td>
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<tr>
<td>4-18-91</td>
<td>Special meeting ASC</td>
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<tr>
<td>April 24, 1991</td>
<td>Follow-up Focus Group meetings with officers of Faculty Senate, Administrative and Classified Staff Councils, including PWC Chairs.</td>
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<tr>
<td>April 29, 1991</td>
<td>Meeting with Costeffex to devise communication plans</td>
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<tr>
<td>May 1, 1991</td>
<td>Announce plans for remainder of year to Insurance Committee</td>
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<tr>
<td>May 10, 1991</td>
<td>** Final date to announce plans for remainder of year to all employees</td>
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<tr>
<td>November 4 to December 2, 1991</td>
<td>Make final presentations to employees regarding health plan</td>
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** Should read: Date to advise employee groups of what lies ahead before end of semester as changes will hinge on budget constraints.
Phase I Services: Needs Assessment & Analysis

1. Determine what data is available and focus on meaningful data. $294 (3 hours)
2. Review and/or develop objectives based on "University Health Care Policy Statement". $1864 (20 hours)
3. Establish how much change in structure is required/acceptable. $788 (8 hours)
4. Establish how much change in cost is required/acceptable. $494 (5 hours)
5. Assist in determining how the current plan is perceived by faculty and staff and what tradeoffs are most acceptable. $694 (7 hours)
6. Compare various health care programs and their attributes and components to the existing plan for cost effectiveness. $835 (8 hours)
7. Compare the current plan to other area employers and other universities. $1576 (17 hours)
Phase II Services: Conceptual Design

1. Help communicate the need for change to employees and employee group welfare committees. $1570 (16 hours)

2. Describe, discuss, and further analyze those approaches to managing health care which, as a result of the needs assessment and analysis in Phase I, appear to be most appropriate for Bowling Green State University. $2258 (20 hours)

Examples include:
  o Increased deductibles and contributions
  o Case management/Utilization Review
  o HMOs
  o Psychiatric care alternatives
  o Direct provider contracting
  o Flexible benefits
  o Caps on provider charges
  o Develop a PPO for hospital services
  o Develop contractless PPOs for hospital, physician, and other services

3. Assist Bowling Green State University in analyzing the data necessary to evaluate the various health care program attributes and components which a new program or programs might contain. $741 (8 hours)

4. Compare various health care programs to the existing plan for cost effectiveness. $1675 (16 hours)
Phase III Services: Design Development

1. Help seek and evaluate feedback from employees and employee committees. $490 (5 hours)

2. In concert with Bowling Green State University benefits administrators and other university officials, design a restructured health benefit package. $2650 (21 hours)

3. Compare the restructured health benefit package against predefined objectives. $347 (4 hours)

4. Determine and recommend ways to maximize employee acceptance of changes, such as funding a Section 125 plan. $705 (6 hours)

5. Help design the decision making process. $388 (6 hours)

6. Assist in comparing the restructured plan to Bowling Green State University goals. $388 (6 hours)
Phase IV Services: Implementation

1. Help present the restructured benefit package to university officials. $735 (5 hours)
2. Help communicate the restructured plan to employees. $1770 (20 hours)
3. Assist in implementing a Section 125 plan. $1176 - $2940 (9 - 23 hours)
4. Assist in contracting with health care providers. $1470 - $3675 (14 - 35 hours)
5. Help Bowling Green State University develop a standard data reporting package in order to manage the restructured plan. $1176 (12 hours)
6. Help Bowling Green State University develop methodology to measure the amounts saved with the restructured plan. $788 (8 hours)
7. Devise additional criteria against which Bowling Green State University can determine whether the new benefit plan is working. $641 (6 hours)

The total cost of the project as outlined above is $29,882.
January 17, 1991

MEMORANDUM

TO: Gregg DeCrane, Chair
    Administrative Staff Council

FROM: Gaylyn J. Finn
        Treasurer and Assistant
        Vice President for Planning and Budgeting

RE: Health Care Information

In response to your January 11, 1991, memo, I am forwarding copies of the 1988/89, 1989/90, and to-date 1990/91 Health Care Analysis Report. This report shows the total of claims and premiums expended on behalf of the Health Care Program and the employee contributions and University accruals received by the program monthly. As you will note, expenditures exceeded accruals in the 1988 and 1989 fiscal years while accruals exceeded claims in fiscal 1990 and have for the first four months of fiscal 1991.

When considering reserves, I would first note that the general ledger balance in the Health Care Account at the end of December was $61,871. An appropriate reserve for a health care program with $8 million in claims would be in the vicinity of $1.5 to $1.8 million depending upon the claims lag. One of the ongoing concerns of Arthur Andersen, the University's external auditors, is the lack of an adequate health care reserve. University management concurs with this concern and has, in recent years, increased the annual accruals at a rate greater than the expected claims growth and is committed to maintaining an accrual rate, which will build an adequate health care reserve over a period of years without creating drastic budget reallocations.

Also attached is a schedule showing the increases in the Budget Accrual Rates, Total Accruals, and Actual Claims for the last four years and the increase in the Budget Accrual Rates for the 1990/91 year. Hopefully, this information will shed some light on the characteristics of the Health Care Program and considerations which must be dealt with when considering new health care benefits and the funding the University wants to contribute to the program. If you have any questions about the attachments, please feel free to call me.

GJF:msb/GF428

Attachments
cc: J. Christopher Dalton
    Jim Morris
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Accrual Variance
**HEALTH CARE ANALYSIS**

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<th>VARIANCE</th>
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<td>504,549.81</td>
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<td>813,569.95</td>
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<td>-252,762.32</td>
<td>573,054.99</td>
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<td>TOTAL</td>
<td>6,054,597.76</td>
<td>5,892,176.26</td>
<td>-162,421.50</td>
<td>6,876,659.92</td>
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<td>6,876,659.92</td>
<td>7,460,582.96</td>
<td></td>
<td>613,923.04</td>
<td>822,062.16</td>
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</tbody>
</table>

-2.8% Accrued Variance

86/89 Average: 504,549.81  491,014.69

Monthly Var.: 68505.18  132200.56

13.6%  27.1%

(1) When Life deductions were cancelled, all University deductions were cancelled. Corrected in Nov.
<table>
<thead>
<tr>
<th>Month</th>
<th>Claims/ Premium</th>
<th>Deductions/ Cash PMTS</th>
<th>Univ. Contr.</th>
<th>Variance</th>
<th>Cumulative Average</th>
<th>Variance</th>
<th>Cumulative Average</th>
<th>Variance</th>
<th>Cumulative Average</th>
<th>From 1989/90</th>
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<td>SEPTEMBER</td>
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<td>267,542.39</td>
<td>352,642.69</td>
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<td>OCTOBER</td>
<td>776,159.76</td>
<td>45,759.58</td>
<td>(1)</td>
<td>730,400.18</td>
<td>564,304.23</td>
<td>989,057.87</td>
<td>732,558.39</td>
<td>-256,499.48</td>
<td>756,652.89</td>
<td>212,898.11</td>
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<td>NOVEMBER</td>
<td>-416,832.67</td>
<td>1,250,866.82</td>
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<td>834,035.95</td>
<td>515,211.71</td>
<td>-459,952.95</td>
<td>729,304.59</td>
<td>260,352.04</td>
<td>657,752.91</td>
<td>43,120.28</td>
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<td>DECEMBER</td>
<td>458,703.87</td>
<td>648,014.72</td>
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<td>189,310.85</td>
<td>501,084.75</td>
<td>-488,413.50</td>
<td>726,091.18</td>
<td>2,476,776.88</td>
<td>615,418.06</td>
<td>29,709.63</td>
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<td>JANUARY</td>
<td>463,391.89</td>
<td>644,616.55</td>
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<td>181,224.66</td>
<td>493,546.18</td>
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<td>615,418.06</td>
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<td>FEBRUARY</td>
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<td>127,115.92</td>
<td>497,326.87</td>
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<td>615,418.06</td>
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<td>MARCH</td>
<td>531,925.15</td>
<td>645,705.00</td>
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<td>113,779.85</td>
<td>502,269.48</td>
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<td>JUNE</td>
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<td>JULY</td>
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<td>-237,300.49</td>
<td>551,190.00</td>
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<td>615,418.06</td>
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<td>615,418.06</td>
<td>0.00</td>
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<tr>
<td>AUGUST</td>
<td>813,569.95</td>
<td>560,807.63</td>
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<td>-252,762.32</td>
<td>573,054.99</td>
<td>0.00</td>
<td>615,418.06</td>
<td>0.00</td>
<td>615,418.06</td>
<td>0.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6,876,659.92</td>
<td>7,190,582.96</td>
<td></td>
<td>613,923.04</td>
<td>2,461,672.22</td>
<td>2,914,568.94</td>
<td>452,896.72</td>
<td>457,333.23</td>
<td>6.7%</td>
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<td>Mo. Ave.</td>
<td>573,054.99</td>
<td>624,215.25</td>
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<td>51,160.25</td>
<td>615,418.06</td>
<td>728,642.24</td>
<td>113,221.18</td>
<td>15.5%</td>
<td>Accrual Variance</td>
<td></td>
</tr>
</tbody>
</table>

8.2% Accrual Variance
89/90 Average 613,923.04
Monthly Var. 113,221.18

(1) When Life deductions were cancelled, all University deductions were cancelled. Corrected in Nov.
BGSU HEALTH CARE PLAN EVALUATION

DEFINING OBJECTIVES

Philosophical Issues

1. What does University want to achieve with Benefits Program

2. How does it want faculty and staff to perceive the program

3. What are the strengths and weaknesses of current program

Equity Issues

4. Who should bear the cost of Health Care - Actively to remain but retire?

5. Should different constituent groups be treated differently under benefits program

Seniority Issues

6. Should length of service with University be a factor in eligibility or level of benefits provided.

Flexibility Issues

6. Benefit choice - to what extent should staff members be given choices in selecting benefits

7. What benefits should be provided as regular part of program

Cost Management Issues

8. How much emphasis should be placed on controlling cost of benefits program

Parity Issues

9. Should all categories of participants pay equally for costs of benefits

a. Single VS Dependent contributions

b. Contract VS Classified contribution levels

10. Is University administration prepared to accept potential reaction to changes made in benefits program
STRATEGY

Scope of Study

Could

1. Should study include personnel policies - fringe benefits? (vacations, tuition assistance, etc) or only health benefits - for part time

Priorities

a. Cost shifting vs cost management
b. Timing of implementation of changes

Are we only going to pay benefits for catastrophic situations? Prevention?

Why can't my health insurance be like my car insurance? That is, if I raise the deductible amount, then I lower my rate (cost).

C. Cafeteria plan -

Why do I have to pay for others' people

Present vs. Past.

Increase Vision (their percentage) 50%?
Assumptions:

1. The current benefit package is a good package and should not be weakened.
2. If an employee is involved in the cost, the employee will be an informed consumer.
3. The employee will assume a reasonable share of the cost.
4. Some costs are avoidable/inappropriate.
5. Control of costs can be from several areas.
6. The University should be involved in personal lifestyle of employees.
7. The lifestyle of employees has an impact on health care costs.
8. Advanced technology will result in higher costs.
9. The University has a responsibility to inform employees of costs.
10. The University can make employees assume responsibility for well being and to develop healthy lifestyles that will promote and maintain wellness.
11. Involvement in alternate health care delivery systems will provide quality, cost effective health care services to BGSU employees.
12. The University will remain committed to making Health Care Cost Management a University-wide effort.

Goals:

1. The University will provide comprehensive health care benefits that will promote quality, cost effective health care and protect its employees and family from the effects of catastrophic illness.
2. The University will make available Wellness Programs that will function in accordance with its Health Care principles.
3. The University will remain committed to making Health Care Cost Management a University-wide effort.
4. The University will maintain a comprehensive utilization review program.
5. The University will promote employee understanding of its Health Care Benefits Program and how it may be used in a cost effective manner.
6. The University will assume a responsible and pro-active role within the Bowling Green medical community to assure that its employees will have access to quality cost effective health care.
GOALS FOR BGSU HEALTH CARE PLAN

Assumptions:

1. The current benefit package is a good package and should not be weakened.
2. If an employee is involved in the cost, the employee will be an informed consumer.
3. The employee will assume some reasonable share of the cost.
4. Some costs are avoidable/inappropriate.
5. Control of costs can be from several areas.
6. The University should be involved in personal lifestyle of employees.
7. The lifestyle of employees has an impact on health care costs.
8. Advanced technology will result in higher costs.
9. The University has a responsibility to inform employee participants of costs.
10. The University expects employees to assume responsibility for well being and to develop healthy lifestyles that will promote and maintain wellness.
11. Involvement in alternate health care delivery systems will provide quality, cost effective health care services to BGSU employees.
12. Include responsibility for health and welfare of employee dependents as well.

Goals:

1. The University will provide comprehensive health care benefits that will promote quality, cost effective health care and protects its employees and families from the effects of catastrophic illness.
2. The University will make available Wellness Programs that will function in accordance with its Health Care principles.
3. The University will remain committed to making Health Care Cost Management a University-wide effort.
4. The University will maintain a comprehensive utilization review program.
5. The University will promote employee understanding of its Health Care Benefits Program and how it may be used in a cost effective manner.
6. The University will assume a responsible and proactive role within the Bowling Green Medical Community to assure that its employees will have access to quality cost effective health care.
March 19, 1991

PWC Members:

Enclosed is the memo I sent Genevieve Stang regarding the Insurance Committee's goals. I hope I "captured" our intent and concerns.

Our next meeting will be April 2nd at 11:00 at the CAC. We will pull together information to be distributed at the ASC meeting on the 4th. I will prepare 125F information. If you could think of other areas of concern to be addressed, please come prepared to discuss them. We also will meet according to our "regular" schedule on April 9th and 23rd.

Ann
MEMORANDUM

TO: Genevieve Stang  
Chair, University Insurance Committee

FROM: Ann Bowers  
Chair, ASC Personnel Welfare Committee

DATE: March 19, 1991

RE: Insurance Committee Health Care Plan Goals

The Administrative Staff Council Personnel Welfare Committee reviewed the Insurance Committee's Health Care Plan Goals at our last meeting and by way of this memo offer these comments and recommendations. It is our understanding that you requested these comments prior to the next Insurance Committee meeting.

Health Care Plan Evaluation (Jim Morris)

Under Flexibility Issues, number 7; add "and what benefits should/could be optional."

Under Cost Management Issues, number 8; add "including administrative costs."

Also somewhere in the objective, we believe health benefits for part-time employees should be addressed...possibly under Equity Issues.

Insurance Committee Goals for BGSU Health Care Plan

Assumptions:

3. We agree that the employee should assume some share of the health care costs, but we are concerned as to who defines what "reasonable" means.

6. The statement should be eliminated as it easily could be construed in a negative manner.

7. and 10. could be combined into the following:

"The health habits of employees has an impact on health care costs; therefore, the University should encourage employees through various incentives and opportunities to assume responsibility for well being and to develop health habits that will promote and maintain wellness."

(We believe "lifestyle" as a term encompasses much more than health habits and potentially could be construed in a negative manner and also could bring in issues of confidentiality)
Goals:

With this goal, again we realize its positive nature but we are concerned that employees might construe it as potentially coercive. For example, an employee might believe that presenting a certain type of medical claim could result in payment based on mandatory attendance at an appropriate support group.

We also would like to see preventive health care issues addressed, such as physical exams and preventive diagnostic testing not presently covered, e.g., mammograms, pap tests, etc.

Overall we find the goals to be thoughtful and balanced. Thank you for the opportunity to respond to them. If you have any questions on the above recommendations, you may refer them to Lori Schumacher, the Administrative Staff Council PWC representative on the Insurance Committee, or to me.
Notes from 3/20/91 Insurance Committee Meeting

At the last PWC meeting on 3/12/91, Ann asked me to summarize my notes from the Insurance Committee Meeting and distribute to all members of PWC before our next meeting which has been set up for 4/2/91.

As noted on the attached schedule, 4/3/91 is when the Insurance Committee will be meeting with Costeffex. So PWC meeting on 4/2/91 will be important. I asked Josh Kannan to come to our PWC meeting on 4/2 because I feel we are the most informed group because of Josh’s background, and I’d like to see us stay that way.

4/4-5, Costeffex will be meeting with various Focus Groups, and Jim Morris stated that these groups will be determined by the VP’s.

4/10, this meeting will be with Martin, Dalton, Finn, and Morris

4/15, CORRECTION. Martin to meet with VP’s and other members of the AD COUNCIL. This is a regularly scheduled Ad Council meeting.

4/24. Add to this group the Chairs of the different Personnel Welfare Committees.

Skip to 5/10. This should be changed to read: date to advise employee groups of that lies ahead before and of semester, and some these changes hence the budget constraints. However, as was brought out in our meeting, there are going to be some changes made for the 91/92 year. and POSSIBLY these changes may all be passed onto the employees. If Administration does nothing in the way of changes, the increase in University costs is projected to go up at least by 1 million. Therefore, employees MAY see cost shifting, premium sharing, increase in deductible, charging a flat rate for all employees (whether single or family), leave insurance as is and take the total increase out of salary pool. Nothing has been decided one way or the other, but we need to make our feelings known about these examples noted above. If you have any other ideas on how to contain costs, please bring to our meeting on 4/2/91.

A follow-up to the memo Ann sent to Genevieve Stanz concerning the goals and assumptions. Each welfare core had changes that we briefly went over, the faculty’s being the longest! The assumptions were where most of the changes were noted. CSF agreed with our concerns with #3 and the term “reasonable”. All agreed to deleted #6, and no one liked the term “life style”. The only goals that anyone had problems with #1. and #2. Therefore, it was decided that goals #3-6 would remain as is. And it was suggested that we as a group don’t have to come up with a set of goals that are homogenous. That this draft was to be used as a springboard and to spark discussion and that is exactly what it did.

Our time was quickly running out, and we didn’t know how to roll all of these changes into a neat list that would apply to all 3 factions, so it was decided that when the Insurance Committee meets with Costeffex that we each present our concerns.

See you on 4/2/91.
STRATEGIES AND SEQUENCE OF EVENTS
FOR
HEALTH CARE PLAN STUDY

<table>
<thead>
<tr>
<th>DATE</th>
<th>NATURE OF EVENT AND PARTIES INVOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 20, 1991</td>
<td>Meet with Insurance Committee to lay out sequence of events</td>
</tr>
<tr>
<td>April 3, 1991</td>
<td>Consultants to meet with Insurance Committee</td>
</tr>
<tr>
<td>April 4-5, 1991</td>
<td>Focus Group meetings with Faculty, Administrative and Classified Staff personnel</td>
</tr>
<tr>
<td>April 10, 1991</td>
<td>Follow-up meeting with Costeffex to discuss results of preliminary Focus Group meetings</td>
</tr>
<tr>
<td>April 15, 1991</td>
<td>Martin to meet with Vice Presidents and other members of Executive Committee</td>
</tr>
<tr>
<td>April 24, 1991</td>
<td>Follow-up Focus Group meetings with officers of Faculty Senate, Administrative and Classified Staff Councils</td>
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<tr>
<td>April 29, 1991</td>
<td>Meeting with Costeffex to devise communication plans</td>
</tr>
<tr>
<td>May 1, 1991</td>
<td>Announce plans for remainder of year to Insurance Committee</td>
</tr>
<tr>
<td>May 10, 1991</td>
<td>Final date to announce plans for remainder of year to all employees</td>
</tr>
<tr>
<td>November 4 to</td>
<td>Make final presentations to employees regarding health plan</td>
</tr>
<tr>
<td>December 2, 1991</td>
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1990-91 EMPLOYER CONTRIBUTIONS FOR MEDICAL INSURANCE
BGSU CONTRACT AND CLASSIFIED STAFF VS. THE STATE OF OHIO

Does Not Include Vision and Dental Coverage

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<tr>
<th></th>
<th>1990-91</th>
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<th>1990-91</th>
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<tbody>
<tr>
<td>State Employee Single</td>
<td>$1362</td>
<td>$2008</td>
<td>$3610</td>
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<tr>
<td>Fac/Admin Staff Single</td>
<td>$1487</td>
<td>$2083</td>
<td>$3996</td>
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<td>Classified Staff Single</td>
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<tr>
<td>State Employee Family</td>
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<td>$4748</td>
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<td>Fac/Admin Staff Family</td>
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<tr>
<td>Classified Staff Family</td>
<td></td>
<td></td>
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</tbody>
</table>

Dollars

1990-91
ANNUAL COST OF HEALTH INSURANCE PER BGSU FACULTY/ADMINISTRATIVE EMPLOYEE WITH FAMILY COVERAGE

Source: OPB; 4/91.
EDUCATIONAL BUDGET INCOME PROJECTIONS: 1991-92

ASSUMING INSTRUCTIONAL SUBSIDY AND TUITION CAP IN EXECUTIVE BUDGET

|               | 1990-91       | 1991-92       | $\text{Change} $ & \% \text{Change} |
|---------------|---------------|---------------|-----------------|------------------|
|               | Projected Income & $1-Apr-91 | Projected Income & 1-Apr-91 | FY 91 to FY 92 | FY 91 to FY 92 |
| Instructional Subsidy | $80,577,133 | $56,965,535 | ($3,611,653) | -5.96% |
| Developmental Education | $20,117 | $0 | ($20,117) | -100.00% |

COMMENTS
- Projected Net Main Campus Subsidy
- Eliminated in Executive Budget

|                      | 1990-91   | 1991-92   | $\text{Change} $ & \% \text{Change} |
|----------------------|-----------|-----------|-----------------|------------------|
| Total State Funds    | $60,597,305 | $56,965,535 | ($3,631,770) | -5.99% |

Student Instructional Fees
- $42,950,000
- $46,386,000
- $3,436,000
- 8.00%

Non-Resident Fee
- $7,050,000
- $7,614,000
- $564,000
- 8.00%

Misc./Off-Campus Fees
- $1,540,000
- $1,663,200
- $123,200
- 8.00%

Total Student Fees
- $51,540,000
- $55,663,200
- $4,123,200
- 8.00%

GSC - Auxiliaries
- $4,343,642
- $4,560,324
- $217,182
- 5.00%

GSC - Grants
- $245,000
- $245,000
- $0
- 0.00%

Interest Income
- $1,337,500
- $1,287,500
- ($100,000)
- -7.21%

Department Sales
- $313,000
- $313,000
- $0
- 0.00%

Application Fees
- $370,000
- $351,500
- ($18,500)
- -5.00%

Miscellaneous Income
- $485,000
- $485,000
- $0
- 0.00%

Total Other Income
- $7,144,142
- $7,242,824
- $98,682
- 1.38%

Prior Year Carryover
- $600,000
- $0
- ($600,000)
- -100.00%

Total Sources of Income
- $119,831,447
- $119,927,159
- ($9,889)
- -0.01%

OPB 4/1/91

Assumes Constant Enrollment and Maximum Allowed Fee Increase

Assumes 5% Increase for 91-92

Lower Interest Rates; More Credit Card Use

Fewer Applications Projected

Carryover Eliminated by 1990-91 Cuts
## BGSU HEALTH CARE BENEFIT COSTS


<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total Costs*</th>
<th>$ Increase over Prior Yr</th>
<th>% Increase over Prior Yr</th>
<th>% Increase over 1985-6</th>
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</thead>
<tbody>
<tr>
<td>1985-86</td>
<td>$4,131,444</td>
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<tr>
<td>1986-87</td>
<td>$4,658,183</td>
<td>$526,739</td>
<td>12.75%</td>
<td>12.75%</td>
</tr>
<tr>
<td>1987-88</td>
<td>$4,324,180</td>
<td>$165,937</td>
<td>3.56%</td>
<td>16.77%</td>
</tr>
<tr>
<td>1988-89</td>
<td>$5,892,176</td>
<td>$1,067,996</td>
<td>22.14%</td>
<td>42.62%</td>
</tr>
<tr>
<td>1989-90</td>
<td>$7,490,533</td>
<td>$1,598,407</td>
<td>27.13%</td>
<td>81.31%</td>
</tr>
<tr>
<td>1990-91</td>
<td>$8,400,000</td>
<td>$909,417</td>
<td>12.14%</td>
<td>103.32%</td>
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<tr>
<td><strong>1981-92(est.)</strong></td>
<td><strong>$9,744,000</strong></td>
<td><strong>$1,344,000</strong></td>
<td><strong>16.00%</strong></td>
<td><strong>135.85%</strong></td>
</tr>
</tbody>
</table>

* Includes Both University and Employee Contributions

OPB 4/16/91
ANNUAL COST OF BGSU HEALTH INSURANCE
(Includes Employee & Univ. Contribution)

- Fac/Admin Staff Single: $1795
- Fac/Admin Staff Family: $2262
- Classified Staff Single: $4296
- Classified Staff Family: $5115

Dollars

1990-91
ANNUAL UNIVERSITY CONTRIBUTION PER EMPLOYEE
FOR BGSU HEALTH INSURANCE COVERAGE

1990-91

Fac/Admin Staff Single
$1795

Classified Staff Single
$2262

Fac/Admin Staff Family
$5+15

Classified Staff Family
$5+15
ANNUAL COST OF BGSU HEALTH INSURANCE
FOR EMPLOYEE WITH FAMILY COVERAGE

Dollars

Faculty/Admin Staff
Classified Staff

1985-86  $2243
1986-87  $2703
1987-88
1988-89
1989-90  $4296
1990-91  $5415
ANNUAL UNIVERSITY CONTRIBUTION FOR HEALTH INSURANCE
FOR BGSU EMPLOYEES WITH FAMILY COVERAGE

Dollars

1985-86 $1332
1986-87 $2703
1987-88
1988-89
1989-90
1990-91

$5415

Faculty/Admin Staff
Classified Staff
Does Not Include Vision and Dental Coverage
MEMORANDUM

TO: Administrative Staff Council Members
FROM: ASC Personnel Welfare Committee
DATE: April 4, 1991
RE: Health benefits

By now you have read the memos from President Olscamp and Vice Presidents Dalton and Martin. In a nutshell, the 16% increase ($1.3 million dollars) in University health care costs projected for the 1991-92 budget will have to be "paid" by the employees of BGSU. Taking 2000 as a rough figure of people employed at BGSU, payment of this increase would average out at $650 per employee. The fact that an appropriate salary increase (if any) most likely will not be part of our 1991/92 contracts, adds great significance to the decisions made on how we will "pay" for our health benefits.

Costeffex was hired, with appropriate input from all constituent groups, to review the University's health care plan with the first priority being to recommend ways to "substantially reduce the rate of increase in the University's contribution for health care benefits for 1991/92 and beyond." (Dalton/Martin memo). Costeffex will be meeting with focus groups (Executive Councils and Personnel Welfare Committees as well as selected members from each constituent group) the rest of this week. According to the timeline enclosed, you can see that on April 24th, the Executive Councils and Personnel Welfare Committees will have another chance for input and by May 10th, decisions will be made as to how that $1.3 million anticipated increase in health care costs will be paid.

Thus, we need input from you and your constituents and we need this input by April 15th. In addition to the enclosed timeline is a list of areas of consideration (not a formal survey) to discuss with your constituents. We recognize that this is not a "scientific" survey, instead we are trying to have people begin to think about health care cost issues and obtain some quick feedback on particular methods of cost-sharing. The Personnel Welfare Committee will appreciate receiving whatever information you can obtain from your constituents as soon as possible but definitely by April 15th. You can call or send the information to any member of the PWC (list of names, numbers and addresses enclosed).

Costeffex will continue to study our health care plan and undertake more formal surveys, throughout the summer and Fall Semester 1991, with the goal of recommending ways in which we can improve our plan while limiting costs to both the employer and employee. The deadline of May 10th for decisions involving the 1991/92 budget, however, require us to respond quickly but with as much feedback from all administrative staff as possible. Your cooperation in obtaining this information is appreciated.
Health Care Costs-Areas of Consideration

1. Given that you will be asked to share the costs of health care benefits would you prefer that the cost-sharing be the same for all employees or pro-rated according to salary.

2. Do you believe that the University should support dependent care coverage? Do you think that the University should support health care for all employees and then ask the employee to buy dependent care?

3. Given that you will be asked to share the costs of health care benefits would you prefer a higher deductible (for example the first $500) or higher percentage of co-payments or higher premium contributions?

4. Would you opt to not be covered by the University (for example, if you and/or your dependents can be covered by another policy) if you had to share more of the health care costs?

5. Other issues or comments on cost-sharing?

Last, for your information, ASC has gone on record supporting and requesting implementation of the 125 Plan. See enclosed information on 125 Plan. No matter what the cost sharing plan will be, we will urge implementation of the 125 Plan and the establishment of flexible spending accounts.

Members of ASC Personnel Welfare Committee

Ann Bowers, Center for Archival Collections, 2-2411
Robert Graham, Institute for Great Lakes Research, 374-3907
Jacquie Joseph, Athletic Department, 2-7066
Pat Koehler, WBGU-TV, 2-7128
Cindy Puffer, Health Services, 2-7443
Lori Schumacher, Payroll, 2-2201
Mary Beth Zachary, Circulation, Jerome Library, 2-2054
### STRATEGIES AND SEQUENCE OF EVENTS FOR HEALTH CARE PLAN STUDY

<table>
<thead>
<tr>
<th>DATE</th>
<th>NATURE OF EVENT AND PARTIES INVOLVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 20, 1991</td>
<td>Meet with Insurance Committee to lay out sequence of events</td>
</tr>
<tr>
<td>April 3, 1991</td>
<td>Consultants to meet with Insurance Committee</td>
</tr>
<tr>
<td>April 4-5, 1991</td>
<td>Focus Group meetings with Faculty, Administrative and Classified Staff personnel</td>
</tr>
<tr>
<td>April 10, 1991</td>
<td>Follow-up meeting with Costeffex to discuss results of preliminary Focus Group meetings (Martin, Dalton, Morris, Finn)</td>
</tr>
<tr>
<td>April 15, 1991</td>
<td>Martin to meet with Vice Presidents and other members of Ad Council</td>
</tr>
<tr>
<td>April 24, 1991</td>
<td>Follow-up Focus Group meetings with officers of Faculty Senate, Administrative and Classified Staff Councils, including PWC Chairs.</td>
</tr>
<tr>
<td>April 29, 1991</td>
<td>Meeting with Costeffex to devise communication plans</td>
</tr>
<tr>
<td>May 1, 1991</td>
<td>Announce plans for remainder of year to Insurance Committee</td>
</tr>
<tr>
<td>May 10, 1991</td>
<td>** Final date to announce plans for remainder of year to all employees</td>
</tr>
<tr>
<td>November 4 to</td>
<td>Make final presentations to employees regarding health plan</td>
</tr>
<tr>
<td>December 2, 1991</td>
<td></td>
</tr>
</tbody>
</table>

** Should read: Date to advise employee groups of what lies ahead before end of semester as changes will hinge on budget constraints.
Summary of Flexible Spending Account Provision

Section 125 of the Internal Revenue Code allows employers to establish a "spending account" for each employee. Into this account each employee may place a specified amount of his or her salary that will then be used for pre-determined purposes as acceptable under the IRS guidelines. The amount placed into the account is pre-tax income and as such is not reported to the IRS as income, although it is reported as salary income to the Public Employees Retirement System. Each year the employee establishes the amount of salary that will be placed into this pre-tax account and the amount that will be used for each primary purpose such as child care, insurance premiums, health care costs not covered by the employer's insurance. The account can then only be used for those purposes, and funds cannot be shifted from one category to another, e.g., between child care and insurance premiums. It is critical that at the beginning of the year, the employee be as accurate as possible in estimating the amount to be placed into each category and into the total fund, as ANY MONEY NOT USED BY THE END OF THE YEAR CANNOT BE CLAIMED BY THE EMPLOYEE.
MEMORANDUM

TO: BGSU Faculty and Staff
FROM: Paul J. Olscamp
President

RE: Comments on Changes in BGSU Health Care Benefit Plan

Since there are a number of rumors circulating on campus concerning potential changes in our health care plan, I thought it important to clarify for you what changes are under consideration for 1991-92 as well as what changes we are not considering for this coming year.

First, there will be no reductions in the current health care plan coverage (medical, dental, vision, prescriptions, etc.) for 1991-92. Nor will there be any reductions in the amount of money the University currently provides for employee and dependent health care benefits.

What is under consideration is having faculty and staff pay the major share of the projected increases in the cost of providing health care benefits for 1991-92. This is, unfortunately, the only realistic option for covering the increased cost of health care benefits, given the fact that projections based on Governor Voinovich's recently released Executive Budget recommendations indicate that there will be a reduction in educational budget revenue for BGSU for 1991-92. Even though we will implement a plan permitting faculty and staff to pay their share of health care “premium” costs with pretax dollars, I fully understand that increased employee cost-sharing is not a step that employees will like. I assure you that it is not an action that we will take without extensive consultation, careful thought and considerable effort to distribute cost-sharing contributions equitably among employee groups.

After the cost-sharing changes dictated by the immediate financial problem have been finalized, a much more extensive cost containment evaluation of our current health care plan will be performed. It will consider level and types of benefits, cost of providers' services, and availability of alternate provider options, among other matters. There will be extensive consultation with employee groups designed to allow us all to work together toward developing a restructured Health Care plan which can meet the long range goals of managing costs for both the University and the employees. It will also be designed to allow further tailoring of benefits to individualized employee needs to include opportunities for tax sheltering of out-of-pocket health care costs. Changes recommended as a result of this process will become effective in 1992-93.
This second phase of our health care plan review should begin this summer with initial recommendations for restructuring of the health care plan available by the end of the fall semester. The spring semester will be mainly devoted to providing extensive information to faculty and staff so they can better understand their opportunities to structure their participation in a revised health care benefits plan in a way that is most advantageous to them. It is the intent of the University that the restructuring of the health care plan be done in such a way that no group of employees is disadvantaged relative to any other, and the needs of all be equally considered.

We originally intended to consider options for increasing employee sharing in the cost of providing health care benefits as part of the full evaluation and restructuring of the BGSU health care plan to be implemented in 1992. However, this spring's fast-breaking state budget crisis, culminating in the release of the Executive Budget during the week before spring break, forced us into a situation where we had to move ahead to plan greater employee cost-sharing for 1991-92. We had no control over this sequence of events, and little warning of the unexpectedly large reductions being proposed. In order to give academic-year employees an opportunity to have input and to be fully apprised of any changes before they left for the summer, we needed to begin soliciting employee input immediately following spring break. Unfortunately, this allowed only minimal advance notice for participating faculty and staff.

We felt that it would be beneficial in gaining this input to utilize Costeffex, the health care consultant recently hired to assist the University in reviewing and restructuring its health care plan. As a result, a representative of Costeffex held a series of meetings on April 3rd - 5th with constituent groups as well as groups of employees (focus groups). Costeffex's charge was to gather input from consultations with employees, and to make recommendations on how best to implement increased employee cost-sharing as an initial strategy to address the University's rapidly increasing health care costs. These recommendations will be shared with constituent groups on April 24th and 25th for their comment before final decisions on the recommendations are made in early May.

I hope that this letter has clarified the changes that we are considering in the BGSU health care benefit plan and the reasons that we are considering those changes. Should you have additional questions, comments, concerns or advice that you would like us to consider, please feel free to communicate them to me, Vice Presidents Martin or Dalton, or Director of Benefits, Jim Morris.
MEMORANDUM

TO: Pat Koehler, Mary Beth Zachary, Cindy Puffer, Bob Graham, Lori Schumacher

FROM: Ann Bowers

DATE: April 18, 1991

RE: Health benefits survey

After our discussion Tuesday, I thought I would summarize for each of you the "to date" results from the survey; however, as we decided this information should not be circulated at this time. Since we are working with just about 50 responses, it would be irresponsible to have the results used as definitive responses from administrative staff.

Question one: cost-sharing equal=22
pro-rated=29
Comments: Use sliding scale if pro-rate
Pro-rate by use, not salary
Phase in costs for classified
Health care does not equal salary, therefore costs should not be pro-rated on salary

Question two: Employee pay dependent care=24
University pick up in some way=26
Comments: More equitable to have dependent care paid by employee
University pay % of dependent care based on salary differences should be based on salary irregardless of constituent group
University pay dependent care but earlier age that coverage ends such as 18 with option for employee to pick up coverage after 18
Need to provide permanent part time staff with ability to at least buy health care
Dependent care should be purchased based on # dependents
Offer three levels: single, couple, family
Options should be provided, i.e. cafeteria plan

Question three: Premium=12
Deductible=17
Copay=17
Comments: 125k plan is necessary, but need to educate people so understand where money not used goes
Deductible should not be so high that it discourages people from seeking medical attention, i.e., $500 per person too high, perhaps per family deductible such as $250 per person/$500 per family
Higher copay so users pay
Higher premium based on salary
Whatever decided, should be combination so equitable (this comment came from several people)
More comments from question three:

- Combine deductible and copay with cap, then goes to 100% coverage.
- If raise premium, then must start incentive plan to help keep costs down.
- Combination: raise deductible on dental/vision, copay prescription drugs; raise major/medical deductible.
- Always place cap on increases in payment so covered for major health costs.

Question four: 25 no
14 yes
5 maybes/not sure depending on high costs were raised.
Comments: More may drop out if positive, not negative incentive to do so.

General Comments:

1. Great concern that cuts not be so severe that discourage utilization. If care is only provided at least level of medical intervention then costs will just increase because health problems will be greater/more costly.
2. Keep in mind that with no salary increase and raise in health care costs, many families/individuals may be forced to make decisions based on first comment.
3. 125K-people want, but are somewhat distrustful as to how it will be presented, administered and where excess monies will go.
4. 1.3 million dollar figure; is this just an easy mark?
5. Preventive care must be provided; especially if we pay more for our health care. Also educational programs, incentive (both positive and negative) to promote better health, i.e. smoking.
6. Provide options and equity.
7. Language used during this time must be very clear: Yes, this is a reduction in our benefits; that is, not what is offered, but that we are paying more for health care.

Copy: Gregg DeCrane, Josh Kaplan, Greg Jordan
April 9, 1991

MEMORANDUM

TO: Paul Yon, Center for Archival Collections

FROM: Jim Litwin, Director of Institutional Studies

SUBJECT: Response to Health Benefits Query

Paul, I am pleased that ASC is taking an active role on the insurance issue since it appears that things are moving toward closure faster than earlier memos indicated. Also, it is necessary to get involved so that rumors can be squashed if they are unfounded, e.g., that Costaffex is basically a front for legitimizing decisions that have already been made. These assertions sometimes take on a life of their own. Here are my general responses:

1. Increased costs of health care should be pro-rated according to salary. I believe in Robin Hood principles as well as fairness.

2. I would generally support purchase of dependent care coverage separate from individual care.

3. I prefer higher premiums and increased deductibles, but not higher co-payments.

4. No, I don't opt for coverage outside of BGSU! I have no other alternatives for insurance.

5. Other comments:
   - Protect people from catastrophic illness such as cancer, heart attack, kidney failure, etc.
   - Require use of generic drugs (if equivalent)
   - Use Section 125 if it means that health care premiums become tax-exempt income. It gives some relief to individuals without any cost to BGSU.
   - Get Faculty Senate, ASC, CSC chairs involved as well as welfare committees. I get concerned when I only see a few central administrators making these decisions. They are all wonderful people, but are they in touch with the situations of the average person?

JLL:tek

Health Care Costs-Areas of Consideration

1. Given that you will be asked to share the costs of health care benefits would you prefer that the cost-sharing be the same for all employees or (yes) pro-rated according to salary.

2. Do you believe that the University should support dependent care coverage? Do you think that the University should support health care for all employees and then ask the employee to buy dependent care? (Yes) (No)

3. Given that you will be asked to share the costs of health care benefits would you prefer a higher deductible (for example the first $500) or higher percentage of co-payments or higher premium contributions? (Yes) (No)

4. Would you opt to not be covered by the University (for example, if you and/or your dependents can be covered by another policy) if you had to share more of the health care costs? (No) (Yes) (Maybe)

5. Other issues or comments on cost-sharing?

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Cindy Puffer, Health Services, 2-7443
Lori Schumacher, Payroll, 2-2201
Mary Beth Zachary, Circulation, Jerome Library, 2-2054
Health Care Costs-Areas of Consideration

1. Given that you will be asked to share the costs of health care benefits, would you prefer that the cost-sharing be the same for all employees or pro-rated according to salary?

2. Do you believe that the University should support dependent care coverage? Do you think that the University should support health care for all employees and then ask the employee to buy dependent care? [Yes, but optional]

3. Given that you will be asked to share the costs of health care benefits, would you prefer a higher deductible (for example, the first $500) or a higher percentage of co-payments or higher premium contributions?

4. Would you opt to not be covered by the University (for example, if you and/or your dependents can be covered by another policy) if you had to share more of the health care costs? [Maybe]

5. Other issues or comments on cost-sharing? [I am not certain that the University should be self-insured. Is this arrangement best?]

Last, for your information, ASC has gone on record supporting and requesting implementation of the 125 Plan. See enclosed information on 125 Plan. No matter what the cost sharing plan will be, we will urge implementation of the 125 Plan and the establishment of flexible spending accounts.

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I don't feel that non-smokers should have to pay the same premiums as smokers. A campaign to encourage people to quit smoking should be started. If it had a effect, it could reduce time lost from sickness and work time lost from people taking smoke breaks.
Health Care Costs - Areas of Consideration

1. Given that you will be asked to share the costs of health care benefits, would you prefer that the cost-sharing be the same for all employees or pro-rated according to salary?

2. Do you believe that the University should support dependent care coverage? Do you think that the University should support health care for all employees and then ask the employee to buy dependent care?

3. Given that you will be asked to share the costs of health care benefits, would you prefer a higher deductible (for example the first $500) or higher percentage of co-payments or higher premium contributions?

4. Would you opt to not be covered by the University (for example, if you and/or your dependents can be covered by another policy) if you had to share more of the health care costs?

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Health Care Costs-Areas of Consideration

1. Given that you will be asked to share the costs of health care benefits would you prefer that the cost-sharing be the same for all employees or pro-rated according to salary. The same for all employees - illnes is not salary dependent.

2. Do you believe that the University should support dependent care coverage? Do you think that the University should support health care for all employees and then ask the employee to buy dependent care? I agree with the second statement - employees should buy dependent care, not the university.

3. Given that you will be asked to share the costs of health care benefits would you prefer a higher deductible (for example the first $500) or higher percentage of co-payments or higher premium contributions? Higher deductible - insurance for major expenses not small ones, which can be handled by individuals.

4. Would you opt to not be covered by the University (for example, if you and/or your dependents can be covered by another policy) if you had to share more of the health care costs? Yes

5. Other issues or comments on cost-sharing?

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The cost should vary by the level of deductability. Those who accept a higher deductible should pay lower rates -- like car insurance.

Health Care Costs-Areas of Consideration

1. Given that you will be asked to share the costs of health care benefits would you prefer that the cost-sharing be the same for all employees or pro-rated according to salary? Neither.

2. Do you believe that the University should support dependent care coverage? Do you think that the University should support health care for all employees and then ask the employee to buy dependent care? Yes. Seems to me that employees with more dependents take more sick time, which costs the Univ. more money already.

3. Given that you will be asked to share the costs of health care benefits would you prefer a higher deductible (for example the first $500) or higher percentage of co-payments or higher premium contributions?

   Higher deductible! Higher deductible! Higher deductible!

4. Would you opt to not be covered by the University (for example, if you and/or your dependents can be covered by another policy) if you had to share more of the health care costs? Yes. If the cost is too high, I'll get another policy by getting another employer.

5. Other issues or comments on cost-sharing? Cost sharing should be inversely proportional to risk sharing. Higher risk (deductible) should = lower cost (rate).

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4. Would you opt to not be covered by the University (for example, if you and/or your dependents can be covered by another policy) if you had to share more of the health care costs?

5. Other issues or comments on cost-sharing?

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3. Given that you will be asked to share the costs of health care benefits would you prefer a higher deductible (for example the first $500) or higher percentage of co-payments or higher premium contributions?

4. Would you opt to not be covered by the University (for example, if you and/or your dependents can be covered by another policy) if you had to share more of the health care costs?  

5. Other issues or comments on cost-sharing?

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Although depend on one coverage
is certainly advisable, with the
present health situation, it seems
more serious to support employees
especially, it would mean that most
employee spouses are also employed
somewhere and also covered. As for
children, whether or not to have children
is a choice for a couple. However, under
the current financial conditions it
seems unfair to asks the children
to bare the burden of someone else's
choice.

Companies often do not want to give bonuses
to employees.

The health care certainly can improve
the well-being of the employees, but

is important to note. Surgery on a small
chip can be less than the treatment of a
large cancer. (Physically healthy)
People can be sick; those who
are sick can feel healthy.
Obviously, there is a problem in understanding the other
up. Some people act as an example, how

are exemplified. I hope you said it would have
the chance to treat the treat.

Let's not forget some common sense and healthy lifestyles.

The key to maintaining a healthy weight is not to eat too much.

Health Care Costs-Areas of Consideration

1. Given that you will be asked to share the costs of health care benefits would you prefer that the cost-sharing be the same for all employees or pro-rated according to salary.

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4. Would you opt to not be covered by the University (for example, if you and/or your dependents can be covered by another policy) if you had to share more of the health care costs?

5. Other issues or comments on cost-sharing?

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Health Care Costs-Areas of Consideration

1. Given that you will be asked to share the costs of health care benefits would you prefer that the cost-sharing be the same for all employees or pro-rated according to salary. - In favor of cafeteria plan

2. Do you believe that the University should support dependent care coverage? Do you think that the University should support health care for all employees and then ask the employee to buy dependent care?
   Yes - partial or both

3. Given that you will be asked to share the costs of health care benefits would you prefer a higher deductible (for example the first $500) or higher percentage of co-payments or higher premium contributions

4. Would you opt to not be covered by the University (for example, if you and/or your dependents can be covered by another policy) if you had to share more of the health care costs? I would, but I'm not.

5. Other issues or comments on cost-sharing? *

Last, for your information, ASC has gone on record supporting and requesting implementation of the 125 Plan. See enclosed information on 125 Plan. No matter what the cost sharing plan will be, we will urge implementation of the 125 Plan and the establishment of flexible spending accounts. Good.

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* I'd like more dispersion of information on the options & I'd like to see bonus taken into consideration of non-self coverage. The 125 is a cafeteria approach to insurance, sound good to me as well
Health Care Costs - Areas of Consideration

1. Given that you will be asked to share the costs of health care, would you prefer that the cost-sharing be the same pro-rated according to salary. **same**

2. Do you believe that the University should support dependent care coverage? Do you think that the University should support health care for all employees and then ask the employee to buy dependent care?

   employees purchase dependent care -- equitably across all classifications could save a lot of $$ here

3. Given that you will be asked to share the costs of health care benefits, would you prefer a higher deductible (for example the first $500) or higher percentage of co-payments or higher premium contributions?

4. Would you opt to not be covered by the University (for example, if you and/or your dependents can be covered by another policy) if you had to share more of the health care costs? **yes**, (e.g., opt for individual coverage @ higher premium; opt out of dependent coverage)

5. Other issues or comments on cost-sharing?

   Keep short-term University budget problems as separate issue from long-term health care cost problems (i.e., let's take care not to make hurried decisions in the guise of ameliorating short-term budget problems that end up being long-term sacrifices (e.g., see attached contributions to Bensi Health Care Program costs have doubled during the past 5 years at consistent $1 mil - $1.5 mil increments. This increase has not been over the short term!

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Jacquie Joseph, Athletic Department, 2-7066
Pat Koehler, WBGU-TV, 2-7128
Cindy Puffer, Health Services, 2-7443
Lori Schumacher, Payroll, 2-2201
Mary Beth Zachory, Circulation, Jerome Library, 2-2054
CONTRIBUTIONS TO BGSU HEALTH CARE PROGRAM COSTS
1985-86 To 1991-92 (Estimated)

$10,000,000
$9,000,000
$8,000,000
$7,000,000
$6,000,000
$5,000,000
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$0


Source: OPB; 4/91. Does not include COBRA contributions from prior employees.
MEMORANDUM

TO: Paul Olscamp
Eloise Clark
Chris Dalton
Mary Edmonds
Bob Martin
Phil Mason

FROM: Faculty Senate, Classified Staff Council and Administrative Staff Council Executive Committees

RE: Cost Reduction Plan for Health Insurance

We would like to propose a plan to meet the need for a $1,300,000 reduction in health insurance costs for the 1991-92 year.

THE PLAN:

1. Classified staff would be required to contribute to the cost of dependent coverage at the same level as contract staff, $892 per year. For each classified staff member currently receiving dependent coverage, $892 would be placed in a salary pool to be distributed as an across the board raise to classified staff.

Assumption: Classified staff participation in dependent coverage would drop by 177 participants, from 768 (78%) to 591 (60%). (Current levels of participation for faculty and administrative staff are, respectively, 56% and 45%).

Assumption: For each person who drops dependent coverage, the savings would be 60% of the average cost of dependent coverage. (We assume that the people who drop have an alternate source of dependent coverage, which is currently primary in half the cases. We choose 60% instead of 50% because the alternate coverage may be potential, rather than actually present, because even when we are secondary we may
pay some expenses, and because we are projecting a 16% increase in utilization.)

Financial impact of salary increase: $768 \times 892 = 685,000$ net cost. This would allow an across the board raise of $584$ for all full time classified staff, plus an additional 15% for PERS, etc. ($584 \times 1020$ Classified staff = $596,000$. $596,000 \times 1.15 = 685,000$.)

Financial impact of new dependent premium: $591 \times 892 = 527,000$ net saving.

Financial impact of 177 people dropping dependent coverage: $177 \times 3,150 \times .6 = 335,000$ net saving.

2. The premium contribution for dependent coverage for all staff would be further increased to $1,080.

Assumption: No further change in the number of participants, which is 110 administrative staff, 319 faculty, plus the estimated 591 classified staff, for a total of 1,020.

Financial impact: $1,020 \times 188 = 192,000$ net saving.

3. All employees would contribute $420 per year to the cost of their individual coverage.

Assumptions: 100 employees would drop coverage due to availability of alternative coverage. A multiplier of .6 will again be used to estimate the savings from dropped coverage. Individual coverage this year cost approximately $2,000.

Financial impact of 100 people dropping individual coverage: $100 \times 2,000 \times .6 = 120,000$ net saving.

Financial impact of premium contribution: $2,085 \times 420 = 876,000$ net saving.

TOTAL NET SAVING = $1,365,000.

RATIONALE AND ADVANTAGES

Our intent was to shift costs as much as possible to other employers, rather than our own staff. Our current plan, particularly the lack of classified staff employee contribution for dependent coverage, results in BGSU paying a disproportionately large share of dependent costs when an employee has a spouse working elsewhere. We estimate that of the $1,365,000 saved by this plan, $455,000 would be saved by shifting expenses to other employers.
We believe this plan is fair in its treatment of the three constituent groups; perhaps more to the point, we believe it would be perceived as fair.

We have made all the changes in premiums, and none in co-payments or deductibles. We saw several advantages to this approach:

1. We believe it is easier to project the financial impact of premium changes than of deductibles or co-payments. (We would suggest that both this assumption, and the other assumptions we used in our estimates, be discussed with Costeffex.)

2. It is certainly easier to utilize a 125k plan to tax shelter premiums than co-payments and deductibles, both for employees and for the University. Employees would not need to estimate how much to contribute, and only the simplest type of 125k plan would be required.

3. The costs are shared by all employees, whereas increases in co-payments and deductibles would shift costs only to those who were ill. While co-payments and deductibles may well have desirable effects on utilization patterns, and be part of longer term changes in our health benefits, we do not think they are appropriate as a way to accomplish large scale cost shifting.

4. University Administration has stated that the immediate changes will not reduce current health plan coverage. We do not believe that this statement was intended to exclude co-payments or deductibles. However, we believe that co-payments and deductibles, by reducing the level of reimbursement for covered expenses, would be perceived as a reduction in coverage by a substantial number of employees.

We tried to make our estimates conservative, and we also built in a margin for error of approximately 5%. In the absolute worst case scenario, in which these changes result in nobody dropping coverage, this plan still generates a net saving of $1,180,000. Thus we believe that it is extremely likely that this plan would meet or exceed the projected need.
FINANCIAL IMPACT ON EMPLOYEES OF PROPOSED PREMIUM CHANGES
by Constituent Group, Type of Coverage, and Combined State and Federal Tax Bracket

<table>
<thead>
<tr>
<th></th>
<th>PRE-TAX</th>
<th>18% TAX</th>
<th>33% TAX</th>
<th>40% TAX</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLASSIFIED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Only</td>
<td>+$164</td>
<td>+$134</td>
<td>+$110</td>
<td>+$98</td>
</tr>
<tr>
<td>Individual &amp; Dependent</td>
<td>-$916</td>
<td>-$751</td>
<td>-$614</td>
<td>-$550</td>
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<tr>
<td>Weighted Average</td>
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<td>-$397</td>
<td>-$324</td>
<td>-$291</td>
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<tr>
<td><strong>FACULTY AND ADMINISTRATIVE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Only</td>
<td>-$420</td>
<td>-$344</td>
<td>-$281</td>
<td>-$252</td>
</tr>
<tr>
<td>Individual &amp; Dependent</td>
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<tr>
<td>Weighted Average</td>
<td>-$514</td>
<td>-$422</td>
<td>-$344</td>
<td>-$309</td>
</tr>
</tbody>
</table>

xc: Gaylyn Finn
John Moore
Jim Morris
Hal Lunde
Kathy Eninger
Gregg DeCrane
Health Care Benefit Plan Project Team


April 24, 1991

This proposal was initially developed by Josh Kaplan. His proposal was favorably reviewed by the Executive Committees of the Faculty Senate, Classified Staff Council, and Administrative Staff Council.

As an approach to addressing the short-term problem for 1991-92 the proposal relies on changes in employee “premium” contributions rather than changes in deductibles or co-insurance. There would be employee contributions for both single and family health care coverage. All employees electing single coverage would pay the same monthly premium. Employees electing family coverage would pay a higher premium, but it, too, would be the same for all employees with family coverage.

A very significant feature of the proposal is that introduction of employee contributions for family and single coverage for classified staff would be accompanied by an across-the-board salary increase for full-time classified staff of approximately $584.

The proposal also presumes that employee premium contributions would be paid with “pretax” dollars via a Section 125 K account, thus reducing the impact of the “premium” contributions on an employee’s take-home pay.

The implementation of the change for fiscal year employees could occur as early as July 1st, if the Section 125 plan can be implemented by then.

A preliminary review of the “Kaplan” proposal by Costeffex indicates that the savings generated by employees opting to drop single or family coverage through the BGSU plan are overestimated by an amount on the order of $300,000.

Two models of changes in premium contributions are attached. Model A reflects the “Kaplan” proposal, which in its current form appears to fall around $300,000 short of meeting the increases in health care costs projected for 1991-92. Model B assumes that this $300,000 is made up by increasing the both the single and dependent premiums proposed in the “Kaplan” plan by $10 per month.

We encourage you to provide feedback to Jim Morris, Director of Benefits, or Vice Presidents Dalton or Martin.
Model A: Meets approximately $1,000,000 of $1,300,000 target.

<table>
<thead>
<tr>
<th></th>
<th>Single Coverage Option</th>
<th>Family Coverage Option</th>
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<tbody>
<tr>
<td></td>
<td>i.e. one employee only</td>
<td>includes enrolling employee &amp; dependents</td>
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<tr>
<td><strong>Employee Contribution</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>monthly</td>
<td>$35</td>
</tr>
<tr>
<td></td>
<td>annual</td>
<td>$420</td>
</tr>
<tr>
<td><strong>Pay Increase</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>monthly</td>
<td>$49</td>
</tr>
<tr>
<td></td>
<td>annual</td>
<td>$584</td>
</tr>
<tr>
<td><strong>Employee Contribution minus Pay Increase</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>monthly difference</td>
<td>($14)</td>
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<td>annual difference</td>
<td>($164)</td>
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**Estimated After Tax Impact**

For 18% Tax Bracket

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<tr>
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<td>($11)</td>
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For 33% Tax Bracket

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<tr>
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<td>($9)</td>
<td>($110)</td>
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<td></td>
<td>$51</td>
<td>$614</td>
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For 40% Tax Bracket

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<td>($8)</td>
<td>($98)</td>
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<tr>
<td></td>
<td>$46</td>
<td>$550</td>
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</table>

Approach suggested by J. Kaplan, M.D.
DRAFT FOR DISCUSSION AND STAFF FEEDBACK
BGSU Health Care Benefits Plan
Classified Staff Contributions for 91-92

Model B: Projected to meet $1,300,000 target.

<table>
<thead>
<tr>
<th>Employee Contribution</th>
<th>Single Coverage Option</th>
<th>Family Coverage Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>monthly</td>
<td>annual</td>
</tr>
<tr>
<td>Pay Increase (partial contribution offset)</td>
<td>$49</td>
<td>$584</td>
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</table>

<table>
<thead>
<tr>
<th>Employee Contribution minus Pay Increase</th>
<th>Single Coverage Option</th>
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<tbody>
<tr>
<td>monthly difference</td>
<td>($4)</td>
<td>$96</td>
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<td>annual difference</td>
<td>($44)</td>
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Estimated After Tax Impact

For 18% Tax Bracket

<table>
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<tr>
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</tr>
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<tr>
<td></td>
<td>monthly</td>
<td>annual</td>
</tr>
<tr>
<td>Pay Increase (partial contribution offset)</td>
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<td>($36)</td>
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For 33% Tax Bracket

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>monthly</td>
<td>annual</td>
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<tr>
<td>Pay Increase (partial contribution offset)</td>
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For 40% Tax Bracket

<table>
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<tr>
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<tr>
<td></td>
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<td>annual</td>
</tr>
<tr>
<td>Pay Increase (partial contribution offset)</td>
<td>($2)</td>
<td>($26)</td>
</tr>
</tbody>
</table>

Approach suggested by J. Kaplan, M.D. /
DRAFT FOR DISCUSSION AND STAFF FEEDBACK
BGSU Health Care Benefits Plan
Faculty/Administrative Staff Contributions for 91-92

Model A: Meets approximately $1,000,000 of $1,300,000 target.

<table>
<thead>
<tr>
<th>Employee Contribution</th>
<th>Single Coverage Option</th>
<th>Family Coverage Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>monthly</td>
<td>annual</td>
</tr>
<tr>
<td>i.e. one employee only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Contribution; for 90-91</td>
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<td></td>
</tr>
<tr>
<td>monthly</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>annual</td>
<td>$0</td>
<td>$0</td>
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Estimated After Tax Impact
For 18% Tax Bracket

<table>
<thead>
<tr>
<th></th>
<th>monthly</th>
<th>annual</th>
<th>monthly</th>
<th>annual</th>
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<tr>
<td>Single Coverage Option</td>
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<tr>
<td>i.e. one employee only</td>
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<td>$344</td>
<td>$103</td>
<td>$1,230</td>
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<td>Family Coverage Option</td>
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<tr>
<td>includes enrolling employee &amp; dependents</td>
<td></td>
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<tr>
<td>monthly</td>
<td>$23</td>
<td>$281</td>
<td>$84</td>
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<tr>
<td>annual</td>
<td>$21</td>
<td>$252</td>
<td>$75</td>
<td>$900</td>
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</table>

Approach suggested by J. Kaplan, M.D.
DRAFT FOR DISCUSSION AND STAFF FEEDBACK
BGSU Health Care Benefits Plan
Faculty/Administrative Staff Contributions for 91-92

Model B: Projected to meet $1,300,000 target.

<table>
<thead>
<tr>
<th></th>
<th>Single Coverage Option</th>
<th>Family Coverage Option</th>
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<tbody>
<tr>
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<td>i.e. one employee only</td>
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<tr>
<td><strong>Employee Contribution</strong></td>
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<tr>
<td>monthly</td>
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<td>$145</td>
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<td>$540</td>
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<th>annual</th>
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</thead>
<tbody>
<tr>
<td>monthly</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>annual</td>
<td>$0</td>
<td>$0</td>
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<table>
<thead>
<tr>
<th><strong>Estimated After Tax Impact</strong></th>
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</thead>
<tbody>
<tr>
<td>For 18% Tax Bracket</td>
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<tr>
<td>annual</td>
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<td>For 33% Tax Bracket</td>
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<td>$97</td>
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<td>monthly</td>
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<tr>
<td>annual</td>
<td>$362</td>
<td>$1,166</td>
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<tr>
<td>For 40% Tax Bracket</td>
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<tr>
<td>monthly</td>
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<tr>
<td>annual</td>
<td>$324</td>
<td>$1,044</td>
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</table>

Prepared by BGSU Health Care Benefit Plan Project Team
MEMORANDUM

TO: Administrative Staff Council Members
FROM: Gregg DeCrane, Chair
ASC
DATE: April 30, 1991
RE: Proposed Health Care Contributions Plan

Please review the proposal attached, share it with your constituents and come to Thursday's meeting prepared to discuss it.
April 30, 1991

MEMORANDUM

TO: Faculty Senate Executive Committee  
Classified Staff Council Executive Committee  
Administrative Staff Council Executive Committee

FROM: Robert Martin, Vice President for Operations 
Chris Dalton, Vice President for Planning & Budgeting


This is in response to your memo of April 23 which proposed a “Cost Reallocation Plan for Health Insurance” to meet the need for a $1.3 million reduction in health insurance costs for the 1991-92 year.

As you know, this plan was discussed extensively during our meetings with employee groups on April 24th and April 25th. As we noted during those meetings, a review of the SEC/CSC/ASC proposal by the underwriting experts at Costeffex, the university’s health care consultant, indicated that the projected reduction in claims resulting from employees who would be expected to drop single or family coverage through the BGSU plan was overestimated. Two plans were therefore presented in the meetings with employee groups on April 24 and 25. Model A, which corresponded to the SEC/CSC/ASC proposal, proposed the introduction of annual employee “premiums” of $420 for single coverage and $1500 for family coverage. Model B made up for the shortfall (initially estimated at approximately $300,000) generated by the overestimate of claims savings by increasing the annual employee contributions to $540 for single coverage and $1740 for family coverage. Further refinement of the analysis has reduced the projected shortfall to approximately $208,000. If this difference were made up by equal increases in the rates for dependent and single coverage, the annual single and family rates would be $480 and $1640, respectively.

Strong support was expressed in all our employee group meetings last week for the concepts in the SEC/CSC/ASC proposal which include: (a) addressing the 1991-92 problem via increased premium contributions rather than changes in deductible and co-insurance levels; (b) introduction of employee contributions for both single and family coverage; (c) equal employee contributions from contract and classified staff; (d) coupling the introduction of classified staff “premium” contributions with an across-the-board salary increase for classified staff (paid for by funds that were used to cover a portion of classified staff family health insurance premiums); and (e) simultaneous implementation of a Section 125K Plan allowing employees to reduce their federal and state taxes by using pretax dollars to make their health care contributions. The major concern that was
The revised proposal, which we are forwarding for your review and comment, has been developed by the Health Care Benefit Plan Project Team taking into account both the clearly expressed desire of the employee groups that employee contributions for family coverage be pro-rated to employee salary, as well as the need to produce a plan which comes close to generating savings equal to the $1.3 million increase projected for health care costs for 1991-92. The only difference between the enclosed proposal and the SEC/CSC/ASC plan is that the annual employee contribution for family coverage has been changed from $1500 (or $1640 if the rates of employee contributions for single and dependent coverage were increased equally to cover the $208,000 shortfall) to $1100 plus 1.5% of annual salary. This proposal, with employee contributions that vary with salary, will result in a cost of less than $1500 for family coverage for faculty and staff with annual BGSU earnings lower than $26,667 (and a cost of less than $1640 for family coverage for employees with annual BGSU earnings lower than $36,000.) Costs of family coverage will, of course, be higher for employees with annual BGSU earnings above these levels.

More details on the proposed plan including the impact on both classified and contract employees with either single or family coverage are included in the enclosed materials. Although the plan now generates savings approximately $71,000 short of the original target of $1.3 million, we are comfortable with its results. The plan presumes that all employee contributions would be paid via a Section 125K account. We are currently planning on a July 1, 1991 implementation date for for the changes in employee contributions for 1991-92, given that the 125K plans can be established by that date. If the implementation is delayed beyond July 1, then the monthly and biweekly contribution rates will be adjusted to generate the annual contribution rates projected assuming a July 1 implementation.

We ask that you and your constituents return any comments you may have on this revised plan to Robert Martin or Chris Dalton by noon on Friday, May 3, 1991. We assure you that your comments will be carefully considered. The final plan for employee sharing of increasing BGSU Health Care Benefit Plan costs will be announced next week, or about May 8th.

We would like to express our appreciation to the Faculty Senate Executive Committee, the Classified Staff Council Executive Committee and the Administrative Staff Council Executive Committee for the fine spirit of cooperation with which they approached working with each other and the central administration on developing a cost reallocation plan to generate the $1.3 million needed to cover the increases in health care costs for 1991-92. Special thanks are also due to Dr. Josh Kaplan, the principal author of the SEC/CSC/ASC plan.

As we near the completion of Phase I of this project, we look forward to your continued assistance as we move forward to the Phase II comprehensive evaluation of the BGSU Health Care Benefit Plan as described in our earlier memo.
BGSU Health Care Benefits
Employee Contributions Plan for 1991-92
Impact on Faculty & Administrative Staff

<table>
<thead>
<tr>
<th></th>
<th>Single Coverage Option</th>
<th>Family Coverage Option</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>i.e. one employee only</td>
<td>includes enrolling employee &amp; dependents</td>
</tr>
<tr>
<td><strong>Employee Contribution</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>$35</td>
<td>$420</td>
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<td><strong>Current Contribution; for 90-91</strong></td>
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<td>annual</td>
</tr>
<tr>
<td></td>
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<tr>
<td><strong>Estimated Increased Contribution (From 1990-91 - After Tax Impact)</strong></td>
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<tr>
<td>With BGSU Salary = $20,000</td>
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<td>Monthly</td>
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<td>With BGSU Salary = $80,000</td>
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<tr>
<td></td>
<td>$260</td>
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Estimated after tax impact is calculated using marginal tax rates assuming standard deductions and 3.5 Exemptions For Family (1 For Single). This approximates the annual after tax impact. The impact on monthly paychecks may be different since that amount is determined by the amounts in the IRS Withholding Tables.

4/30/91 Prepared by BGSU Health Care Benefit Plan Project Team
## BGSU Health Care Benefits
### Employee Contributions Plan for 1991-92
#### Impact on Classified Staff

<table>
<thead>
<tr>
<th></th>
<th><strong>Single Coverage Option</strong></th>
<th><strong>Family Coverage Option</strong></th>
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<tr>
<td></td>
<td>i.e. one employee only</td>
<td>includes enrolling employee &amp; dependents</td>
</tr>
<tr>
<td><strong>Employee Contribution</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biweekly</td>
<td>$16.15</td>
<td>$42.31 + 1.5% of Biweekly Salary</td>
</tr>
<tr>
<td>Annual</td>
<td>$420</td>
<td>$1100 + 1.5% of Annual Salary</td>
</tr>
<tr>
<td><strong>Pay Increase (partial contribution offset)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biweekly</td>
<td>$22.40</td>
<td>$22.40</td>
</tr>
<tr>
<td>Annual</td>
<td>$582.40</td>
<td>$582.40</td>
</tr>
<tr>
<td><strong>Estimated After Tax Impact</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Contribution - Pay Increase)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Annual BGSU Salary = $16,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual</td>
<td>($133)</td>
<td>$621</td>
</tr>
<tr>
<td>Biweekly</td>
<td>($5)</td>
<td>$24</td>
</tr>
<tr>
<td>With Annual BGSU Salary = $25,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual</td>
<td>($130)</td>
<td>$719</td>
</tr>
<tr>
<td>Biweekly</td>
<td>($5)</td>
<td>$28</td>
</tr>
<tr>
<td>With Annual BGSU Salary = $40,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual</td>
<td>($109)</td>
<td>$900</td>
</tr>
<tr>
<td>Biweekly</td>
<td>($4)</td>
<td>$35</td>
</tr>
</tbody>
</table>

Estimated after tax impact is calculated using marginal tax rates assuming standard deductions and 3.5 Exemptions For Family (1 For Single). This approximates the annual after tax impact. The impact on biweekly paychecks may be different since that amount is determined by the amounts in the IRS Withholding Tables.

4/30/91 Prepared by BGSU Health Care Benefit Plan Project Team
PREMIUM CONTRIBUTIONS FOR 1991-92 BGSU FAMILY HEALTH CARE COVERAGE

PREMIUM = $1100 + 1.5% OF SALARY

EXAMPLES FOR VARIOUS ANNUAL EMPLOYEE EARNINGS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,000</td>
<td>$1,325</td>
<td>$110.42</td>
<td>$51</td>
<td>17.97%</td>
<td>$1,087</td>
<td>$90.57</td>
<td>$41.80</td>
</tr>
<tr>
<td>$20,000</td>
<td>$1,400</td>
<td>$116.67</td>
<td>$54</td>
<td>18.72%</td>
<td>$1,133</td>
<td>$94.33</td>
<td>$45.77</td>
</tr>
<tr>
<td>$25,000</td>
<td>$1,475</td>
<td>$122.92</td>
<td>$57</td>
<td>19.46%</td>
<td>$1,188</td>
<td>$99.00</td>
<td>$48.99</td>
</tr>
<tr>
<td>$30,000</td>
<td>$1,550</td>
<td>$129.17</td>
<td>$60</td>
<td>19.46%</td>
<td>$1,248</td>
<td>$104.03</td>
<td>$50.01</td>
</tr>
<tr>
<td>$35,000</td>
<td>$1,625</td>
<td>$135.42</td>
<td>$63</td>
<td>19.46%</td>
<td>$1,309</td>
<td>$109.06</td>
<td>$50.34</td>
</tr>
<tr>
<td>$40,000</td>
<td>$1,700</td>
<td>$141.67</td>
<td>$65</td>
<td>19.46%</td>
<td>$1,369</td>
<td>$114.10</td>
<td>$52.66</td>
</tr>
<tr>
<td>$45,000</td>
<td>$1,775</td>
<td>$147.92</td>
<td>$69</td>
<td>19.46%</td>
<td>$1,430</td>
<td>$119.13</td>
<td>$54.98</td>
</tr>
<tr>
<td>$50,000</td>
<td>$1,850</td>
<td>$154.17</td>
<td>$71</td>
<td>33.20%</td>
<td>$1,506</td>
<td>$124.16</td>
<td>$57.53</td>
</tr>
<tr>
<td>$55,000</td>
<td>$1,925</td>
<td>$160.42</td>
<td>$74</td>
<td>33.20%</td>
<td>$1,576</td>
<td>$129.16</td>
<td>$59.46</td>
</tr>
<tr>
<td>$60,000</td>
<td>$2,000</td>
<td>$166.67</td>
<td>$77</td>
<td>33.20%</td>
<td>$1,646</td>
<td>$134.16</td>
<td>$61.46</td>
</tr>
<tr>
<td>$65,000</td>
<td>$2,075</td>
<td>$172.92</td>
<td>$80</td>
<td>33.20%</td>
<td>$1,716</td>
<td>$139.16</td>
<td>$63.46</td>
</tr>
<tr>
<td>$70,000</td>
<td>$2,150</td>
<td>$179.17</td>
<td>$83</td>
<td>33.20%</td>
<td>$1,786</td>
<td>$144.16</td>
<td>$65.46</td>
</tr>
<tr>
<td>$75,000</td>
<td>$2,225</td>
<td>$185.42</td>
<td>$86</td>
<td>33.20%</td>
<td>$1,856</td>
<td>$149.16</td>
<td>$67.46</td>
</tr>
<tr>
<td>$80,000</td>
<td>$2,300</td>
<td>$191.67</td>
<td>$89</td>
<td>33.20%</td>
<td>$1,926</td>
<td>$154.16</td>
<td>$69.46</td>
</tr>
<tr>
<td>$85,000</td>
<td>$2,375</td>
<td>$197.92</td>
<td>$91</td>
<td>33.20%</td>
<td>$1,996</td>
<td>$159.16</td>
<td>$71.46</td>
</tr>
<tr>
<td>$90,000</td>
<td>$2,450</td>
<td>$204.17</td>
<td>$94</td>
<td>33.20%</td>
<td>$2,067</td>
<td>$164.16</td>
<td>$73.46</td>
</tr>
<tr>
<td>$95,000</td>
<td>$2,525</td>
<td>$210.42</td>
<td>$97</td>
<td>33.94%</td>
<td>$2,137</td>
<td>$169.00</td>
<td>$75.42</td>
</tr>
<tr>
<td>$100,000</td>
<td>$2,600</td>
<td>$216.67</td>
<td>$100</td>
<td>33.94%</td>
<td>$2,207</td>
<td>$173.92</td>
<td>$77.38</td>
</tr>
<tr>
<td>$105,000</td>
<td>$2,675</td>
<td>$222.92</td>
<td>$103</td>
<td>38.94%</td>
<td>$2,277</td>
<td>$178.84</td>
<td>$79.34</td>
</tr>
<tr>
<td>$110,000</td>
<td>$2,750</td>
<td>$229.17</td>
<td>$106</td>
<td>38.94%</td>
<td>$2,347</td>
<td>$183.76</td>
<td>$81.30</td>
</tr>
<tr>
<td>$115,000</td>
<td>$2,825</td>
<td>$235.42</td>
<td>$109</td>
<td>33.90%</td>
<td>$2,417</td>
<td>$188.68</td>
<td>$83.26</td>
</tr>
</tbody>
</table>

Note: "After-Tax" values are approximations calculated using the projected tax brackets (marginal rates) derived assuming the employee takes the standard deduction ($5,450), has 3.5 exemptions (at $2,050 each) and benefits from a 9.25% reduction in taxable salary from the pick-up of employee retirement contributions. Numbers will be slightly different for PERS participants (8.5% reduction in taxable salary for retirement).
MEMORANDUM

TO: BGSU Faculty and Staff
FROM: Paul J. Olscamp
President
RE: Employee Health Care Contributions for 1991-92

As you are no doubt aware, the central administration has spent much of the last month discussing options for increasing employee contributions for health care coverage with many groups. Increasing employee health care contributions is necessary because of the continued rapid escalation of BGSU employee health care costs, projected to increase $1.3 million for 1991-92, and which have in recent years increased at an average annual rate of more than 15%. Recent major reductions in state allocations coupled with limitations on our ability to raise student fees have removed the flexibility to use increased subsidy and fee income to cover the increases in employee health care benefit costs. In an attempt to address these concerns we have, over the past month, consulted with the Insurance Committee, the Executive Committees of the Faculty Senate, Administrative Staff Council and the Classified Staff Council, and employee focus groups. More than 25 such meetings have been held. We have also received recommendations and comments from the Faculty Senate, Administrative Staff Council, and Classified Staff Council, as well as individual faculty and staff members.

The advice from groups and individuals, as well as the input from Administrative Council, the Health Care Benefits Project Team, and the representatives from Costeffex, our health care consultants, has been carefully studied. The responses from the Classified Staff Council, Administrative Staff Council and Faculty Senate to the proposal put forth in the April 30th memo from Vice Presidents Martin and Dalton, along with several constituent group proposals, have also been evaluated.

It is clear from the collective responses that this is a difficult and potentially divisive issue. Although I have made a sincere effort to be informed by these responses and to recommend a proposal that is balanced and fair to all constituent groups, I have no illusions that every employee of the University will perceive my choice as fair. Equity, like beauty, is apparently in the eye of the beholder.

In the final analysis, given the lack of agreement among the various constituent groups on how best to allocate the necessary increases in employee contributions, as well as the upcoming comprehensive review of the health care benefits plan which may well result in a restructuring of the plan for 1992-93 and after, I have decided that the most reasonable approach to cover the increase in health care costs for 1991-92 is to increment the 1990-91 employee contributions by an amount equivalent to the projected 16% increase in employee health care costs. This plan would result in the employee contributions for health care coverage for 1991-92 shown in the table on the top of the next page. Because for single coverage the health care benefits are the same for all employee groups, I will recommend the same contribution level for single coverage for 1991-92 for both classified and contract employees.
Single Coverage  $1969  $ 315  $ 0  $ 315
Classified Family  $5415  $ 866  $ 0  $ 866
Contract Family  $4296  $ 687  $892  $1579

I recognize that these changes will result in a reduction in the take-home pay of all employees who participate in the BGSU health care plan. This reduction will, as noted below, be somewhat mitigated by the introduction of a Section 125K plan. In addition, I will recommend to the Board of Trustees, if the final budget bill from the Ohio General Assembly provides for a sufficient increase in the BGSU budget, a one-time adjustment of $315 to the base salary for all BGSU full-time faculty and staff for 1991-92 to help lessen the impact of the higher employee contributions for health care coverage. If this adjustment, which will have a higher priority than a general salary increment, is not possible for 1991-92, it will be made at the earliest subsequent opportunity that university revenues allow.

**Section 125K Plan.** The new levels of employee contributions for health care coverage are currently scheduled, pending approval by the Board of Trustees, to become effective with the beginning of the new fiscal year on July 1, 1991. At the same time that the employee contribution levels are increased, a Section 125K Plan will be implemented which will allow faculty and staff to make their health care plan "premium" contributions with pretax dollars. This will result in a reduction in "taxable" income and therefore a lowering of both federal and state income tax obligations. **THIS WILL NOT HAPPEN AUTOMATICALLY! YOU MUST FILL OUT A FORM ELECTING TO HAVE YOUR "TAXABLE" INCOME REDUCED BY AN AMOUNT EQUAL TO YOUR EMPLOYEE HEALTH CARE "PREMIUM" CONTRIBUTION. IT IS, THEREFORE, VERY IMPORTANT THAT YOU FILL OUT AND RETURN THE SECTION 125K ELECTION FORM THAT YOU WILL BE RECEIVING FROM THE BENEFITS OFFICE LATER THIS MONTH. FAILURE TO FILE AN ELECTION FORM PRIOR TO JUNE 1ST WILL RESULT IN YOUR LOSING THE OPPORTUNITY TO REDUCE YOUR INCOME TAXES BY UTILIZING THIS SECTION 125K PLAN IN MAKING YOUR HEALTH CARE "PREMIUM" CONTRIBUTIONS IN THE 1991-92 YEAR.**

**Information Meeting.** A sheet providing more detailed information on the advantages of a 125K plan is enclosed. In addition, an open counseling session, with a tax expert in attendance, will be held in the Jenson Auditorium, 115 Education Building, from 10:00 a.m. to 1:00 p.m. on Wednesday, May 15, 1991. All those who wish to attend will have an opportunity to ask private questions of the tax consultant and any other university official there.

It will be possible for employees to choose not to participate in the BGSU Health Care Plan, if they have alternate health care coverage through, for example, a spouse's employer. We very strongly urge that employees not drop the BGSU plan unless they have adequate alternative health insurance.

**1991-92 Contracts.** As noted above, we are unable to estimate the probability of a general salary increase for 1991-92 at this time. For continuing employees on contract it is our intention to forward the appropriate fiscal or academic year contracts for 1991-92, which will include notification of the 1991-92 salary level, in July. As many of you will recall from prior years, contracts are normally issued in July in the year when the state is passing its biennial budget. This is a result of our having to wait for determination of the final state budget in Columbus before the BGSU Board of Trustees can approve the BGSU budget for the coming year.
SECTION 125K PLAN CONSIDERATIONS

The University will be implementing, on July 1, 1991, a "contribution conversion plan" which is the simplest form of a Section 125K or flexible benefits plan. The "contribution conversion plan" allows for a reduction in the employee's pay equal to his/her health care contribution. This is a tax effective method of delivering health care as the employee does not pay taxes (federal and state income) on the compensation which he/she uses to pay the employee contributions for the health care benefits. All that is required is that the employee agree to a payroll reduction in the amount of the required contribution (health care premium) in exchange for receiving health care benefits. Because the "contribution conversion plan" avoids rather than defers the tax, it does not create a liability for future taxes.

The election to participate (a Section 125K election form that must be signed by the employee) must be made 30 days prior to the beginning of the plan year and is irrevocable during that plan year, unless there is a "change in family status". A "change in family status" results when there is a change in the employee's family situation. Divorce, legal separation, birth or death of a child, and the spouse's obtaining or losing employment are all examples of a "change in family status". Such change allows for immediate election (enrollment).

It should be pointed out that participation in a Section 125K plan may reduce, by an amount equal to twenty percent (20%) of the Section 125K payroll reduction, the maximum amount an employee can defer in a 403(b) Tax Deferred Annuity program. At the projected contribution levels, this limitation will impact only those employees earning less than $55,000 and deferring the full twenty percent (20%) of taxable income allowed. The initial review of the University's records indicates that fewer than twenty employees would be affected. Those individuals will be personally contacted to review their specific situation.

Also employees approaching retirement with thirty four (34) or more years of state service who are participating in a 403(b) Tax Deferred Annuity program should contact the Benefits Office to ensure that their retirement benefit will not be adversely affected by taxable income reductions.

Below are six examples which describe the impact of electing the Section 125K contribution conversion plan (see reverse side also).

<table>
<thead>
<tr>
<th>A single classified employee earning $20,000 and paying $315 annual for benefits:</th>
<th>A married faculty member with two children earning $50,000 and paying annually $1,579 for benefits:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>USING</strong></td>
<td><strong>USING</strong></td>
</tr>
<tr>
<td><strong>AFTER-TAX</strong></td>
<td><strong>PRE-TAX</strong></td>
</tr>
<tr>
<td>DOLLARS</td>
<td>DOLLARS</td>
</tr>
<tr>
<td>Income</td>
<td>$20,000</td>
</tr>
<tr>
<td>PERS 8.5%</td>
<td>$1,700</td>
</tr>
<tr>
<td>Annual Benefit Contributions</td>
<td>$0</td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$18,300</td>
</tr>
<tr>
<td>Estimated taxes; federal and state</td>
<td>$2,289</td>
</tr>
<tr>
<td>Income after taxes</td>
<td>$16,011</td>
</tr>
<tr>
<td>Less benefit contributions</td>
<td>$315</td>
</tr>
<tr>
<td>Actual spendable income</td>
<td>$15,696</td>
</tr>
<tr>
<td>Increase in spendable income</td>
<td>$0</td>
</tr>
</tbody>
</table>

The difference of $59 shows the added value of paying benefit contributions with pre-tax dollars. The difference of $319 again illustrates the advantage of paying benefit contributions with pre-tax dollars.
### A single employee (PERS) earning $50,000 and paying $315 annual for benefits:

<table>
<thead>
<tr>
<th></th>
<th>USING AFTER-TAX DOLLARS</th>
<th>USING PRE-TAX DOLLARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>PERS 8.5%</td>
<td>$4,250</td>
<td>$4,250</td>
</tr>
<tr>
<td>Annual Benefit</td>
<td>$0</td>
<td>$315</td>
</tr>
<tr>
<td>Contributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$45,750</td>
<td>$45,435</td>
</tr>
<tr>
<td>Estimated taxes; federal and state</td>
<td>$10,380</td>
<td>$10,275</td>
</tr>
<tr>
<td>Income after taxes</td>
<td>$35,370</td>
<td>$35,160</td>
</tr>
<tr>
<td>Less benefit contributions</td>
<td>$315</td>
<td>$0</td>
</tr>
<tr>
<td>Actual spendable income</td>
<td>$35,055</td>
<td>$35,160</td>
</tr>
<tr>
<td>Increase in spendable income</td>
<td>$0</td>
<td>$105</td>
</tr>
</tbody>
</table>

The difference of $105 shows the added value of paying benefit contributions with pre-tax dollars.

### A married classified employee earning $20,000 with two children and paying $866 annually for benefits:

<table>
<thead>
<tr>
<th></th>
<th>USING AFTER-TAX DOLLARS</th>
<th>USING PRE-TAX DOLLARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>$20,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>PERS 8.5%</td>
<td>$1,700</td>
<td>$1,700</td>
</tr>
<tr>
<td>Annual Benefit</td>
<td>$0</td>
<td>$866</td>
</tr>
<tr>
<td>Contributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$18,300</td>
<td>$17,434</td>
</tr>
<tr>
<td>Estimated taxes; federal and state</td>
<td>$904</td>
<td>$743</td>
</tr>
<tr>
<td>Income after taxes</td>
<td>$17,396</td>
<td>$16,691</td>
</tr>
<tr>
<td>Less benefit contributions</td>
<td>$866</td>
<td>$0</td>
</tr>
<tr>
<td>Actual spendable income</td>
<td>$16,530</td>
<td>$16,691</td>
</tr>
<tr>
<td>Increase in spendable income</td>
<td>$0</td>
<td>$161</td>
</tr>
</tbody>
</table>

The difference of $161 again illustrates the advantage of paying benefit contributions with pre-tax dollars.

### A married classified employee earning $40,000 with two children and paying $866 annual for benefits:

<table>
<thead>
<tr>
<th></th>
<th>USING AFTER-TAX DOLLARS</th>
<th>USING PRE-TAX DOLLARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>$40,000</td>
<td>$40,000</td>
</tr>
<tr>
<td>PERS 8.5%</td>
<td>$3,400</td>
<td>$3,400</td>
</tr>
<tr>
<td>Annual Benefit</td>
<td>$0</td>
<td>$866</td>
</tr>
<tr>
<td>Contributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$36,600</td>
<td>$35,734</td>
</tr>
<tr>
<td>Estimated taxes; federal and state</td>
<td>$4,433</td>
<td>$4,364</td>
</tr>
<tr>
<td>Income after taxes</td>
<td>$32,167</td>
<td>$31,470</td>
</tr>
<tr>
<td>Less benefit contributions</td>
<td>$866</td>
<td>$0</td>
</tr>
<tr>
<td>Actual spendable income</td>
<td>$31,301</td>
<td>$31,470</td>
</tr>
<tr>
<td>Increase in spendable income</td>
<td>$0</td>
<td>$169</td>
</tr>
</tbody>
</table>

The difference of $169 shows the added value of paying benefit contributions with pre-tax dollars.

### A married classified employee earning $30,000 and paying annually $1,579 for benefits:

<table>
<thead>
<tr>
<th></th>
<th>USING AFTER-TAX DOLLARS</th>
<th>USING PRE-TAX DOLLARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>$30,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>PERS 8.5%</td>
<td>$2,550</td>
<td>$2,550</td>
</tr>
<tr>
<td>Annual Benefit</td>
<td>$0</td>
<td>$1,579</td>
</tr>
<tr>
<td>Contributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$27,450</td>
<td>$25,871</td>
</tr>
<tr>
<td>Estimated taxes; federal and state</td>
<td>$2,652</td>
<td>$2,345</td>
</tr>
<tr>
<td>Income after taxes</td>
<td>$24,798</td>
<td>$23,526</td>
</tr>
<tr>
<td>Less benefit contributions</td>
<td>$1,579</td>
<td>$0</td>
</tr>
<tr>
<td>Actual spendable income</td>
<td>$23,219</td>
<td>$23,526</td>
</tr>
<tr>
<td>Increase in spendable income</td>
<td>$0</td>
<td>$307</td>
</tr>
</tbody>
</table>

The difference of $307 again illustrates the advantage of paying benefit contributions with pre-tax dollars.
MEMORANDUM

SUBJECT: Health Care Coverage under B.G.S.U. Health Plan

FROM: James Morris, Benefits Manager

Enclosed is information regarding health care contributions for the 1991-92 Fiscal year. Please take a few minutes to read all of the information before completing any of the forms or making any decisions.

As stated in President Olscamp's memorandum of May 9, 1991, participation in the B.G.S.U. Health Care Plan after July 1, 1991 will require employee contributions. The required annual contribution for single (employee only) and family coverage for the 1991-92 Fiscal year is indicated below:

<table>
<thead>
<tr>
<th>TYPE OF COVERAGE</th>
<th>1991-92 EMPLOYEE COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single (Employee Only)</td>
<td>$315.00</td>
</tr>
<tr>
<td>Classified Family</td>
<td>$866.00</td>
</tr>
<tr>
<td>Contract/Faculty Family</td>
<td>$1,579.00</td>
</tr>
</tbody>
</table>

You may choose not to participate in the B.G.S.U. Health Plan because of the availability of health care coverage thru your spouse's employer. Before deciding to discontinue any coverage currently in effect for yourself and/or other family members, you are strongly urged to evaluate all of your options carefully.

A summary of benefits currently provided under the B.G.S.U. Health Care Plan is enclosed for comparison with other coverages that may be available.

The following information must be provided on the enclosed Group Health Benefit Plan Enrollment Form:

1. Your full name (Please type or print)
2. Your social security number
3. Type of coverage that you want to continue (if any) after July 1, 1991. This should be indicated on the Enrollment Form asking for Type of Coverage. Be selecting either single (employee only) of family coverage, it is understood that authorization to deduct the required contribution from your pay is given to the University.
4. You must sign the form on the line above where the employee's signature is requested.

A Section 125 Contribution Conversion Plan Election Form must also be completed by each employee. The completed form must be sign and dated on or before May 31, 1991 and returned to the Benefits Office no later than June 7, 1991, if you want your contributions to be deducted from your pay on a before-tax basis.
To indicate your election for the 14-month period from July 1, 1991 through August 31, 1992, you should check the appropriate box (single or family) for both the short period from July 1, 1991 through August 31, 1991 and the Plan year which commences on September 1, 1991 and ends on August 31, 1992.

If you indicate your election for the short period only, it will be necessary for you to complete another Election Form before August 1, 1991.

The Election Form must be signed on the back (reverse side) in order for your election to become effective.

Before placing the forms in the enclosed postage paid return envelope, please make sure that all of the information is given and that both the Group Health Plan Enrollment and the Section 125 Contribution Form are signed and placed in the envelope.

Please contact the Benefits Office if you have any questions regarding the forms. The HELP line telephone number is 372-HELP.

djs

Enclosures
This is a brief summary of the Health Care Benefits available to full-time faculty, administrative and classified staff and their eligible dependents.

**HOSPITAL IN-PATIENT BENEFITS**

- Semi-private room, intensive and/or coronary care accommodations: Payment in full
- Private Room accommodations: Payment based on hospital average semi-private room rate
- Maximum Days of Care: 120 days per confinement
- Miscellaneous hospital services and supplies: Payment in full except for convenience items, such as TV, telephone, etc.

**HOSPITAL OUT-PATIENT BENEFITS**

- Out-patient laboratory tests, x-rays, EKG's, etc.: Payment based on Usual, Customary and Reasonable (UCR) charges
- Emergency room treatment for accidental injury: Payment based on U.C.R. charges if treatment is rendered within 72 hours of accident

**PHYSICIAN'S SERVICES BENEFITS**

- In-patient or out-patient surgery: Payment based on Usual, Customary and Reasonable (UCR) charges
- Physician's visits in the hospital: Payment on UCR per visit
- Out-patient laboratory tests, x-rays, EKG's, etc.: Payment based on UCR limits
Emergency First Aid for accidental injury

Payment based on the UCR charges for the initial treatment if rendered within 72 hours of the accident.

OUT-PATIENT MENTAL ILLNESS, SUBSTANCE ABUSE AND ALCOHOLISM TREATMENT

Services rendered by Mental, Substance Abuse or Alcoholism Treatment Facility and/or Professional charges

100% of first $550.00 in calendar year. Thereafter, benefits are payable under major medical.

Lifetime Maximum for out-patient treatment of mental illness, substance abuse or alcoholism is $20,000 per individual.

NOTE: Benefits for treatment rendered by an Extended Care Facility, Skilled Nursing Facility, as well as Home Health Care and Hospice Care are payable under certain circumstances. The Benefits Office can provide information regarding these benefits.

PRESCRIPTION DRUG PLAN BENEFITS

Co-payment for prescription order or refill

Brand-name drugs - 20% of cost of prescription

Generic drugs - none

MAJOR MEDICAL BENEFITS

Deductible (per individual) $100.00 per calendar year

Benefits percentage Plan pay 80% of first $4,500.00; 100% thereafter for balance of the calendar year

Maximum Out-of-Pocket Expense (per individual) $1,000.00 per calendar year
**DENTAL BENEFITS**

<table>
<thead>
<tr>
<th>Preventative Services</th>
<th>100% of UCP charges for cleanings. Two treatments per calendar year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Maintenance and Minor Restorative</td>
<td>80% of UCP charges (after meeting $25.00 deductible per individual per year)</td>
</tr>
<tr>
<td>Dentures, bridgework and major restorative services</td>
<td>50% of UCP charges (after meeting $25.00 deductible per individual per year)</td>
</tr>
<tr>
<td>Orthodontic Services for dependent children under the age of 19</td>
<td>50% of UCP charges to a $500.00 maximum per covered person</td>
</tr>
<tr>
<td>Maximum aggregate dental benefit payable</td>
<td>$750.00 per individual per calendar year</td>
</tr>
</tbody>
</table>

**NOTE:** DENTAL COVERAGE IS NOT AVAILABLE FOR DEPENDENTS OF FACULTY AND ADMINISTRATIVE STAFF

**VISION CARE**

| Eye Examination | Up to $25.00 after $5.00 deductible. Limited to one examination every 730 days (2 years) |
| Prescription Lenses | Maximum allowance determined by type of lenses |
| Frames | Maximum frame allowance of $20.00 |
| Deductible | $10.00 applied to payment for lenses and/or frames |

Benefits for lenses and frames are limited to one every 730 calendar days (2 years).

**NOTE:** VISION CARE BENEFITS ARE NOT AVAILABLE TO DEPENDENTS OF FACULTY AND ADMINISTRATIVE STAFF
**GROUP HEALTH BENEFIT PLAN**
**ENROLLMENT FORM**

**PLEASE PRINT**

<table>
<thead>
<tr>
<th>TYPE</th>
<th>NEW</th>
<th>CHANGE OF STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST NAME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIRST NAME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMPLOYER**

- **LOCATION**
- **DEPT.**
- **UNIT**

**LIBRARY**

**HOME STREET**

**HOME CITY/STATE/COUNTRY**

- **OCCUPATION**
- **DATE EMPLOYED** 7/4/86

**IS YOUR SPOUSE EMPLOYED?**

- **NAME, ADDRESS, AND PHONE NUMBER OF SPOUSE EMPLOYER**

**GROUP HEALTH BENEFIT PLAN ENROLLMENT FORM**

<table>
<thead>
<tr>
<th>TYPE OF COVERAGE (CHECK ONE)</th>
<th>FAMILY (EMPLOYEE &amp; ELIGIBLE DEPENDENTS)</th>
<th>□ NO COVERAGE</th>
</tr>
</thead>
</table>

**LIST OF DEPENDENTS**

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>MI</th>
<th>LAST NAME</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>DATE OF BIRTH</th>
<th>SEX</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEP. #1</td>
<td></td>
<td></td>
<td>272-88-6064</td>
<td>1-20-77</td>
<td>M</td>
<td>SPOUSE</td>
</tr>
<tr>
<td>DEP. #2</td>
<td></td>
<td></td>
<td>275-88-6064</td>
<td>9-20-77</td>
<td>M</td>
<td>CHILD</td>
</tr>
<tr>
<td>DEP. #3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEP. #4</td>
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<tr>
<td>DEP. #5</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**ARE YOU YOUR SPOUSE OR DEPENDENTS COVERED UNDER ANY OTHER HEALTH PLAN OR MEDICARE?**

- **SPouse (But in process of dissolution)**

**ARE ANY OF THE ABOVE DEPENDENT(s) A FULL-TIME STUDENT AT A COLLEGE OR UNIVERSITY?**

- **NO**

**ARE ANY DEPENDENTS MENTALLY OR PHYSICALLY HANDICAPPED?**

- **NO**

**HEREBY, REQUEST THE AMOUNT(S) AND FORM(S) OF COVERAGE FOR WHICH I AM ELIGIBLE UNDER THE PLAN(S) OF MY EMPLOYER/ORGANIZATION AND I AUTHORIZE YOUR TO DEDUCT THE REQUIRED CONTRIBUTION, IF ANY, FROM MY EARNINGS/FUND. I RESERVE THE RIGHT TO REVISE THIS AUTHORIZATION AT ANY TIME UPON WRITTEN NOTICE.**

**IF NO COVERAGE HAS BEEN SELECTED, I HEREBY REFUSE THE BENEFIT PLAN OFFERED BY MY EMPLOYER AND UNDERSTAND THAT MY FUTURE ENROLLMENT MAY BE SUBJECT TO CERTAIN RESTRICTIONS OR REQUIREMENTS.**

**I AUTHORIZE MY PHYSICIAN TO DISCLOSE MEDICAL INFORMATION CONCERNING MYSELF OR A MEMBER OF MY FAMILY TO J.W. DIDION & ASSOCIATES, INC. FOR PURPOSES OF HOSPITAL UTILIZATION REVIEW (HUR). I UNDERSTAND THAT NON-COMPLIANCE WITH HUR OR SECOND OPINION SURGERY PROGRAMS (SOP) COULD RESULT IN PENALTIES.**

**SIGNATURES**

- **Employee Signature**
- **Date**

**TO BE COMPLETED BY EMPLOYER**

<table>
<thead>
<tr>
<th>EFFECTIVE DATE:</th>
<th>NAME CHANGE - FORMERLY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) NEW ENROLLMENT</td>
<td>( ) CHANGE DEPENDENT STATUS:</td>
</tr>
<tr>
<td>( ) REINSTATEMENT</td>
<td>Reason:</td>
</tr>
<tr>
<td>( ) CANCELLATION</td>
<td>Date Change Occurred:</td>
</tr>
</tbody>
</table>
SECTION 125 CONTRIBUTION CONVERSION PLAN OF BOWLING GREEN STATE UNIVERSITY

Election of Health Benefits and Compensation Reduction Agreement

Name: ____________________________________________________________

Address: __________________________________________________________

Social Security Number: ____________________________________________

You are eligible to elect either family medical coverage or single medical coverage under the Contribution Conversion Plan of Bowling Green State University. The Contribution Conversion Plan will be administered on a September 1 - August 31 Plan Year, with a short Plan Year from July 1, 1991 - August 31, 1991.

1. Your share of the cost for family medical coverage is $866 a year for Classified Employees and $1,579 a year for Contract Employees.

2. Your share of the cost for single medical coverage is $315 a year.

If you elect either family or single medical coverage, your pay will be reduced each payroll period in substantially equal installments to cover your share of the cost of the benefits you elect.

Based upon the above:


<table>
<thead>
<tr>
<th>Short Period</th>
<th>Plan Year</th>
<th>SECTION 125 CONTRIBUTION CONVERSION ELECTION OPTIONS</th>
</tr>
</thead>
</table>

I elect to receive family medical coverage under the Contribution Conversion Plan of Bowling Green State University.

I do NOT elect to participate in the Contribution Conversion Plan of Bowling Green State University.

PLEASE SIGN ON BACK

Any previous election and compensation reduction agreement under the Contribution Conversion Plan relating to the same benefits is hereby revoked.
I and Bowling Green State University agree that my pay will be reduced, on a BEFORE TAX basis, by the amount of my required contribution for the benefit option(s) I have elected under the Contribution Conversion Plan, effective for the years beginning July 1, 1991, and September 1, 1991, continuing for each succeeding pay period until this agreement is amended or terminated.

NOTE: The pay reduction may not be effective for any pay period that begins before you have signed this form and returned it to the Plan Administrator (Benefits Office).

I understand that:

• I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the next September 1, unless I have a change in family status (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, and such other events as the Plan Administrator determines will permit a change or revocation of an election in accordance with Internal Revenue Service rules and regulations and any insurance policies or other documents maintained to provide Plan benefits). Any change in benefit election as a result of a change in family status is subject to the open enrollment procedure provided in any insurance policy or other documents maintained by the University to provide medical benefits.

• If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my pay reduction will automatically be adjusted to reflect that increase or decrease. If the increase is significant, I will be permitted to cancel this agreement.

• Prior to September 1 of each year, I will be offered the opportunity to change my benefit election(s) for the following Plan Year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue my benefit coverage then in effect for the new Plan Year (September 1 to August 31).

• The Plan Administrator may adjust the amount of a highly compensated or key employee's pay reduction, cancel such participant's participation or otherwise modify this agreement in accordance with the Contribution Conversion Plan if he believes it advisable in order to satisfy the requirements of the Internal Revenue Code of 1986, as amended from time to time.

• If I am a highly compensated or key employee, under certain circumstances I may be required to include the amount of my pay reduction under the Contribution Conversion Plan in my taxable income.

• The reduction in my cash compensation under this agreement will be in addition to any reductions under other agreements or benefit plans.

This agreement is subject to the terms of the Contribution Conversion Plan of Bowling Green State University and any policies of insurance or other documents maintained to provide appropriate benefits; it shall be governed by and construed in accordance with the laws of the State of Ohio; and it revokes any prior election and compensation reduction agreement relating to these benefits.

__________________________  _______________________
Employee's signature Date: ________________

Q: Submitted 6/3/91

Acceptor and agreed to by BOWLING GREEN STATE UNIVERSITY

By: __________________________  Date: ________________

NOTE: To be valid, this Election Agreement must be countersigned by the University.
Vice Presidents/Les Barber - Please review and return to me by Thursday, September 12.

September 6, 1991

PERSONAL AND CONFIDENTIAL

MEMORANDUM

TO: Vice Presidents
FROM: Paul J. Olscamp

UNIVERSITY TASK FORCE ON HEALTH CARE

I am suggesting the following individuals as members of the Task Force for the institution wide study of health care policy and cost at the University.

Albert, Jim, Math & Statistics, Faculty
Boren, Don, Legal Studies, Faculty
Bowers, Dick, HPER,
Child, Jim, Philosophy, Faculty
Edmonds, Mary, Vice President for Student Affairs, Administration
Eninger, Kathy, Painter, Classified Staff
Erickson, Patricia, Applied Human Ecology, Faculty
Finn, Gaylyn, Treasurer, Administrative Staff
Hyslop, Joyce, Business Education, Classified Staff
Kaplan, Josh, M.D. Director of the Health Center, Administrative Staff
Keeley, Barbara, College of Health and Human Services, Faculty
Kreilekamp, Robert, Channel 27, Classified Staff
Leathers, Park, Accounting, MIS, Faculty
Moore, John, Director, Personnel, Administrative Staff
Morris, Jim, Benefits Manager, Administrative Staff
Mueller, Paul, Department of Finance, Faculty
UNIVERSITY TASK FORCE ON HEALTH CARE
October 16, 1991

Albert, Jim, Math & Statistics, Faculty
Boren, Don, Legal Studies, Faculty
Bowers, Dick, HPER,
Child, Jim, Philosophy, Faculty
Edmonds, Mary, Vice President for Student Affairs, Administration
Eninger, Kathy, Painter, Classified Staff
Erickson, Patricia, Applied Human Ecology, Faculty
Finn, Gaylyn, Treasurer, Administrative Staff
Hyslop, Joyce, Business Education, Classified Staff
Kaplan, Josh, M.D. Director of the Health Center, Administrative Staff
Keeley, Barbara, College of Health and Human Services, Faculty
Kriekamp, Robert, Channel 27, Classified Staff
Leathers, Park, Accounting, MIS, Faculty
Moore, John, Director, Personnel, Administrative Staff
Morris, Jim, Benefits Manager, Administrative Staff
Mueller, Paul, Department of Finance, Faculty
BGSU HEALTH CARE NEWSLETTER

This is the first in a series of newsletters which is intended to help the participants in the BGSU Health Care Plan become more familiar with the administration and operation of the Plan and to provide information regarding the Plan's provisions by explaining the Plan's terminology in layman's language. Responses to some of the most frequently asked questions about the Plan are given in this newsletter.

How is the BGSU Health Care Plan Administered?

The term "self funding" has frequently been used to describe the method of funding health benefits under the BGSU Health Care Plan. Self-funding simply means that the dollars that normally would be used to pay premiums to an insurance company are deposited into a "Health Care" account from which benefits are paid. To protect itself against "catastrophic" claims, the University does purchase excess loss insurance from an insurance company to limit its liability on any one claim as well as the total amount of claims during any given year. In other words, if one claim or if the total claims exceed a predetermined limit, the insurance company pays the excess.

Another term that is frequently used in connection with the Plan is Third Party Administrator or "T.P.A." The Third Party Administrator is the firm that the University has contracted to process health care claims for employees and their eligible dependents. Effective September 1, 1990 Didion & Associates, a firm located in Columbus, Ohio became the Third Party Administrator for the University's Health Care Plan. Didion & Associates processes and pays claims in accordance with the Plan's provisions and industry standards and practices in claims administration.

Since January of this year, Didion has processed an average of 2000 medical claims per month. Over 90% of these claims have been processed within (10) working days from the date they are received.

What Factors Determine Health Care Costs?

The two primary factors that determine health care costs are claims expense and administration expenses.

The basic components of claims expense are claims that are generated by the Plan's covered employees and their eligible dependents and increases in claim costs due to inflation and changes in types of medical services used and changes in plan design. Claim costs accounted for approximately 95% of the total Health Care costs for the Plan Year ending August 31, 1991. Administration expenses are the costs of running the plan and include premiums for excess loss insurance and claims administration fees paid to the Third Party Administrator. For the 1990-91 Plan Year, Administration fees accounted for approximately 3% of the total Health Care costs with excess loss insurance premiums accounting for the remaining 2%.

What Can Participants do to Help Control Health Care Costs?

In order to help curb the constantly increasing cost of health care, we as participants must become more cost conscious health care consumers.
Both the University and Didion & Associates have programs to help us become more informed consumers of Health Care services and supplies.

Didion has a Customer Service Department as well as a Health Care Management Department which can assist us in such areas as determining if second surgical opinions are necessary prior to having elective surgery and in obtaining a predetermination of the Usual, Customary and Reasonable (U.C.R) allowances for surgeon's fees before the surgery is performed. For further information regarding these services you can contact either the Benefits Office or Didion & Associates. The telephone number for the Benefits Office is 372-2112 and the Toll free telephone number for Didion & Associates is 1-800-282-3920.

One of the most successful Reward Programs the University has for employees is the Self-Audit Reward Program which can result in a cash reward for participants who detect errors in bills received from providers for medical services and supplies. Since its inception over $5,000 in rewards has been paid to employees participating in the Health Care Plan. A description of the Self-Audit Reward Program is provided on page 20 of the Health Care Booklet which was recently distributed to all employees participating in the Health Care Plan.

In summary, Health Care Costs are everyone's concern and the combined efforts of the University and the participants will be required to help hold down health care costs.

Future issues of the Health Care Newsletter will discuss other actions which can be taken by participants to help control Health Care costs. Any comments or suggestions that you may have will be appreciated.

November 1991
To: HCA Committee Members.

From: Don Boren, Chair

Re: Timetable for the Committee Report

I have set forth below a timetable for completing our work. I realize that this may not be realistic. In some sections I believe our deliberations will be very quick, in others we may spend two or three times the estimated time. I am not as concerned about the time as the order in which each section will be considered. We can discuss the specifics at the 2/11/92 meeting.

HEALTH CARE TASK FORCE
PROPOSED TIMETABLE

2/11/92 I. The Delivery System - Fynn
   A. Self-funded
   B. Insurance
   C. Health Maintenance Organizations
   D. Preferred Provider Organizations
   E. Flexible Programs
II. Coalition with other Employers - Fynn
III. Analysis of Use Pattern - Kaplan

2/18/92 IV. Employee Assistance Programs and Deductible on Mental Health Coverage - Moore
V. Wallness - Bowers

2/25/92 VII. Background of Current Plan - Mueller & Leathers
VIII. Restructuring of Current Coverage - Morris
   A. Mental Health
   B. Substance Abuse
   C. Dental
   D. Vision
   E. Prescription Drugs (completed 1/28/92)
   F. Alternative Delivery Use of Health Center - Kaplan, Hyslop
      A. Lab. Work
      B. Physicals
      C. Prescription Drugs (completed 1/28/92)

3/3/92 IX. Cost Containment
   A. Restructuring Employee Contribution Levels - Albert, Kreinkamp, & Morris
      1. Deductibles
      2. Co-payments
      3. Managed Care
      4. Payment Formula
      5. Utilization Review

3/17/92 X. Education Programs Eninger & Keeley
3/24/92 Spring Break
3/31/92 Coverage/ Costs Among Groups
   A. Administrative Staff, Classified Staff, Faculty
   B. Single and Family Coverage Options
   C. Male and Female
   D. High Risk and Low Risk
   E. Cafeteria Style Plans

4/7/92 Deliberations and Adoption of Final Report
MEMORANDUM

TO: Paul J. Olscamp, President
FROM: Don Boren, Chair, Health Care Task Force
RE: Health Care Task Force Report

Please find enclosed the Health Care Task Force Report.

The one area of the report that may be inaccurate is in estimated cost of savings. Our estimates are at best a somewhat educated guess. Our concern is the large variance in projected premium savings between Costeffect and Didion, by increasing co-payments and deductibles. Last year, Costeffect estimated a premium savings of $1,780,000.00, if a $300.00 deductible and a 80% co-payment were adopted for all medical costs. Didion roughly estimated the savings at 8 percent. The Task Force selected Didion's more conservative projection. We have requested Didion to determine cost, based on last year's utilization, with the $200.00 deductible/80% co-payment. This report should be completed within two weeks.

I would like to thank all the members of the Task Force. They undertook a difficult task and worked diligently until it was completed. We all hope that our work will help the University during this very difficult time.

/et
Attachment

DISTRIBUTION:
Jim Albert, Math & Statistics
Dick Bowers, HPER
Jim Child, Philosophy
Mary Ellen Cloninger, Athletics
Kathy Eninger, Physical Plant
Patricia Erickson, Applied Human Ecology
Gaylyn Finn, Treasurer
Joyce Hyslop, Business Administration
Josh Kaplan, Health Center
Barbara Keeley, Health and Human Services
Robert Kreienkamp, Channel 27
Park Leathers, Accounting & MIS
John Moore, Personnel
Jim Morris, Benefits Manager
Paul Mueller, Finance
HEALTH CARE TASK FORCE
REPORT TO THE PRESIDENT
MAY, 1992

Members: Don Boren (Chair), Dick Bowers, Jim Childs, Mary Ellen Cloninger, Pat Erickson, Gaylyn Finn, Joyce Hyslop, Josh Kaplan, Barbara Keeley, Robert Kreienkamp, Park Leathers, John Moore, Jim Morris, Paul Mueller.

INTRODUCTION

The Health Care Task Force was formed by President Olscamp on October 15, 1991. The Task Force consisted of 16 members. Three members resigned during the year. Mary Edmonds, vice president for academic affairs was replaced by Mary Ellen Cloninger, associate athletic director. Jim Albert, math and statistics, and Kathy Eninger, classified staff, were not replaced because both resignations occurred near the end of the academic year.

The Task Force was charged with recommending to the President "actions and policies necessary to implement an employee health care benefits plan which ensures the availability of quality health care to university employees while holding future increases in the cost of providing health care coverage to both the University and the employees to reasonable levels."

The Task Force divided its work into two stages. The Task Force's primary objective in the first stage is to recommend ways to immediately decrease health care costs for the next fiscal year. The projected cost increase for health care for the 1992-93 fiscal year is $1,500,000. These recommendations are designed to help offset this increase and keep the University's and employee's cost at or below the 1991-92 level.

These savings would be realized by:

1. Change prescription drug plans $82,000
2. Revise vision coverage 60,000
3. Increase co-payments and deductible 720,000
4. Cap on mental health and substance dependency/employee assistance program/utilization review 85,000
5. Cap on chiropractic care 43,000

Total Projected University Savings 1,000,000

1992-93 Projected Cost Increase 1,500,000

1992-93 Net Projected Increase in Cost $500,000

The Task Force recommends that additional funds be used to establish a health promotion program, an employee assistance program, and to provide for early diagnosis of disease by routine testing for breast cancer, cholesterol, high blood pressure, and other early diagnostic testing.

The second stage entails developing a long-range plan to reduce health care costs. It consists of negotiating rates with health care providers, exploring whether certain health care services could be provided through the use of University health care facilities, and perhaps entering into an area health care consortium. The Task Force is willing to continue working on long-range planning if requested.
HEALTH CARE TASK FORCE
RECOMMENDATIONS

1. The University continue to provide for health care costs through our present self-funded system.

2. The University explore providing health care coverage through an integrated plan that provides employees the option of selecting the traditional fee-for-service arrangement, a health maintenance organization, or a preferred provider organization.

3. Prescription drug benefits continue to be provided through the prescription drug card program (PCS).

4. The PCS maximum allowable cost be used to determine payment levels for generic drugs.

5. When a brand name drug is selected in lieu of its generic equivalent, PCS will only pay the cost of the generic equivalent.

6. A maintenance drug program be implemented to provide for the purchase of maintenance drugs for longer-term medication than the current plan allows.

7. The University renegotiate prescription ingredient costs and dispensing fees.

8. The University offer an optional vision plan to replace the present vision plan which will no longer be funded.

9. The University establish a flexible spending arrangement to allow employees to pay out-of-pocket health care and other allowable costs with pretax dollars.

10. The University’s health benefits for chiropractic services be limited to the following:

   Services provided by a licensed chiropractor (D.C.) would be covered by the plan provided such services are within the scope of his/her license.

   For neuro-musculoskeletal disorders, the plan will pay 80% of covered services up to a maximum of $25 per visit with a maximum of one visit per day and 20 visits per calendar year.

   X-rays will be covered if they are necessary to analyze a disorder. A maximum of $150 will be considered for x-rays and diagnosis during any calendar year. These maximums would apply to each covered person. Additional charges for ultrasound and diathermy in connection with a chiropractic visit would not be covered.

11. The following changes be made in mental health benefits: special deductibles, co-payments, and maximum payments be established for mental health as described below.

   In-patient benefits:
   The plan pay 80% of covered services (defined in existing plan) with an annual maximum of 30 days in-patient treatment up to an annual maximum benefit of $30,000.

   Out-patient benefits:
   The plan will pay for covered services (defined in existing plan) up to $1,000 per calendar year with a co-payment percentage of: visits 1-3 80% up to $75 per visit; visits 4-6 80% up to $60 per visit; visits 7+ 50% up to $40 a visit.
12. The following changes be made in chemical dependency benefits: special deductibles, co-payments, and maximum payments be established for chemical dependency as described below.

The plan will pay 80% of in-patient or out-patient benefits on an episode of care basis. An episode of care can be a combination of in-patient and/or out-patient treatment. The treatment plan must be approved in advance. No more than two in-patient admissions related to chemical dependency care would be covered during any calendar year with a maximum lifetime benefit of $30,000.

13. The University contract with an employee assistance program (EAP) provider to facilitate early intervention into personal and workplace problems and to monitor care for mental health and chemical dependency benefits.

14. No changes be made to the University's present dental coverage.

15. Pre-certification of hospital admissions should be implemented.

16. Employees of the University be given an option of three different health care plans (see Appendix C). The plans will vary as to the type of deductibles and co-pays; the types of coverage will be the same for all three plans. Plan A will have the current deductibles and co-pays for major medical. Plan B and C will be comprehensive plans with an 80% co-pay on most medical costs. Plan B will have a $200/$400 deductible with a maximum out-of-pocket cost of $1,000/$2,000. Plan C will have a $500/$1,000 deductible with a maximum out-of-pocket cost of $1,500/$3,000.

17. Employees' contribution levels increase or decrease the same dollar amount for each employee group and that, for purposes of budgeting, the usage be divided by the total number of employees covered, instead of dividing usage by faculty, contract, and classified groups.

18. No change be made in the current plan design regarding contributions for family and dependent coverage.

19. The University adopt a plan to educate employees about their health care options.

20. The University design a plan for health promotion and encourage the use of the fitwell assessment/counseling program through the Student Recreation Center.
HEALTH CARE TASK FORCE
FINAL RECOMMENDATIONS AND RATIONALE

THE DELIVERY SYSTEM

A. Self-Funded vs. Insured Plan

1. THE UNIVERSITY CONTINUE TO PROVIDE FOR HEALTH CARE COSTS THROUGH OUR PRESENT SELF-FUNDED SYSTEM.

Rationale

Employers fund health care costs either by commercial carriers or a self-funded program. Self-funded programs are usually more cost effective since administrative costs are traditionally less [a 1988 survey found that administrative costs for insured plans was 6.6% compared to 5.2% for self-funded programs, see Foster Higgins, Health Care Benefits Survey (1988)]. The primary advantage of commercial insurance is that costs are more predictable and not as subject to fluctuations in loss experience. The majority of larger employers, who are better able to absorb cost fluctuations, are self-funded. Sixty-five percent of larger employers (1,000 or more employees) are self-funded while the majority of smaller employers (less than 1,000) are insured through an outside source. Most self-funded employers purchase stop-loss insurance to protect against high-cost catastrophic cases.

The University’s program is typical of what other large employers are doing. The University is self-funded with stop-loss coverage of $150,000 per claim and an aggregate stop-loss of 12.5% of expected claims. The University uses a third party administrator (TPA, Didion) to handle claims. Didion is reimbursed on a per employee basis. The current rate of 3% for administrative costs and 2% for stop-loss does not appear excessive when compared to a 1988 average administrative expense of 4.9% for large employers. However, this comparison may be misleading in that the higher dollar amount of claims paid, the smaller will be the percentage paid for administrative expense.

The Task Force did not compare cost between our TPA and insurance. This comparison was made two years ago and the rate for similar coverage under insurance was significantly higher.

B. Preferred Provider Organizations/Health Maintenance Organizations

2. THE UNIVERSITY EXPLORE PROVIDING HEALTH CARE COVERAGE THROUGH AN INTEGRATED PLAN THAT PROVIDES EMPLOYEES THE OPTION OF SELECTING THE TRADITIONAL FEE-FOR-SERVICE ARRANGEMENT, A HEALTH MAINTENANCE ORGANIZATION, OR A PREFERRED PROVIDER ORGANIZATION.

Rationale

There are three kinds of health care delivery plans in the United States today: the traditional fee-for-service plan; health maintenance organizations (HMO); and preferred provider organizations (PPOs). The fee-for-service plan traditionally pays physicians the UCR (usual, customary, and reasonable) price for services rendered. The plan does not limit coverage to any one group of physicians, and in most plans the patient is responsible for fees that exceed the UCR rate.

HMOs provide a fixed, predetermined amount of payment (capitation basis) for each plan participant regardless of the actual number or nature of services provided over a set period of
time. Much of the recent growth in HMO enrollment has been in individual physician associations (IPA). An IPA-type HMO is open to all community physicians who meet the HMO's criteria. Physicians who participate in an IPA maintain their own offices and continue to see non-HMO patients. HMOs appear to be effective in controlling costs. A 1980 study found that total costs for members of HMOs were 20%-40% less than the costs for members of fee-for-service plans. (Employee Benefits, BASICS Third Quarter 1990)

PPOs are hospitals, clinics, and physician groups that contract with employers to provide health care service at a discounted fee-for-service basis in exchange for a greater potential volume of patients. Participants covered by a PPO have the option of deciding at the point of service whether to receive care from the PPO or another provider. Typically, if the patient selects another provider the patient is responsible for additional costs. Employers have reported mixed experiences regarding the cost effectiveness of PPOs. One study found that 24% of employers reported reduced costs; 17% indicated no effect on costs; and 4% reported a sizable increase. (Employee Benefits, BASICS Third Quarter 1990)

The use of HMOs and PPOs is becoming widespread. In 1990, Foster Higgins conducted a study of health care benefits for Ohio colleges and universities. The study found that nationwide 83% of universities over 1,000 employees and 52% of Ohio universities offer either an HMO or PPO. This study also reported mixed results on the effectiveness of controlling costs. Thirty-three percent of respondents from Ohio universities agreed that HMOs were effective in controlling costs compared with 59% of universities in the nationwide survey. The majority of respondents in both the Ohio (67%) and national (57%) surveys agreed that PPOs were effective in controlling costs.

There is insufficient information to decide whether PPOs and HMOs would be effective alternatives to our present indemnity plan. A major problem is that no alternative delivery plans are available in Wood County and none of the Toledo plans have been extended to this area. If the University is to offer these plans as an alternative, a plan would need to be created.

For alternative delivery plans to be successful, there must be sufficient inducements for the physicians and patients to enter the plan. The inducement for physicians to enter into an HMO or PPO is to increase the number of patients. These plans would offer little advantage to physicians if a substantial majority of physicians in the community are members, or if the physician's case load is such that he can not serve additional patients. This indicates that plans would have a greater chance of success in geographic areas with a large number of physicians and patients. A 1991 survey, conducted by Youngstown State University, supports this premise. The survey found that, with the exception of Kent State University, all Ohio universities that offered HMOs or PPOs were located in large metropolitan areas.

Another factor necessary for the success of HMOs and PPOs is that the costs offered by the plan must be sufficiently lower than an indemnity plan to induce employees to join. Hospitals that serve the majority of university employees already offer low costs. The most recent survey of hospital costs conducted by the Employers Coalition of Northwest Ohio found that Wood County Hospital and Blanchard Valley Hospital are two of the lowest cost providers in this region. For an alternative delivery plan to be successful, these institutions must be willing to reduce costs even lower.

While HMOs and PPOs do not appear to be viable at this time, potential savings warrant the University continuing to explore these alternatives. The best alternative would appear to be a plan which integrates an indemnity plan and an HMO or PPO. All employees would enroll in the plan at a discounted fee-for-service basis or a capitated rate. The plan would offer a point-of-service option with partial coverage for participants who receive care from outside providers.
PRESCRIPTION DRUGS

3. PRESCRIPTION DRUG BENEFITS CONTINUE TO BE PROVIDED THROUGH THE PRESCRIPTION DRUG CARD PROGRAM (PCS).

Rationale

Prescription drug benefits play an important role in the treatment of illness. Prescription drug card programs are becoming more common with colleges and universities in Ohio and with large employers in Northwest Ohio (see Appendix B).

The prescription drug card program has been widely accepted by employees primarily because of its convenience since no claim form is required when the card is used to purchase prescription drugs. The only drawback to the PCS is that it has been difficult to maintain effective cost management procedures. PCS recently implemented several cost containment procedures to assist employers in maintaining more effective cost management of their prescription drug programs.

4. THE PCS MAXIMUM ALLOWABLE COST BE USED TO DETERMINE PAYMENT LEVELS FOR GENERIC DRUGS.

Rationale

Under the present arrangement, PCS reimburses dispensing pharmacies based on the Average Wholesale Price (AWP) for ingredient costs plus a dispensing fee. Average Wholesale Price is determined by the suggested list price of drug products that pharmacists pay to the drug wholesalers or suppliers. It seldom reflects the costs of the drugs to the pharmacist since it does not take into consideration volume discounts, rebates and other incentives offered by suppliers. PCS has compiled a maximum allowable cost for each of approximately 450 generic drugs which more accurately reflects the actual ingredient cost to the pharmacist. By adopting the maximum allowable cost program, the cost of the program would be reduced by approximately 4% per year. This would result in a savings of approximately $32,000 during the initial plan year.

5. WHEN A BRAND-NAME DRUG IS SELECTED IN LIEU OF ITS GENERIC EQUIVALENT, PCS WILL ONLY PAY THE COST OF THE GENERIC EQUIVALENT.

Rationale

When brand name drugs are dispensed, the individual is required to make a 20% co-payment with the balance being paid by PCS. In some instances, brand name drugs are dispensed when a generic equivalent is available. It is recommended that in these instances the individual be required to pay the difference between the maximum allowable cost for the generic equivalent in lieu of the 20% co-payment. This will encourage the use of generic drugs whenever possible which will result in significantly lower costs for the prescription drug card program.

6. A MAINTENANCE DRUG PROGRAM BE IMPLEMENTED TO PROVIDE FOR THE PURCHASE OF MAINTENANCE DRUGS FOR LONGER TERM MEDICATION THAN THE CURRENT PLAN ALLOWS.

Rationale

Approximately 28% of the total prescriptions purchased under the prescription drug card program for the 12 month period January 1, 1991 through December 31, 1991 were maintenance drugs. Under the current plan the maximum dosage that cardholders can purchase with each prescription is a 34 day supply.
Effective July 1, 1992, PCS will have available a maintenance drug program which will allow cardholders to purchase up to a 90 day supply of maintenance drugs under one prescription. This will significantly reduce the number of prescriptions purchased under the program and will reduce the dispensing fees paid to pharmacists by approximately $10,000.

7. THE UNIVERSITY RENEGOTIATE PRESCRIPTION INGREDIENT COSTS AND DISPENSING FEES.

Rationale

Based on the volume of prescription drug purchases through the Prescription Drug Card Program, PCS has agreed to negotiate a discount of 10% below the average wholesale price for all prescriptions purchased through the PCS network of participating pharmacies. PCS did, however, recommend that the University adjust the dispensing fee paid to the pharmacists. It was recommended that the dispensing fee be increased from $2.60 to $3.23 which is the prevailing fee provided under Medicaid in Ohio.

The above arrangement would result in a net reduction in prescription drug costs of approximately $50,000 per year based on the current annual costs of approximately $862,000.

VISION

8. THE UNIVERSITY OFFER AN OPTIONAL VISION PLAN TO REPLACE THE PRESENT VISION PLAN WHICH WILL NO LONGER BE FUNDED.

Rationale

The Health Care Plan currently provides benefits for vision care on an indemnity basis with specific allowances for each type of service. The current annual claim cost of providing vision care coverage to eligible employees and dependents (classified employees only) is approximately $60,000. The plan offers very limited coverage, paying approximately 1/3 of the costs of typical vision care. The policy pays on a reasonable and customary basis which offers no costs savings over the retail costs.

The Task Force recommends that the University offer to all employees an optional VSP Plan through the Section 125 Plan.

The Task Force explored providing vision care through Vision Service Plan (VSP), a preferred provider arrangement. The VSP Plan would cost approximately $75,900 per year if coverage were provided for the 886 employees and 624 dependent units (classified employees only) covered under the current plan. If vision coverage were expanded to provide benefits to dependents of faculty members and administrative staff, the estimated annual cost would be approximately $121,200.

The Task Force believes that these additional costs are not justified in a period of rapidly expanding medical costs. The approximately $60,000 costs savings in not providing vision care could be better spent in providing coverage in more critical areas.
SECTION 125 PLAN

9. THE UNIVERSITY ESTABLISH A FLEXIBLE SPENDING ARRANGEMENT TO ALLOW EMPLOYEES TO PAY OUT-OF-POCKET HEALTH CARE AND OTHER ALLOWABLE COSTS WITH PRETAX DOLLARS.

Rationale

Last year the University established a 125 Plan that allows employees to pay their share of health care premiums with pre-tax dollars. Expanding this plan to permit employees to pay as much of their health care and other costs (i.e., dependent care, vision, deductibles, and co-pays), as allowed under Internal Revenue Code Section 125, with pre-tax dollars reduces the financial burden on employees and allows them to design a benefit package that best meets their needs.

CHIROPRACTIC SERVICES

10. THE UNIVERSITY'S HEALTH BENEFITS FOR CHIROPRACTIC SERVICES BE LIMITED TO THE FOLLOWING:

SERVICES PROVIDED BY A LICENSED CHIROPRACTOR (D.C.) WOULD BE COVERED BY THE PLAN PROVIDED SUCH SERVICES ARE WITHIN THE SCOPE OF HIS/HER LICENSE.

FOR NEURO-MUSCULOSKELETAL DISORDERS, THE PLAN WILL PAY A MAXIMUM OF 80% OF COVERED SERVICES UP TO $25 PER VISIT WITH A MAXIMUM OF ONE VISIT PER DAY AND 20 VISITS PER CALENDAR YEAR.

X-RAYS WILL BE COVERED IF THEY ARE NECESSARY TO ANALYZE A DISORDER. A MAXIMUM OF $150 WILL BE CONSIDERED FOR X-RAYS AND DIAGNOSIS DURING ANY CALENDAR YEAR. THESE MAXIMUMS WILL APPLY TO EACH COVERED PERSON. ADDITIONAL CHARGES FOR ULTRASOUND, DIATHERMY IN CONNECTION WITH A CHIROPRACTIC VISIT WOULD NOT BE COVERED.

Rationale

The current plan pays 80% of the reasonable and customary charges for chiropractic services. There is no limit to the number of services that can be provided. In reviewing the claims utilization data provided by Didion & Associates, the possible over utilization of these services might be occurring. There were also indications that certain providers are taking some liberties with this benefit in view of the type and extent of services they are providing to their patients.

It is anticipated that the above payment limitations will result in a cost reduction of approximately $43,000 per year for chiropractic services.

MENTAL HEALTH

11. THE FOLLOWING CHANGES BE MADE IN MENTAL HEALTH BENEFITS: SPECIAL DEDUCTIBLES, COPAYMENTS, AND MAXIMUM PAYMENTS BE ESTABLISHED FOR MENTAL HEALTH AS DESCRIBED BELOW.

IN-PATIENT BENEFITS:
THE PLAN PAY 80% OF COVERED SERVICES (DEFINED IN EXISTING PLAN) WITH AN ANNUAL MAXIMUM OF 30 DAYS IN-PATIENT TREATMENT UP TO AN ANNUAL MAXIMUM BENEFIT $30,000.
OUT-PATIENT BENEFITS:
THE PLAN PAY FOR COVERED SERVICES (DEFINED IN EXISTING PLAN) UP TO $1,000 PER CALENDAR YEAR WITH A CO-PAYMENT PERCENTAGE OF:
VISITS 1-3 80% UP TO $75 PER VISIT; VISITS 4-6 80% UP TO $130 PER VISIT; VISITS 7+ 50% UP TO $40 PER VISIT.

Rationale

The Task Force compared the University's utilization data with industrial standards to identify areas of high utilization. These areas were then examined to determine the cause of the high utilization and what is customarily standard in health care plans.

The Task Force found that the University's utilization of mental health and chemical dependency benefits substantially exceeded the average in health care costs. The Task Force asked Square Lakes Corporation, a medical consulting firm, to compare the University's utilization with industry averages. The University's utilization for the most recent period that data is available (9-1-90 through 8-31-91) was used as the basis of comparison. Square Lakes found that the University's inpatient utilization, of 83 inpatient days per 1,000 group members, is within the industry average of 80 to 160 days per 1,000 members. However, outpatient visits for this period are over three times higher than the industry standard. The University had 916 outpatient visits per 1,000 members compared with the industry standard of 250 to 300 per 1,000 members.

The Task Force further found that the University's coverage for mental and chemical dependency is unique, in that the plan does not provide for special limits on coverage or for utilization review. The most recent Foster Higgins Survey (Health Care Benefits Survey 1991 / Indemnity Plans p. 8) found that 87% of employers now have special limits for mental disorder and substance abuse benefits.

Under the current plan, costs for treatment for mental illness and alcohol and substance abuse is covered under both the basic medical and the major medical benefits. The basic medical benefits, for outpatient treatment, pays for 100% of costs up to $550 per person per calendar year for mental illness, alcoholism, and substance abuse treatment. Once the $550 limit is exhausted, the patient qualifies for major medical coverage with the only limit being a maximum lifetime coverage of $20,000. For inpatient services the plan pays for 120 days per confinement for treatment for both mental illness, and alcohol and substance abuse treatment. Treatment for both mental disorder and alcohol and substance abuse are covered under major medical with a maximum lifetime coverage of $20,000 for these illnesses.

CHEMICAL DEPENDENCY

12. THE FOLLOWING CHANGES BE MADE IN CHEMICAL DEPENDENCY BENEFITS:
SPECIAL DEDUCTIBLES, CO-PAYMENTS, AND MAXIMUM PAYMENTS BE ESTABLISHED FOR CHEMICAL DEPENDENCY AS DESCRIBED BELOW.

THE PLAN PAYS 80% OF IN-PATIENT OR OUT-PATIENT BENEFITS ON AN EPISODE OF CARE BASIS. AN EPISODE OF CARE CAN BE A COMBINATION OF IN-PATIENT AND/OR OUT-PATIENT TREATMENT. THE TREATMENT PLAN MUST BE APPROVED IN ADVANCE. NO MORE THAN TWO IN-PATIENT ADMISSIONS RELATED TO CHEMICAL DEPENDENCY CARE WOULD BE COVERED DURING ANY CALENDAR YEAR WITH A MAXIMUM LIFETIME BENEFIT OF $30,000.
OUT-PATIENT BENEFITS FOR CHEMICAL DEPENDENCY RELATED CARE BE THE SAME AS OUT-PATIENT MENTAL HEALTH BENEFITS.
Rationale

The Task Force examined several plans to determine the type of limits that would be fair but still guard against overutilization. The Task Force believes that this combination of co-payments and maximum benefits best accomplishes these goals. For the 1990-91 fiscal year, the University's costs for providing treatment for mental disorder and alcohol and substance abuse was $568,546. It is believed that adoption of the restrictions will result in substantial savings to the University.

EMPLOYEE ASSISTANCE PROGRAM/UTILIZATION REVIEW

13. THE UNIVERSITY CONTRACT WITH AN EMPLOYEE ASSISTANCE PROGRAM (EAP) PROVIDER TO FACILITATE EARLY INTERVENTION INTO PERSONAL AND WORKPLACE PROBLEMS AND TO MONITOR CARE FOR MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS.

Rationale

The University is currently paying in excess of $500,000 a year for treatment of mental disorders. An EAP could provide a means of reducing these costs through utilization reviews and, in some cases, a less expensive alternative when specific treatment is not warranted.

The University's current plan does not provide for pre-certification, continuing stay reviews, concurrent reviews, and case management reviews for mental health and chemical dependency benefits. Because of the highly sensitive nature of treatment for mental disorders and chemical dependency, the Task Force believes that utilization review would be best accomplished by an independent contractor. The Task Force believes that the University would benefit from this service.

The Task Force further believes that an important component of mental health services would be the adoption of an employee assistance program which would contract for a fee to provide for initial consultation for personal and workplace problems.

Data indicates the cost for an employee assistance program/utilization review would be $90,000. The savings that would result from the implementation of such a program would be approximately $175,000 with a net savings to the University of approximately $85,000.

DENTAL

14. NO CHANGES BE MADE TO THE UNIVERSITY'S PRESENT DENTAL COVERAGE.

Rationale

The dental plan covers 100% of routine preventive care, twice per year for most services. For most restorative work the plan plays 50% of basic charges after a $25 deductible has been met, and 50% of major restorative charges. Total payments for all services is limited to $750 per year. Orthodontic services are not provided for adults, but 50% or $500, whichever is less, is paid for dependent children (classified plan only). Dental care benefits are not available for dependents of contract staff.

For the 12 month period ending August 31, 1991, the University paid $466,131 in dental claims. Administrative fees for dental and vision in the aggregate was $73,501. Increase in costs has been relatively small compared to other health care costs. Dental care is customarily covered in health care plans. The 1990 Foster Higgins Health Care Benefits Survey found that 76% of Ohio and 85% of colleges and universities nationally provide dental coverage.
HOSPITAL PRE-ADMISSION CERTIFICATION

15. PRE-CERTIFICATION OF HOSPITAL ADMISSIONS SHOULD BE IMPLEMENTED.

Rationale

Hospital in-patient costs exceeded $2,000,000 for the 1990-91 plan year. A pre-certification requirement would help to determine whether: 1) hospitalization is medically necessary; 2) another form of treatment or facility setting is available and appropriate; and 3) if the length of stay is appropriate.

In addition, potential catastrophic illnesses and injuries which will require intensive medical treatment can often be identified during the initial hospital admission process. This provides for more effective medical cost management on an individual basis for this type of situation.

CO-PAYMENTS AND DEDUCTIBLES

16. EMPLOYEES OF THE UNIVERSITY BE GIVEN AN OPTION OF THREE DIFFERENT HEALTH CARE PLANS (SEE APPENDIX C). THE PLANS WILL VARY AS TO THE TYPE OF DEDUCTIBLES AND CO-PAYS; THE TYPES OF COVERAGE WILL BE THE SAME FOR ALL THREE PLANS. PLAN A WILL HAVE THE CURRENT DEDUCTIBLES AND CO-PAYS FOR MAJOR MEDICAL. PLAN B AND C WILL BE COMPREHENSIVE PLANS WITH AN 80% CO-PAY ON MOST MEDICAL COSTS. PLAN B WILL HAVE A $200/$400 DEDUCTIBLE WITH MAXIMUM OUT OF POCKET COSTS OF $1,000/$2,000. PLAN C WILL HAVE A $500/$1,000 DEDUCTIBLE WITH MAXIMUM OUT OF POCKET COSTS OF $1,500/$3,000.

Rationale

Plan B (the base plan) will be offered to employees at the existing employee premium contribution. Employees selecting Plan A would pay all of the additional costs of receiving this coverage. Employees selecting Plan C would be given the savings to the University associated with the higher deductible and co-pay. This saving could either be taken as reduction in monthly premium contributions or placed in the Section 125 Plan.

Today, most employers offer their employees a comprehensive health plan (one in which a co-pay applies to all medical claims). The 1991 Foster-Higgins Survey found that 73% of large employers offer such a plan. While such plans shift costs to employees, costs savings to the employer and perhaps to the employees through lower premiums justify the adoption of comprehensive plans. With the University's projected increase in medical costs for the 1992-93 at $1,500,000, the Task Force believes that many employees may elect not to be insured because of high premium costs. Employees who perceive an inability to afford higher insurance premiums may choose to assume a higher risk for catastrophic medical costs and paying higher deductibles and co-payments in lieu of going without coverage.

Plan B was adopted as the base plan which the committee hopes can be offered to employees without an increase in premiums. Didion projected a cost savings of $720,000 if the deductible were increased from $100 to $200 and the 20% co-payment were extended to basic services as well as major medical.

The Task Force was divided as to whether Plan C should be offered as an alternative. Those opposed to the Plan were afraid that employees may elect this Plan for the initial cost savings and be unable to pay the higher deductible. The Task Force recommends that the University determine premiums for each of these plans and the Task Force then meet to determine if the reduced premium is sufficient to warrant this option.
17. **EMPLOYEES' CONTRIBUTION LEVELS INCREASE OR DECREASE THE SAME DOLLAR AMOUNT FOR EACH EMPLOYEE GROUP AND THAT, FOR PURPOSES OF BUDGETING, THE USAGE BE DIVIDED BY THE TOTAL NUMBER OF EMPLOYEES COVERED, INSTEAD OF DIVIDING USAGE BY FACULTY, CONTRACT, AND CLASSIFIED GROUPS.**

**Rationale**

Separating changes in contribution levels promotes divisiveness between the employee groups. Utilization can vary greatly within a short period of time for the three groups. Dividing the usage by groups can be misleading and may not reflect true average usage but usage based on catastrophic or unforeseen emergencies, or usage by age and gender that inflate the totals for a particular employee group.

The Task Force was divided on the issue of cost indexing according to salary level. No recommendation will be made at this time.

18. **NO CHANGE BE MADE IN THE CURRENT PLAN DESIGN REGARDING CONTRIBUTIONS FOR FAMILY AND DEPENDENT COVERAGE.**

**Rationale**

The Task Force has not had adequate time to study whether the percentage level of contributions for single and family coverage should be changed. It is, therefore, recommended that the contribution levels remain the same until there is adequate time to analyze this question.

**HEALTH PROMOTION & INFORMATION ACTIVITIES**

19. **THE UNIVERSITY ADOPT A PLAN TO EDUCATE EMPLOYEES ABOUT THEIR HEALTH CARE OPTIONS.**

**Rationale**

To assist employees to better utilize their health care benefits, an educational plan must be initiated. The planning, implementing and evaluating of such a plan could be coordinated by the benefits/personnel office whose principle responsibility would be to develop and maintain this educational program and assist employees to use the insurance wisely.

The first part of the educational process must include a series of informational sessions to explain to all employees what choices are being offered. All employees must be allowed to attend during work hours.

20. **THE UNIVERSITY DESIGN A PLAN FOR HEALTH PROMOTION AND TO ENCOURAGE THE USE OF THE FITWELL ASSESSMENT/COUNSELING PROGRAM THROUGH THE STUDENT RECREATION CENTER.**

**Rationale**

It is estimated that 60% of work related accidents are preventable. A crucial part of the health promotion program would be to analyze the University's accident history and address the needs identified there.

We should continue to use the sources already available to us such as the Monitor and BG News and continue the EGSU Health Care Newsletter that the Benefits Office has started. The State of Ohio also has many pamphlets and training films available either for free or for a small fee that we should take advantage of for use in workshops.
Information sheets and reference material should be available, strategically located around campus for employee use. This information should include not only pamphlets for specific programs such as high blood pressure, cancer prevention, back health, but also books such as Take Care of Yourself, The AMA Family Medical Guide, The AMA Guide to Prescription and Over-the-Counter Drugs, etc.

Some health education workshops that need to be offered and repeated include, but certainly are not limited to, the following: food and nutrition information; self care classes—self breast exam, self testicular exam; safety; exercise; stress reduction; smart consumer; weight control; and smoking cessation.

An increasing body of evidence suggests that physical activity and physical fitness contribute to good health. Establishing a health promotion program which is utilized by employees will reduce health care costs.

The University has the resources to establish a model program in health promotion. But much work must be done to fully realize this potential. The critical factor is to devise a program that will be utilized by employees.

In 1989, the Health Promotion Task Force recommended the establishment of a fitwell assessment/counseling program in which the University would subsidize the cost of employee: 1) blood pressure screening; 2) health risk appraisal (CDC Program); 3) cholesterol screening; 4) body composition analysis by computer; and 5) ECG-monitored exercise treadmill examination. These tests would be done through the BGSU Student Recreation Center at a total estimated cost to the University of $32,340. The Task Force endorses this recommendation.

Additional planning must be done to encourage employee utilization. Goals must be established that are realistic, measurable, and specific to the University population.
APPENDIX A

BACKGROUND ON OUR CURRENT PLAN

A. Administration

1. BGSU's Health Care Plan has been self-funded since 1982. Previously coverage was funded through insurance premiums. Under state law, the University still must maintain stop-loss coverage, which insures against catastrophic losses on an individual or in total. Current limits (before stop-loss takes effect) are $150,000 for an individual case and 125% of expected costs for the 12-month period. Premiums increase as the insurer perceives greater chance for utilization of the stop-loss coverage. Current annual costs are approximately $225,000. The University can reduce this premium only by accepting a larger deductible for individual claims.

2. From 1982 to 1990 the BGSU Plan was administered by Benefit Plans Risk Management (later acquired by Administrative Service Consultants). In 1990, after reviewing proposals from 15 potential administrators, the University selected Didion & Associates as its new administrator, which it retains on a year-to-year contract. The selection was based on a combination of price and perceived service benefits. Current costs of administration are $220,000 annually, approximately $100 per participating employee. About 2/3 of the administrative cost relates to medical claims and 1/3 to dental and vision claims.

B. Coverage - Highlights of the University's coverage are as follows:

1. Full-time employees may choose no coverage, single coverage, or family coverage. Part-time employees are not eligible for coverage.

2. Both classified and contract employees currently pay $315 annually for single coverage (zero prior to 1991-92). Classified family coverage is $866 annually and contract families pay $1579; the former was zero prior to 1991-92, and the latter was $892 in 1980-91.

3. Unmarried dependent children are covered under family coverage through the age of 23 and beyond if mentally retarded or physically handicapped.

4. As of October 1, 1991, a total of 2234 employees were eligible for coverage. A breakdown by participation level follows:

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a. Of the 123 contract employees (administrative staff and faculty) waiving medical coverage, 58 (4.6% of contract employees) have coverage through a BGSU spouse, and 65 (5.2% of contract employees) do not have coverage through BGSU. Of the 48 classified staff waiving coverage, 22 (2.2% of classified employees) have coverage through a BGSU spouse and 26 (2.7%) do not have BGSU coverage. Presumably contract staff married to classified staff (with dependents) will waive their BGSU coverage (and the classified staff member will retain coverage) since family coverage premiums are lower for classified staff and family visual/dental is included.
b. While no conclusive explanation for the higher election of family coverage by classified employees is available, possible reasons are that (1) classified staff are more likely to have dependents needing coverage, and/or (2) family coverage at BGSU is more attractive cost-wise to classified employees. No data are available as to the former hypothesis. Some support for the latter is indicated by the higher percentage of contract staff waiving coverage completely (presumably because of utilization of the spouse’s plan), though the numbers involved here are small. It also is notable that only 5% of contract staff with family coverage indicate that they also have family coverage under the spouse's plan whereas 30% of classified staff with family coverage also have family coverage elsewhere. Presumably this is strongly related to the relative costs and benefits available to the two groups. It is not possible to determine the number of covered persons or dependents who could be covered by other plans if so elected, the number electing single coverage because their dependents are covered elsewhere, or those not receiving needed coverage because of the cost of the plan.

5. The University must provide benefits (under Ohio and federal law) up to 36 months beyond termination of employment or eligibility, provided required conditions are met and contributions are made.

6. Five separate coverages are provided in the University’s health plan: basic medical benefits, supplemental major medical benefits, prescription drug benefits, dental care benefits, and vision care benefits. The first three are available to all covered employees and dependents. Only employees and the dependents of classified staff are eligible for dental care and vision care.

7. Basic medical benefits include inpatient hospital charges (including physician), outpatient diagnostic laboratory tests and medical procedures, inpatient and outpatient surgery, outpatient mental illness treatment, and outpatient alcoholism and substance abuse treatment. Reasonable and customary charges are covered, if medically required, with the following limitations:

a. Inpatient hospital charges (semi-private room) are limited to 120 days of care per confinement, with a 90-day waiting period to begin a new eligibility period. (Other charges may be partially covered through major medical.) Skilled care facilities, extended care facilities, home health services, and hospice care can be substituted in certain circumstances.

b. Only the first $550 of outpatient mental illness treatment and first $550 of outpatient alcoholism and substance abuse treatment are covered by the Plan. (Additional charges are partially covered under major medical.)

8. Supplemental major medical includes hospital or physician charges beyond the basic limit, non-surgical medical services by a physician at-home or in-office, blood and blood products, rental of medical equipment, inhalation therapy, local ambulance services, physical therapy, medical supplies, braces, and prosthetic appliances, outpatient treatment of mental illness, alcoholism or substance abuse, private duty nursing, and artificial kidney rental and dialysis supplies. Each covered person (employee or dependent) pays a $100 deductible, then pays 20% of the next $4500 for a maximum yearly payment of $1,000. There is a $20,000 lifetime maximum (restorable in part) for outpatient treatment of mental illness, alcoholism, and drug abuse.

9. Prescription drugs are supplied through the PCS plan. The Plan pays 100% for generic drugs and 80% for non-generic drugs.

10. The dental plan covers 100% of routine preventive care, twice per year for most services. For
most restorative work the plan pays 80% of basic charges e.g., fillings, after a $25 deductible, and 50% of major restorative charges e.g., bridges and crowns. Total payment for all services is limited to $750 per year. Orthodontic services are not provided for adults, but 50% or $500, whichever is less, is paid for dependent children (classified plan only).

11. Vision services pay $25 bi-annually for an eye examination for each covered person and $45 to $150 (each biennium) for lenses and frames. As with the dental plan, this is not available to dependents of contract staff.

C. Cost of major components of health care.

1. Principal components of health care cost for the year ended August 31, 1991 compared with costs to date for 1992, are as follows:

<table>
<thead>
<tr>
<th>Plan Year</th>
<th>9/1/91-3/31/92</th>
<th>1992 Annualized</th>
<th>Projected 1992 Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Claims</td>
<td>$6,133,653</td>
<td>$4,305,584</td>
<td>$7,380,996</td>
</tr>
<tr>
<td>Prescription claims</td>
<td>793,172</td>
<td>503,016</td>
<td>862,308</td>
</tr>
<tr>
<td>Dental claims</td>
<td>466,121</td>
<td>249,088</td>
<td>427,008</td>
</tr>
<tr>
<td>Visual claims</td>
<td>54,619</td>
<td>31,962</td>
<td>54,792</td>
</tr>
<tr>
<td>Stop loss premiums</td>
<td>164,155</td>
<td>39,927</td>
<td>171,300</td>
</tr>
<tr>
<td>Administrative fees</td>
<td>244,168</td>
<td>135,163</td>
<td>231,708</td>
</tr>
<tr>
<td>Total</td>
<td>$7,856,178</td>
<td>$5,324,740</td>
<td>$9,128,112</td>
</tr>
</tbody>
</table>

2. Cost of major components of medical coverage is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Total Cost</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient hospital</td>
<td>$2,060,000</td>
<td>40.5%</td>
</tr>
<tr>
<td>Out-patient hospital</td>
<td>1,712,000</td>
<td>33.7%</td>
</tr>
<tr>
<td>Office visits</td>
<td>1,314,000</td>
<td>25.8%</td>
</tr>
<tr>
<td>Total</td>
<td>$5,086,000</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

3. Usage of in-patient, out-patient, and office visits varied significantly among administrative staff, faculty, and classified staff in 1991. Providing medical services through in-patient costs is relatively costly. It is inappropriate to make generalizations from one year's data, but this would appear to explain, to some extent, the higher costs for classified staff and lower cost for administrative. Percentage distributions of total medical costs by employee group for FY 1991 are presented below:

<table>
<thead>
<tr>
<th></th>
<th>In-Patient</th>
<th>Out-Patient</th>
<th>Office Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative staff</td>
<td>36%</td>
<td>40%</td>
<td>24%</td>
</tr>
<tr>
<td>Faculty</td>
<td>34</td>
<td>35</td>
<td>31</td>
</tr>
<tr>
<td>Classified staff</td>
<td>46</td>
<td>31</td>
<td>23</td>
</tr>
<tr>
<td>All employees</td>
<td>40%</td>
<td>34%</td>
<td>26%</td>
</tr>
</tbody>
</table>
4. The six highest diagnoses in each category for FY 1991 are as follows:

a. In-patient:
   (1) Genital/urinary $279,000 13.5%
   (2) Pregnancy/birth $233,000 12.3
   (3) Circulatory $234,016 11.4
   (4) Digestive $211,000 10.2
   (5) Neoplasm $196,000 9.5
   (6) Mental $193,000 9.4

   $1,355,000 66.3%

b. Out-patient:
   (1) Genital/urinary $274,000 16.0%
   (2) Miscellaneous $196,000 11.4
   (3) Neoplasm $177,000 10.3
   (4) Muscular/skeletal $167,000 9.8
   (5) Neurology $160,000 9.4
   (6) Injury/poison $151,000 8.8

   $1,125,000 65.7%

c. Office visits
   (1) Mental $297,000 22.6%
   (2) Muscular/skeletal $204,000 15.5
   (3) Digestive $132,000 10.1
   (4) Respiratory $89,000 6.8
   (5) Genital/urinary $84,000 6.7
   (6) Injury/poison $84,000 6.4

   $894,000 68.1%

d. Overall
   (1) Genital/urinary $641,000 12.6%
   (2) Muscular/skeletal $514,000 10.1
   (3) Mental $501,000 9.9
   (4) Digestive $457,000 9.0
   (5) Neoplasm $440,000 8.6
   (6) Circulatory $396,000 7.8

   $2,949,000 58.0%

5. As with in-patient, out-patient, and office visit costs, there were significant differences among the staffs in principal diagnoses for medical care in FY 1991. These are presented below, though once again it is inappropriate to make sweeping conclusions from one year's data:

a. Administrative staff:

   Genital/urinary $53,000 14.2%
   Pregnancy/birth $88,000 11.5
   Digestive $80,000 10.5
   Muscular/skeletal $80,000 10.5
   Neoplasm $75,000 9.8
   Neurology $62,000 8.1

   $438,000 64.6%
b. Faculty:

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental</td>
<td>$290,000</td>
<td>18.0%</td>
</tr>
<tr>
<td>Genital/urinary</td>
<td>256,000</td>
<td>15.9%</td>
</tr>
<tr>
<td>Neoplasm</td>
<td>152,000</td>
<td>9.5%</td>
</tr>
<tr>
<td>Muscular/skeletal</td>
<td>127,000</td>
<td>7.9%</td>
</tr>
<tr>
<td>Digestive</td>
<td>125,000</td>
<td>7.8%</td>
</tr>
<tr>
<td>Circulatory</td>
<td>108,000</td>
<td>6.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,058,000</strong></td>
<td><strong>65.8%</strong></td>
</tr>
</tbody>
</table>

c. Classified staff:

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscular/skeletal</td>
<td>$307,000</td>
<td>11.3%</td>
</tr>
<tr>
<td>Genital/urinary</td>
<td>276,000</td>
<td>10.2%</td>
</tr>
<tr>
<td>Injury/poison</td>
<td>245,000</td>
<td>9.0%</td>
</tr>
<tr>
<td>Digestive</td>
<td>251,000</td>
<td>9.3%</td>
</tr>
<tr>
<td>Circulatory</td>
<td>238,000</td>
<td>8.8%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>230,000</td>
<td>8.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,547,000</strong></td>
<td><strong>57.1%</strong></td>
</tr>
</tbody>
</table>

Note: The data on costs come from reports on file within the Benefits Office.
## APPENDIX B

### Marathon Oil

Through a local pharmacy covered at 30%, after deductible for health care is met. Mail order available for maintenance drugs (generally 30 days) $5.00 cost if generic, $15.00 cost if brand.

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### Owens Corning Fiberglass

**Owens Corning Plan**
- 20% employee copay;
- 50% copay if fail to obtain generic when one is manufactured; 30-90 day supply by mail order with copay of $13.00

---

### Cleveland State University

<table>
<thead>
<tr>
<th>CIGNA Comprehensive</th>
<th>Medical Value Plan</th>
<th>Paramount Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIGNA Health Plan</td>
<td>Copay per Fx for</td>
<td>Copay per Fx for</td>
</tr>
<tr>
<td>$2.00 Generic</td>
<td>35 day supply $5.00</td>
<td>24 day supply $5.00</td>
</tr>
<tr>
<td>$5.00 Brand Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Pharmacies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Contraceptives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FSA**

- Oral Contraceptives Included

---

### Kent State University

**Kent State University**

<table>
<thead>
<tr>
<th>CIGNA Comprehensive</th>
<th>Preferred Plan</th>
<th>Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIGNA Health Plan</td>
<td>Preferred FPO (Open Choice)</td>
<td></td>
</tr>
<tr>
<td>$2.00 Generic Deductible</td>
<td>FSA</td>
<td>$3.00 Generic</td>
</tr>
<tr>
<td>$5.00 Brand Name 80% Coverage</td>
<td>Oral Contraceptives Included</td>
<td>Plan Pharmacies</td>
</tr>
<tr>
<td>Plan Pharmacies</td>
<td></td>
<td>Oral Contraceptives Included</td>
</tr>
<tr>
<td>Oral Contraceptives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Included</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FSA**

*Individuals with conditions requiring a 90 day supply of medications or other prescribed materials may use the Mail Order Express Pharmacy service. The individual pays only 20% of the wholesale price for these materials, not subject to the $200 calendar year deductible. ($200 deductible for all covered services.)*

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### University of Cincinnati

**Option A**

- Comprehensive Medical Plan
- $2 copay/Fx

**Option C**

- U-care
- Network: $2 generic
- Non-Network: $4 name

**Option D**

- University Health Plan
- $3.00 copay/Fx at any UHP participating pharmacy

*There was an Option B, but it was not available to employees.*
University of Toledo
Blue Cross/Blue Shield
Major Medical

HMO Health Ohio
$5 copay at participating pharmacies

*Deductible Ind $100/Fam$300, out of pocket limit for copay Ind $500/Fam$1,800, copay at 20%

Miami University
Covered under major medical. (Deductible Ind $100/Fam$200, out of pocket limit for copay Ind $400/Fam $800, copay at 20%).

Ohio State
Buckeye Health Plan
20% after deductible

OSU Health Plan
In-Network: Generic at 90%

Out-of Network: Generic at 90%

Brand name at 80%

Traditional Health Plan
Generic at 90%

Brand names at 80% (or 80% after deductible*)

*Deductibles are dependent on the plan being used

Bowling Green State University
Plan pays 100% if generic drug and 80% if name brand drug is used.

Ohio University
A $2 deductible for brand name drugs and a $4 deductible for generic drugs through the PCS card. Mail order program is also available through Americas Pharmacies, Inc. The mail order program has a $2 deductible for a brand name and no deductible for a generic.
**PLAN A**

Hospital charges, in-hospital doctor care, surgical, x-ray and lab are paid 100% of R&C* with no deductible applied. There is no lifetime maximum for these charges.

Other Major Medical expenses are subject to an 80% co-pay after the deductible of $100 per person, to a maximum of $4,500 per year. Additional eligible expenses after the $1,000 out-of-pocket per person is met are 100% of R&C* for the remainder of the calendar year.

Mental illness, chemical dependency, and chiropractic services limited.

Preadmission certification - $200 non-compliance penalty.

Voluntary Second Opinion Surgery.

**COMPREHENSIVE MEDICAL (PLAN B)**

$200/$400 DEDUCTIBLE

$1,000/$2,000 OUT OF POCKET

Diagnostic ex-ray and lab charges have no deductible for the first $500; after the first $500, the deductible applies.

Charges for accidents (physician's office or emergency room) have no deductible for the first $300; after the first $300, the deductible applies.

All other charges are subject to an 80%/20% co-pay of the R&C* after the deductible of $200 single or $400 family is met, to a maximum of $4,000/$8,000. Additional eligible expenses are 100% of the R&C* for the remainder of the calendar year.

Plan maximum is $1,000,000.

Mental illness, chemical dependency, and chiropractic services limited.

Preadmission certification - $200 non-compliance penalty.

Voluntary Second Opinion Surgery.

**COMPREHENSIVE MEDICAL (PLAN C)**

$500/$1,000 DEDUCTIBLE

$1,500/$3,000 OUT OF POCKET

Diagnostic ex-ray and lab charges have no deductible for the first $500; after the first $500, the deductible applies.

Charges for accidents (physician's office or emergency room) have no deductible for the first $300; after the first $300, the deductible applies.

All other charges are subject to a 80%/20% co-pay of the R&C* after the deductible of $500 single or $1,000 family is met, to a maximum of $5,000/$10,000. Additional eligible expenses are 100% of the R&C* for the remainder of the calendar year.

Plan maximum is $1,000,000.

Mental illness, chemical dependency, and chiropractic services limited.

Preadmission certification - $200 non-compliance penalty.

Voluntary Second Opinion Surgery.

*Charges that do not exceed the amount usually charged by most providers in the same geographic area for services, treatment or materials, taking into account the nature of the illness. Based on reasonable and customary rates after deductible is met.*
HEALTH CARE TASK FORCE
REPORT TO THE PRESIDENT
MAY, 1992

Members: Don Boren (Chair), Dick Bowers, Jim Childs, Mary Ellen Cloninger, Pat Erickson, Gaylyn Finn, Joyce Hyslop, Josh Kaplan, Barbara Keeley, Robert Kreienkamp, Park Leathers, John Moore, Jim Morris, Paul Mueller.

INTRODUCTION

The Health Care Task Force was formed by President Olscamp on October 15, 1991. The Task Force consisted of 16 members. Three members resigned during the year. Mary Edmonds, vice president for academic affairs was replaced by Mary Ellen Cloninger, associate athletic director. Jim Albert, math and statistics, and Kathy Eninger, classified staff, were not replaced because both resignations occurred near the end of the academic year.

The Task Force was charged with recommending to the President "actions and policies necessary to implement an employee health care benefits plan which ensures the availability of quality health care to university employees while holding future increases in the cost of providing health care coverage to both the University and the employees to reasonable levels."

The Task Force divided its work into two stages. The Task Force’s primary objective in the first stage is to recommend ways to immediately decrease health care costs for the next fiscal year. The projected cost increase for health care for the 1992-93 fiscal year is $1,500,000. These recommendations are designed to help offset this increase and keep the University’s and employee’s cost at or below the 1991-92 level.

These savings would be realized by:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Projected Annual Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Change prescription drug plans</td>
<td>$92,000</td>
</tr>
<tr>
<td>2. Revise vision coverage</td>
<td>60,000</td>
</tr>
<tr>
<td>3. Increase co-payments and deductible</td>
<td>720,000</td>
</tr>
<tr>
<td>4. Cap on mental health and substance dependency/ employee assistance program/utilization review</td>
<td>85,000</td>
</tr>
<tr>
<td>5. Cap on chiropractic care</td>
<td>43,000</td>
</tr>
<tr>
<td>Total Projected University Savings</td>
<td>1,000,000</td>
</tr>
<tr>
<td>1992-93 Projected Cost Increase</td>
<td>1,500,000</td>
</tr>
<tr>
<td>1992-93 Net Projected Increase in Cost</td>
<td>$500,000</td>
</tr>
</tbody>
</table>

The Task Force recommends that additional funds be used to establish a health promotion program, an employee assistance program, and to provide for early diagnosis of disease by routine testing for breast cancer, cholesterol, high blood pressure, and other early diagnostic testing.

The second stage entails developing a long-range plan to reduce health care costs. It consists of negotiating rates with health care providers, exploring whether certain health care services could be provided through the use of University health care facilities, and perhaps entering into an area health care consortium. The Task Force is willing to continue working on long-range planning if requested.
HEALTH CARE TASK FORCE
RECOMMENDATIONS

1. The University continue to provide for health care costs through our present self-funded system.

2. The University explore providing health care coverage through an integrated plan that provides employees the option of selecting the traditional fee-for-service arrangement, a health maintenance organization, or a preferred provider organization.

3. Prescription drug benefits continue to be provided through the prescription drug card program (PCS).

4. The PCS maximum allowable cost be used to determine payment levels for generic drugs.

5. When a brand name drug is selected in lieu of its generic equivalent, PCS will only pay the cost of the generic equivalent.

6. A maintenance drug program be implemented to provide for the purchase of maintenance drugs for longer-term medication than the current plan allows.

7. The University renegotiate prescription ingredient costs and dispensing fees.

8. The University offer an optional vision plan to replace the present vision plan which will no longer be funded.

9. The University establish a flexible spending arrangement to allow employees to pay out-of-pocket health care and other allowable costs with pretax dollars.

10. The University's health benefits for chiropractic services be limited to the following:

   Services provided by a licensed chiropractor (D.C.) would be covered by the plan provided such services are within the scope of his/her license.

   For neuro-musculoskeletal disorders, the plan will pay 80% of covered services up to a maximum of $25 per visit with a maximum of one visit per day and 20 visits per calendar year.

   X-rays will be covered if they are necessary to analyze a disorder. A maximum of $150 will be considered for x-rays and diagnosis during any calendar year. These maximums would apply to each covered person. Additional charges for ultrasound and diathermy in connection with a chiropractic visit would not be covered.

11. The following changes be made in mental health benefits: special deductibles, co-payments, and maximum payments be established for mental health as described below.

   In-patient benefits:
   The plan pay 80% of covered services (defined in existing plan) with an annual maximum of 30 days in-patient treatment up to an annual maximum benefit of $30,000.

   Out-patient benefits:
   The plan will pay for covered services (defined in existing plan) up to $1,000 per calendar year with a co-payment percentage of: visits 1-3 80% up to $75 per visit; visits 4-6 80% up to $60 per visit; visits 7+ 50% up to $40 a visit.
12. The following changes be made in chemical dependency benefits: special deductibles, co-payments, and maximum payments be established for chemical dependency as described below.

The plan will pay 80% of in-patient or out-patient benefits on an episode of care basis. An episode of care can be a combination of in-patient and/or out-patient treatment. The treatment plan must be approved in advance. No more than two in-patient admissions related to chemical dependency care would be covered during any calendar year with a maximum lifetime benefit of $30,000.

13. The University contract with an employee assistance program (EAP) provider to facilitate early intervention into personal and workplace problems and to monitor care for mental health and chemical dependency benefits.

14. No changes be made to the University's present dental coverage.

15. Pre-certification of hospital admissions should be implemented.

16. Employees of the University be given an option of three different health care plans (see Appendix C). The plans will vary as to the type of deductibles and co-pays; the types of coverage will be the same for all three plans. Plan A will have the current deductibles and co-pays for major medical. Plan B and C will be comprehensive plans with an 80% co-pay on most medical costs. Plan B will have a $200/$400 deductible with a maximum out-of-pocket cost of $1,000/$2,000. Plan C will have a $500/$1,000 deductible with a maximum out-of-pocket cost of $1,500/$3,000.

17. Employees' contribution levels increase or decrease the same dollar amount for each employee group and that, for purposes of budgeting, the usage be divided by the total number of employees covered, instead of dividing usage by faculty, contract, and classified groups.

18. No change be made in the current plan design regarding contributions for family and dependent coverage.

19. The University adopt a plan to educate employees about their health care options.

20. The University design a plan for health promotion and encourage the use of the fitwell assessment/counseling program through the Student Recreation Center.
THE DELIVERY SYSTEM

A. Self-Funded vs. Insured Plan

1. THE UNIVERSITY CONTINUE TO PROVIDE FOR HEALTH CARE COSTS THROUGH OUR PRESENT SELF-FUNDED SYSTEM.

Rationale

Employers fund health care costs either by commercial carriers or a self-funded program. Self-funded programs are usually more cost effective since administrative costs are traditionally less [a 1988 survey found that administrative costs for insured plans was 6.6% compared to 5.2% for self-funded programs, see Foster Higgins, Health Care Benefits Survey (1988)]. The primary advantage of commercial insurance is that costs are more predictable and not as subject to fluctuations in loss experience. The majority of larger employers, who are better able to absorb cost fluctuations, are self-funded. Sixty-five percent of larger employers (1,000 or more employees) are self-funded while the majority of smaller employers (less than 1,000) are insured through an outside source. Most self-funded employers purchase stop-loss insurance to protect against high-cost catastrophic cases.

The University's program is typical of what other large employers are doing. The University is self-funded with stop-loss coverage of $150,000 per claim and an aggregate stop-loss of 125% of expected claims. The University uses a third party administrator (TPA, Didion) to handle claims. Didion is reimbursed on a per employee basis. The current rate of 3% for administrative costs and 2% for stop-loss does not appear excessive when compared to a 1988 average administrative expense of 4.9% for large employers. However, this comparison may be misleading in that the higher dollar amount of claims paid, the smaller will be the percentage paid for administrative expense.

The Task Force did not compare cost between our TPA and insurance. This comparison was made two years ago and the rate for similar coverage under insurance was significantly higher.

B. Preferred Provider Organizations/Health Maintenance Organizations

2. THE UNIVERSITY EXPLORE PROVIDING HEALTH CARE COVERAGE THROUGH AN INTEGRATED PLAN THAT PROVIDES EMPLOYEES THE OPTION OF SELECTING THE TRADITIONAL FEE-FOR-SERVICE ARRANGEMENT, A HEALTH MAINTENANCE ORGANIZATION, OR A PREFERRED PROVIDER ORGANIZATION.

Rationale

There are three kinds of health care delivery plans in the United States today: the traditional fee-for-service plan; health maintenance organizations (HMOs); and preferred provider organizations (PPOs). The fee-for-service plan traditionally pays physicians the UCR (usual, customary, and reasonable) price for services rendered. The plan does not limit coverage to any one group of physicians, and in most plans the patient is responsible for fees that exceed the UCR rate.

HMOs provide a fixed, predetermined amount of payment (capitation basis) for each plan participant regardless of the actual number or nature of services provided over a set period of
time. Much of the recent growth in HMO enrollment has been in individual physician associations (IPA). An IPA-type HMO is open to all community physicians who meet the HMO's criteria. Physicians who participate in an IPA maintain their own offices and continue to see non-HMO patients. HMOs appear to be effective in controlling cost. A 1980 study found that total costs for members of HMOs were 20%-40% less than the costs for members of fee-for-service plans. (Employee Benefits, BASICS Third Quarter 1990)

PPOs are hospitals, clinics, and physician groups that contract with employers to provide health care service at a discounted fee-for-service basis in exchange for a greater potential volume of patients. Participants covered by a PPO have the option of deciding at the point of service whether to receive care from the PPO or another provider. Typically, if the patient selects another provider the patient is responsible for additional costs. Employers have reported mixed experiences regarding the cost effectiveness of PPOs. One study found that 24% of employers reported reduced costs; 17% indicated no effect on costs; and 4% reported a sizable increase. (Employee Benefits, BASICS Third Quarter 1990)

The use of HMOs and PPOs is becoming widespread. In 1990, Foster Higgins conducted a study of health care benefits for Ohio colleges and universities. The study found that nationwide 63% of universities over 1,000 employees and 52% of Ohio universities offer either an HMO or PPO. This study also reported mixed results on the effectiveness of controlling costs. Thirty-three percent of respondents from Ohio universities agreed that HMOs were effective in controlling costs compared with 89% of universities in the nationwide survey. The majority of respondents in both the Ohio (67%) and national (57%) surveys agreed that PPOs were effective in controlling costs.

There is insufficient information to decide whether PPOs and HMOs would be effective alternatives to our present indemnity plan. A major problem is that no alternative delivery plans are available in Wood County and none of the Toledo plans have been extended to this area. If the University is to offer these plans as an alternative, a plan would need to be created.

For alternative delivery plans to be successful, there must be sufficient inducements for the physicians and patients to enter the plan. The inducement for physicians to enter into an HMO or PPO is to increase the number of patients. These plans would offer little advantage to physicians if a substantial majority of physicians in the community are members, or if the physician's case load is such that he can not serve additional patients. This indicates that plans would have a greater chance of success in geographic areas with a large number of physicians and patients. A 1991 survey, conducted by Youngstown State University, supports this premise. The survey found that, with the exception of Kent State University, all Ohio universities that offered HMOs or PPOs were located in large metropolitan areas.

Another factor necessary for the success of HMOs and PPOs is that the costs offered by the plan must be sufficiently lower than an indemnity plan to induce employees to join. Hospitals that service the majority of university employees already offer low costs. The most recent survey of hospital costs conducted by the Employers Coalition of Northwest Ohio found that Wood County Hospital and Blanchard Valley Hospital are two of the lowest cost providers in this region. For an alternative delivery plan to be successful, these institutions must be willing to reduce costs even lower.

While HMOs and PPOs do not appear to be viable at this time, potential savings warrant the University continuing to explore these alternatives. The best alternative would appear to be a plan which integrates an indemnity plan and an HMO or PPO. All employees would enroll in the plan at a discounted fee-for-service basis or a capitated rate. The plan would offer a point-of-service option with partial coverage for participants who receive care from outside providers.
PRESCRIPTION DRUGS

3. PRESCRIPTION DRUG BENEFITS CONTINUE TO BE PROVIDED THROUGH THE PRESCRIPTION DRUG CARD PROGRAM (PCS).

Rationale

Prescription drug benefits play an important role in the treatment of illness. Prescription drug card programs are becoming more common with colleges and universities in Ohio and with large employers in Northwest Ohio (see Appendix B).

The prescription drug card program has been widely accepted by employees primarily because of its convenience since no claim form is required when the card is used to purchase prescription drugs. The only drawback to the PCS is that it has been difficult to maintain effective cost management procedures. PCS recently implemented several cost containment procedures to assist employers in maintaining more effective cost management of their prescription drug programs.

4. THE PCS MAXIMUM ALLOWABLE COST BE USED TO DETERMINE PAYMENT LEVELS FOR GENERIC DRUGS.

Rationale

Under the present arrangement, PCS reimburses dispensing pharmacies based on the Average Wholesale Price (AWP) for ingredient costs plus a dispensing fee. Average Wholesale Price is determined by the suggested list price of drug products that pharmacists pay to the drug wholesalers or suppliers. It seldom reflects the costs of the drugs to the pharmacist since it does not take into consideration volume discounts, rebates and other incentives offered by suppliers. PCS has compiled a maximum allowable cost for each of approximately 450 generic drugs which more accurately reflects the actual ingredient cost to the pharmacist. By adopting the maximum allowable cost program, the cost of the program would be reduced by approximately 4% per year. This would result in a savings of approximately $32,000 during the initial plan year.

5. WHEN A BRAND-NAME DRUG IS SELECTED IN LIEU OF ITS GENERIC EQUIVALENT, PCS WILL ONLY PAY THE COST OF THE GENERIC EQUIVALENT.

Rationale

When brand name drugs are dispensed, the individual is required to make a 20% co-payment with the balance being paid by PCS. In some instances, brand name drugs are dispensed when a generic equivalent is available. It is recommended that in these instances the individual be required to pay the difference between the maximum allowable cost for the generic equivalent in lieu of the 20% co-payment. This will encourage the use of generic drugs whenever possible which will result in significantly lower costs for the prescription drug card program.

6. A MAINTENANCE DRUG PROGRAM BE IMPLEMENTED TO PROVIDE FOR THE PURCHASE OF MAINTENANCE DRUGS FOR LONGER TERM MEDICATION THAN THE CURRENT PLAN ALLOWS.

Rationale

Approximately 28% of the total prescriptions purchased under the prescription drug card program for the 12 month period January 1, 1991 through December 31, 1991 were maintenance drugs. Under the current plan the maximum dosage that cardholders can purchase with each prescription is a 34 day supply.
Effective July 1, 1992, PCS will have available a maintenance drug program which will allow cardholders to purchase up to a 90 day supply of maintenance drugs under one prescription. This will significantly reduce the number of prescriptions purchased under the program and will reduce the dispensing fees paid to pharmacists by approximately $10,000.

7. THE UNIVERSITY RENEGOTIATE PRESCRIPTION INGREDIENT COSTS AND DISPENSING FEES.

**Rationale**

Based on the volume of prescription drug purchases through the Prescription Drug Card Program, PCS has agreed to negotiate a discount of 10% below the average wholesale price for all prescriptions purchased through the PCS network of participating pharmacies. PCS did, however, recommend that the University adjust the dispensing fee paid to the pharmacists. It was recommended that the dispensing fee be increased from $2.60 to $3.23 which is the prevailing fee provided under Medicaid in Ohio.

The above arrangement would result in a net reduction in prescription drug costs of approximately $50,000 per year based on the current annual costs of approximately $862,000.

**VISION**

8. THE UNIVERSITY OFFER AN OPTIONAL VISION PLAN TO REPLACE THE PRESENT VISION PLAN WHICH WILL NO LONGER BE FUNDED.

**Rationale**

The Health Care Plan currently provides benefits for vision care on an indemnity basis with specific allowances for each type of service. The current annual claim cost of providing vision care coverage to eligible employees and dependents (classified employees only) is approximately $60,000. The plan offers very limited coverage, paying approximately 1/3 of the costs of typical vision care. The policy pays on a reasonable and customary basis which offers no costs savings over the retail costs.

The Task Force recommends that the University offer to all employees an optional VSP Plan through the Section 125 Plan.

The Task Force explored providing vision care through Vision Service Plan (VSP), a preferred provider arrangement. The VSP Plan would cost approximately $75,900 per year if coverage were provided for the 886 employees and 624 dependent units (classified employees only) covered under the current plan. If vision coverage were expanded to provide benefits to dependents of faculty members and administrative staff, the estimated annual cost would be approximately $121,200.

The Task Force believes that these additional costs are not justified in a period of rapidly expanding medical costs. The approximately $60,000 costs savings in not providing vision care could be better spent in providing coverage in more critical areas.
SECTION 125 PLAN

9. THE UNIVERSITY ESTABLISH A FLEXIBLE SPENDING ARRANGEMENT TO ALLOW EMPLOYEES TO PAY OUT-OF-POCKET HEALTH CARE AND OTHER ALLOWABLE COSTS WITH PRETAX DOLLARS.

Rationale

Last year the University established a 125 Plan that allows employees to pay their share of health care premiums with pre-tax dollars. Expanding this plan to permit employees to pay as much of their health care and other costs (i.e., dependent care, vision, deductibles, and co-pays), as allowed under Internal Revenue Code Section 125, with pre-tax dollars reduces the financial burden on employees and allows them to design a benefit package that best meets their needs.

CHIROPRACTIC SERVICES

10. THE UNIVERSITY’S HEALTH BENEFITS FOR CHIROPRACTIC SERVICES BE LIMITED TO THE FOLLOWING:

SERVICES PROVIDED BY A LICENSED CHIROPRACCTOR (D.C.) WOULD BE COVERED BY THE PLAN PROVIDED SUCH SERVICES ARE WITHIN THE SCOPE OF HIS/HER LICENSE.

FOR NEURO-MUSCULOSKELETAL DISORDERS, THE PLAN WILL PAY A MAXIMUM OF 80% OF COVERED SERVICES UP TO $25 PER VISIT WITH A MAXIMUM OF ONE VISIT PER DAY AND 20 VISITS PER CALENDAR YEAR.

X-RAYS WILL BE COVERED IF THEY ARE NECESSARY TO ANALYZE A DISORDER. A MAXIMUM OF $150 WILL BE CONSIDERED FOR X-RAYS AND DIAGNOSIS DURING ANY CALENDAR YEAR. THESE MAXIMUMS WILL APPLY TO EACH COVERED PERSON. ADDITIONAL CHARGES FOR ULTRASOUND, DIATHERMY IN CONNECTION WITH A CHIROPRACTIC VISIT WOULD NOT BE COVERED.

Rationale

The current plan pays 80% of the reasonable and customary charges for chiropractic services. There is no limit to the number of services that can be provided. In reviewing the claims utilization data provided by Didion & Associates, the possible over utilization of these services might be occurring. There were also indications that certain providers are taking some liberties with this benefit in view of the type and extent of services they are providing to their patients.

It is anticipated that the above payment limitations will result in a cost reduction of approximately $43,000 per year for chiropractic services.

MENTAL HEALTH

11. THE FOLLOWING CHANGES BE MADE IN MENTAL HEALTH BENEFITS: SPECIAL DEDUCTIBLES, COPAYMENTS, AND MAXIMUM PAYMENTS BE ESTABLISHED FOR MENTAL HEALTH AS DESCRIBED BELOW.

IN-PATIENT BENEFITS:
THE PLAN PAY 80% OF COVERED SERVICES (DEFINED IN EXISTING PLAN) WITH AN ANNUAL MAXIMUM OF 30 DAYS IN-PATIENT TREATMENT UP TO AN ANNUAL MAXIMUM BENEFIT $30,000.
OUT-PATIENT BENEFITS:
THE PLAN PAY FOR COVERED SERVICES (DEFINED IN EXISTING PLAN) UP TO $1,000 PER CALENDAR YEAR WITH A CO-PAYMENT PERCENTAGE OF:
VISITS 1-3 80% UP TO $75 PER VISIT; VISITS 4-6 80% UP TO $60 PER VISIT; VISITS 7+ 50% UP TO $40 PER VISIT.

Rationale

The Task Force compared the University's utilization data with industrial standards to identify areas of high utilization. These areas were then examined to determine the cause of the high utilization and what is customarily standard in health care plans.

The Task Force found that the University's utilization of mental health and chemical dependency benefits substantially exceeded the average in health care costs. The Task Force asked Square Lakes Corporation, a medical consulting firm, to compare the University's utilization with industry averages. The University's utilization for the most recent period that data is available (9-1-90 through 8-31-91) was used as the basis of comparison. Square Lakes found that the University's inpatient utilization, of 83 inpatient days per 1,000 group members, is within the industry average of 80 to 100 days per 1,000 members. However, outpatient visits for this period are over three times higher than the industry standard. The University had 916 outpatient visits per 1,000 members compared with the industry standard of 250 to 300 per 1,000 members.

The Task Force further found that the University's coverage for mental and chemical dependency is unique, in that the plan does not provide for special limits on coverage or for utilization review. The most recent Foster Higgins Survey (Health Care Benefits Survey 1991 /Indemnity Plans p. 8) found that 87% of employers now have special limits for mental disorder and substance abuse benefits.

Under the current plan, costs for treatment for mental illness and alcohol and substance abuse is covered under both the basic medical and the major medical benefits. The basic medical benefits, for outpatient treatment, pays for 100% of costs up to $550 per person per calendar year for mental illness, alcoholism, and substance abuse treatment. Once the $550 limit is exhausted, the patient qualifies for major medical coverage with the only limit being a maximum lifetime coverage of $20,000. For inpatient services the plan pays for 120 days per confinement for treatment for both mental illness, and alcohol and substance abuse treatment. Treatment for both mental disorder and alcohol and substance abuse are covered under major medical with a maximum lifetime coverage of $20,000 for these illnesses.

CHEMICAL DEPENDENCY

12. THE FOLLOWING CHANGES BE MADE IN CHEMICAL DEPENDENCY BENEFITS: SPECIAL DEDUCTIBLES, CO-PAYMENTS, AND MAXIMUM PAYMENTS BE ESTABLISHED FOR CHEMICAL DEPENDENCY AS DESCRIBED BELOW.

THE PLAN PAYS 80% OF IN-PATIENT OR OUT-PATIENT BENEFITS ON AN EPISODE OF CARE BASIS. AN EPISODE OF CARE CAN BE A COMBINATION OF IN-PATIENT AND/OR OUT-PATIENT TREATMENT. THE TREATMENT PLAN MUST BE APPROVED IN ADVANCE. NO MORE THAN TWO IN-PATIENT ADMISSIONS RELATED TO CHEMICAL DEPENDENCY CARE WOULD BE COVERED DURING ANY CALENDAR YEAR WITH A MAXIMUM LIFETIME BENEFIT OF $30,000. OUT-PATIENT BENEFITS FOR CHEMICAL DEPENDENCY RELATED CARE BE THE SAME AS OUT-PATIENT MENTAL HEALTH BENEFITS.
Rationale

The Task Force examined several plans to determine the type of limits that would be fair but still guard against overutilization. The Task Force believes that this combination of co-payments and maximum benefits best accomplishes these goals. For the 1990-91 fiscal year, the University's costs for providing treatment for mental disorder and alcohol and substance abuse was $568,846. It is believed that adoption of the restrictions will result in substantial savings to the University.

EMPLOYEE ASSISTANCE PROGRAM/UTILIZATION REVIEW

13. THE UNIVERSITY CONTRACT WITH AN EMPLOYEE ASSISTANCE PROGRAM (EAP) PROVIDER TO FACILITATE EARLY INTERVENTION INTO PERSONAL AND WORKPLACE PROBLEMS AND TO MONITOR CARE FOR MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS.

Rationale

The University is currently paying in excess of $500,000 a year for treatment of mental disorders. An EAP could provide a means of reducing these costs through utilization reviews and, in some cases, a less expensive alternative when specific treatment is not warranted.

The University's current plan does not provide for pre-certification, continuing stay reviews, concurrent reviews, and case management reviews for mental health and chemical dependency benefits. Because of the highly sensitive nature of treatment for mental disorders and chemical dependency, the Task Force believes that utilization review would be best accomplished by an independent contractor. The Task Force believes that the University would benefit from this service.

The Task Force further believes that an important component of mental health services would be the adoption of an employee assistance program which would contract for a fee to provide for initial consultation for personal and workplace problems.

Data indicates the cost for an employee assistance program/utilization review would be $90,000. The savings that would result from the implementation of such a program would be approximately $175,000 with a net savings to the University of approximately $85,000.

DENTAL

14. NO CHANGES BE MADE TO THE UNIVERSITY'S PRESENT DENTAL COVERAGE.

Rationale

The dental plan covers 100% of routine preventive care, twice per year for most services. For most restorative work the plan plays 80% of basic charges after a $25 deductible has been met, and 50% of major restorative charges. Total payments for all services is limited to $750 per year. Orthodontic services are not provided for adults, but 50% or $500, whichever is less, is paid for dependent children (classified plan only). Dental care benefits are not available for dependents of contract staff.

For the 12 month period ending August 31, 1991, the University paid $466,131 in dental claims. Administrative fees for dental and vision in the aggregate was $73,301. Increase in costs has been relatively small compared to other health care costs. Dental care is customarily covered in health care plans. The 1990 Foster Higgins Health Care Benefits Survey found that 76% of Ohio and 85% of colleges and universities nationally provide dental coverage.
HOSPITAL PRE-ADMISSION CERTIFICATION

15. PRE-CERTIFICATION OF HOSPITAL ADMISSIONS SHOULD BE IMPLEMENTED.

Rationale

Hospital in-patient costs exceeded $2,000,000 for the 1990-91 plan year. A pre-certification requirement would help to determine whether: 1) hospitalization is medically necessary; 2) another form of treatment or facility setting is available and appropriate; and 3) if the length of stay is appropriate.

In addition, potential catastrophic illnesses and injuries which will require intensive medical treatment can often be identified during the initial hospital admission process. This provides for more effective medical cost management on an individual basis for this type of situation.

CO-PAYMENTS AND DEDUCTIBLES

16. EMPLOYEES OF THE UNIVERSITY BE GIVEN AN OPTION OF THREE DIFFERENT HEALTH CARE PLANS (SEE APPENDIX C). THE PLANS WILL VARY AS TO THE TYPE OF DEDUCTIBLES AND CO-PAYS; THE TYPES OF COVERAGE WILL BE THE SAME FOR ALL THREE PLANS. PLAN A WILL HAVE THE CURRENT DEDUCTIBLES AND CO-PAYS FOR MAJOR MEDICAL. PLAN B AND C WILL BE COMPREHENSIVE PLANS WITH AN 80% CO-PAY ON MOST MEDICAL COSTS. PLAN B WILL HAVE A $200/$400 DEDUCTIBLE WITH MAXIMUM OUT OF POCKET COSTS OF $1,000/$2,000. PLAN C WILL HAVE A $500/$1,000 DEDUCTIBLE WITH MAXIMUM OUT OF POCKET COSTS OF $1,500/$3,000.

Rationale

Plan B (the base plan) will be offered to employees at the existing employee premium contribution. Employees selecting Plan A would pay all of the additional costs of receiving this coverage. Employees selecting Plan C would be given the savings to the University associated with the higher deductible and co-pay. This saving could either be taken as reduction in monthly premium contributions or placed in the Section 125 Plan.

Today, most employers offer their employees a comprehensive health plan (one in which a co-pay applies to all medical claims). The 1991 Foster-Higgins Survey found that 73% of large employers offer such a plan. While such plans shift costs to employees, costs savings to the employer and perhaps to the employees through lower premiums justify the adoption of comprehensive plans. With the University's projected increase in medical costs for the 1992-93 at $1,500,000, the Task Force believes that many employees may elect not to be insured because of high premium costs. Employees who perceive an inability to afford higher insurance premiums may choose to assume a higher risk for catastrophic medical costs and paying higher deductibles and co-payments in lieu of going without coverage.

Plan B was adopted as the base plan which the committee hopes can be offered to employees without an increase in premiums. Didion projected a cost savings of $720,000 if the deductible were increased from $100 to $200 and the 20% co-payment were extended to basic services as well as major medical.

The Task Force was divided as to whether Plan C should be offered as an alternative. Those opposed to the Plan were afraid that employees may elect this Plan for the initial cost savings and be unable to pay the higher deductible. The Task Force recommends that the University determine premiums for each of these plans and the Task Force then meet to determine if the reduced premium is sufficient to warrant this option.
17. EMPLOYEES' CONTRIBUTION LEVELS INCREASE OR DECREASE THE SAME DOLLAR AMOUNT FOR EACH EMPLOYEE GROUP AND THAT, FOR PURPOSES OF BUDGETING, THE USAGE BE DIVIDED BY THE TOTAL NUMBER OF EMPLOYEES COVERED, INSTEAD OF DIVIDING USAGE BY FACULTY, CONTRACT, AND CLASSIFIED GROUPS.

Rationale

Separating changes in contribution levels promotes divisiveness between the employee groups. Utilization can vary greatly within a short period of time for the three groups. Dividing the usage by groups can be misleading and may not reflect true average usage but usage based on catastrophic or unforeseen emergencies, or usage by age and gender that inflate the totals for a particular employee group.

The Task Force was divided on the issue of cost indexing according to salary level. No recommendation will be made at this time.

18. NO CHANGE BE MADE IN THE CURRENT PLAN DESIGN REGARDING CONTRIBUTIONS FOR FAMILY AND DEPENDENT COVERAGE.

Rationale

The Task Force has not had adequate time to study whether the percentage level of contributions for single and family coverage should be changed. It is, therefore, recommended that the contribution levels remain the same until there is adequate time to analyze this question.

HEALTH PROMOTION & INFORMATION ACTIVITIES

19. THE UNIVERSITY ADOPT A PLAN TO EDUCATE EMPLOYEES ABOUT THEIR HEALTH CARE OPTIONS.

Rationale

To assist employees to better utilize their health care benefits, an educational plan must be initiated. The planning, implementing and evaluating of such a plan could be coordinated by the benefits/personnel office whose principle responsibility would be to develop and maintain this educational program and assist employees to use the insurance wisely.

The first part of the educational process must include a series of informational sessions to explain to all employees what choices are being offered. All employees must be allowed to attend during work hours.

20. THE UNIVERSITY DESIGN A PLAN FOR HEALTH PROMOTION AND TO ENCOURAGE THE USE OF THE FITWELL ASSESSMENT/COUNSELING PROGRAM THROUGH THE STUDENT RECREATION CENTER.

Rationale

It is estimated that 60% of work related accidents are preventable. A crucial part of the health promotion program would be to analyze the University's accident history and address the needs identified there.

We should continue to use the sources already available to us such as the Monitor and BG News and continue the BGSU Health Care Newsletter that the Benefits Office has started. The State of Ohio also has many pamphlets and training films available either for free or for a small fee that we should take advantage of for use in workshops.
Information sheets and reference material should be available, strategically located around campus for employee use. This information should include not only pamphlets for specific programs such as high blood pressure, cancer prevention, back health, but also books such as *Take Care of Yourself, The AMA Family Medical Guide, The AMA Guide to Prescription and Over-the-Counter Drugs*, etc.

Some health education workshops that need to be offered and repeated include, but certainly are not limited to, the following: food and nutrition information; self care classes—self breast exam, self testicular exam; safety; exercise; stress reduction; smart consumer; weight control; and smoking cessation.

An increasing body of evidence suggests that physical activity and physical fitness contribute to good health. Establishing a health promotion program which is utilized by employees will reduce health care costs.

The University has the resources to establish a model program in health promotion. But much work must be done to fully realize this potential. The critical factor is to devise a program that will be utilized by employees.

In 1989, the Health Promotion Task Force recommended the establishment of a fitwell assessment/counseling program in which the University would subsidize the cost of employee:

1) blood pressure screening;
2) health risk appraisal (CDC Program);
3) cholesterol screening;
4) body composition analysis by computer; and
5) ECG-monitored exercise treadmill examination.

These tests would be done through the BGSU Student Recreation Center at a total estimated cost to the University of $32,340. The Task Force endorses this recommendation.

Additional planning must be done to encourage employee utilization. Goals must be established that are realistic, measurable, and specific to the University population.
A. Administration

1. BGSU's Health Care Plan has been self-funded since 1982. Previously coverage was funded through insurance premiums. Under state law, the University still must maintain stop-loss coverage, which insures against catastrophic losses on an individual or in total. Current limits (before stop-loss takes effect) are $150,000 for an individual case and 125% of expected costs for the 12-month period. Premiums increase as the insurer perceives greater chance for utilization of the stop-loss coverage. Current annual costs are approximately $225,000. The University can reduce this premium only by accepting a larger deductible for individual claims.

2. From 1982 to 1990 the BGSU Plan was administered by Benefit Plans Risk Management (later acquired by Administrative Service Consultants). In 1990, after reviewing proposals from 15 potential administrators, the University selected Didion & Associates as its new administrator, which it retains on a year-to-year contract. The selection was based on a combination of price and perceived service benefits. Current costs of administration are $220,000 annually, approximately $100 per participating employee. About 2/3 of the administrative cost relates to medical claims and 1/3 to dental and vision claims.

B. Coverage - Highlights of the University's coverage are as follows:

1. Full-time employees may choose no coverage, single coverage, or family coverage. Part-time employees are not eligible for coverage.

2. Both classified and contract employees currently pay $315 annually for single coverage (zero prior to 1991-92). Classified family coverage is $866 annually and contract families pay $1579; the former was zero prior to 1991-92, and the latter was $892 in 1990-91.

3. Unmarried dependent children are covered under family coverage through the age of 23 and beyond if mentally retarded or physically handicapped.

4. As of October 1, 1991, a total of 2234 employees were eligible for coverage. A breakdown by participation level follows:

<table>
<thead>
<tr>
<th></th>
<th>Administrative</th>
<th>Faculty</th>
<th>Classified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>Employee only</td>
<td>227</td>
<td>43%</td>
<td>303</td>
</tr>
<tr>
<td>Family coverage</td>
<td>234</td>
<td>44%</td>
<td>366</td>
</tr>
<tr>
<td>Waiving medical coverage</td>
<td>70</td>
<td>13%</td>
<td>58</td>
</tr>
<tr>
<td>Total</td>
<td>531</td>
<td>100%</td>
<td>722</td>
</tr>
</tbody>
</table>

a. Of the 123 contract employees (administrative staff and faculty) waiving medical coverage, 58 (4.6% of contract employees) have coverage through a BGSU spouse, and 65 (5.2% of contract employees) do not have coverage through BGSU. Of the 48 classified staff waiving coverage, 22 (2.2% of classified employees) have coverage through a BGSU spouse and 26 (2.7%) do not have BGSU coverage. Presumably contract staff married to classified staff (with dependents) will waive their BGSU coverage (and the classified staff member will retain coverage) since family coverage premiums are lower for classified staff and family visual/dental is included.
a. While no conclusive explanation for the higher election of family coverage by classified employees is available, possible reasons are that (1) classified staff are more likely to have dependents needing coverage, and/or (2) family coverage at BGSU is more attractive cost-wise to classified employees. No data are available as to the former hypothesis. Some support for the latter is indicated by the higher percentage of contract staff waiving coverage completely (presumably because of utilization of the spouse’s plan), though the numbers involved here are small. It also is notable that only 5% of contract staff with family coverage indicate that they also have family coverage under the spouse’s plan whereas 30% of classified staff with family coverage also have family coverage elsewhere. Presumably this is strongly related to the relative costs and benefits available to the two groups. It is not possible to determine the number of covered persons or dependents who could be covered by other plans if so elected, the number electing single coverage because their dependents are covered elsewhere, or those not receiving needed coverage because of the cost of the plan.

5. The University must provide benefits (under Ohio and federal law) up to 36 months beyond termination of employment or eligibility, provided required conditions are met and contributions are made.

6. Five separate coverages are provided in the University’s health plan: basic medical benefits, supplemental major medical benefits, prescription drug benefits, dental care benefits, and vision care benefits. The first three are available to all covered employees and dependents. Only employees and the dependents of classified staff are eligible for dental care and vision care.

7. Basic medical benefits include inpatient hospital charges (including physician), outpatient diagnostic laboratory tests and medical procedures, inpatient and outpatient surgery, outpatient mental illness treatment, and outpatient alcoholism and substance abuse treatment. Reasonable and customary charges are covered, if medically required, with the following limitations:

   a. Inpatient hospital charges (semi-private room) are limited to 120 days of care per confinement, with a 90-day waiting period to begin a new eligibility period. (Other charges may be partially covered through major medical.) Skilled care facilities, extended care facilities, home health services, and hospice care can be substituted in certain circumstances.

   b. Only the first $550 of outpatient mental illness treatment and first $550 of outpatient alcoholism and substance abuse treatment are covered by the Plan. (Additional charges are partially covered under major medical.)

8. Supplemental major medical includes hospital or physician charges beyond the basic limit, non-surgical medical services by a physician at-home or in-office, blood and blood products, rental of medical equipment, inhalation therapy, local ambulance services, physical therapy, medical supplies, braces, and prosthetic appliances, outpatient treatment of mental illness, alcoholism or substance abuse, private duty nursing, and artificial kidney rental and dialysis supplies. Each covered person (employee or dependent) pays a $100 deductible, then pays 20% of the next $4500 for a maximum yearly payment of $1,000. There is a $20,000 lifetime maximum (restorable in part) for outpatient treatment of mental illness, alcoholism, and drug abuse.

3. Prescription drugs are supplied through the PCS plan. The Plan pays 100% for generic drugs and 80% for non-generic drugs.

10. The dental plan covers 100% of routine preventive care, twice per year for most services.
most restorative work the plan pays 80% of basic charges e.g., fillings, after a $25 deductible, and 50% of major restorative charges, e.g., bridges and crowns. Total payment for all services is limited to $750 per year. Orthodontic services are not provided for adults, but 50% or $500, whichever is less, is paid for dependent children (classified plan only).

11. Vision services pay $25 bi-annually for an eye examination for each covered person and $45 to $150 (each biennium) for lenses and frames. As with the dental plan, this is not available to dependents of contract staff.

C. Cost of major components of health care.

1. Principal components of health care cost for the year ended August 31, 1991 compared with costs to date for 1992, are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Plan Year</th>
<th>9/1/91-3/31/92</th>
<th>1992 Annualized</th>
<th>Projected 1992 Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Claims</td>
<td>$56,133,653</td>
<td>$4,305,584</td>
<td>$7,300,996</td>
<td>20.3%</td>
</tr>
<tr>
<td>Prescription claims</td>
<td>733,172</td>
<td>503,016</td>
<td>862,308</td>
<td>8.7</td>
</tr>
<tr>
<td>Dental claims</td>
<td>466,131</td>
<td>249,088</td>
<td>427,008</td>
<td>-8.4</td>
</tr>
<tr>
<td>Visual claims</td>
<td>54,619</td>
<td>31,962</td>
<td>54,792</td>
<td>0.0</td>
</tr>
<tr>
<td>Stop loss premiums</td>
<td>164,135</td>
<td>99,927</td>
<td>171,300</td>
<td>4.0</td>
</tr>
<tr>
<td>Administrative fees</td>
<td>244,468</td>
<td>135,163</td>
<td>231,708</td>
<td>-5.2</td>
</tr>
<tr>
<td>Total</td>
<td>$7,856,178</td>
<td>$5,324,740</td>
<td>$9,128,112</td>
<td>16.1%</td>
</tr>
</tbody>
</table>

2. Cost of major components of medical coverage is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Total Cost</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient hospital</td>
<td>$2,060,000</td>
<td>40.5%</td>
</tr>
<tr>
<td>Out-patient hospital</td>
<td>1,712,000</td>
<td>33.7%</td>
</tr>
<tr>
<td>Office visits</td>
<td>1,314,000</td>
<td>25.8%</td>
</tr>
<tr>
<td></td>
<td>$5,086,000</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

3. Usage of in-patient, out-patient, and office visits varied significantly among administrative staff, faculty, and classified staff in 1991. Providing medical services through in-patient costs is relatively costly. It is inappropriate to make generalizations from one year's data, but this would appear to explain, to some extent, the higher costs for classified staff and lower cost for administrative. Percentage distributions of total medical costs by employee group for FY 1991 are presented below:

<table>
<thead>
<tr>
<th></th>
<th>In-Patient</th>
<th>Out-Patient</th>
<th>Office Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative staff</td>
<td>36%</td>
<td>40%</td>
<td>24%</td>
</tr>
<tr>
<td>Faculty</td>
<td>34</td>
<td>35</td>
<td>31</td>
</tr>
<tr>
<td>Classified staff</td>
<td>46</td>
<td>31</td>
<td>23</td>
</tr>
<tr>
<td>All employees</td>
<td>40%</td>
<td>34%</td>
<td>26%</td>
</tr>
</tbody>
</table>
4. The six highest diagnoses in each category for FY 1991 are as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis</th>
<th>Cost</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. In-patient:</td>
<td>(1) Genital/urinary</td>
<td>$279,000</td>
<td>13.5%</td>
</tr>
<tr>
<td></td>
<td>(2) Pregnancy/birth</td>
<td>253,000</td>
<td>12.3%</td>
</tr>
<tr>
<td></td>
<td>(3) Circulatory</td>
<td>234,016</td>
<td>11.4%</td>
</tr>
<tr>
<td></td>
<td>(4) Digestive</td>
<td>211,000</td>
<td>10.2%</td>
</tr>
<tr>
<td></td>
<td>(5) Neoplasm</td>
<td>196,000</td>
<td>9.5%</td>
</tr>
<tr>
<td></td>
<td>(6) Mental</td>
<td>193,000</td>
<td>9.4%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$1,366,000</td>
<td>66.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis</th>
<th>Cost</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Out-patient:</td>
<td>(1) Genital/urinary</td>
<td>$274,000</td>
<td>16.0%</td>
</tr>
<tr>
<td></td>
<td>(2) Miscellaneous</td>
<td>186,000</td>
<td>11.4%</td>
</tr>
<tr>
<td></td>
<td>(3) Neoplasm</td>
<td>177,000</td>
<td>10.3%</td>
</tr>
<tr>
<td></td>
<td>(4) Muscular/skeletal</td>
<td>167,000</td>
<td>9.8%</td>
</tr>
<tr>
<td></td>
<td>(5) Neurology</td>
<td>160,000</td>
<td>9.4%</td>
</tr>
<tr>
<td></td>
<td>(6) Injury/poison</td>
<td>151,000</td>
<td>8.8%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$1,125,000</td>
<td>65.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis</th>
<th>Cost</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Office visits</td>
<td>(1) Mental</td>
<td>$297,000</td>
<td>22.6%</td>
</tr>
<tr>
<td></td>
<td>(2) Muscular/skeletal</td>
<td>204,000</td>
<td>15.5%</td>
</tr>
<tr>
<td></td>
<td>(3) Digestive</td>
<td>132,000</td>
<td>10.1%</td>
</tr>
<tr>
<td></td>
<td>(4) Respiratory</td>
<td>89,000</td>
<td>6.8%</td>
</tr>
<tr>
<td></td>
<td>(5) Genital/urinary</td>
<td>88,000</td>
<td>6.7%</td>
</tr>
<tr>
<td></td>
<td>(6) Injury/poison</td>
<td>84,000</td>
<td>6.4%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$894,000</td>
<td>68.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis</th>
<th>Cost</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>d. Overall</td>
<td>(1) Genital/urinary</td>
<td>$641,000</td>
<td>12.6%</td>
</tr>
<tr>
<td></td>
<td>(2) Muscular/skeletal</td>
<td>514,000</td>
<td>10.1%</td>
</tr>
<tr>
<td></td>
<td>(3) Mental</td>
<td>501,000</td>
<td>9.9%</td>
</tr>
<tr>
<td></td>
<td>(4) Digestive</td>
<td>457,000</td>
<td>9.0%</td>
</tr>
<tr>
<td></td>
<td>(5) Neoplasm</td>
<td>440,000</td>
<td>8.6%</td>
</tr>
<tr>
<td></td>
<td>(6) Circulatory</td>
<td>396,000</td>
<td>7.8%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$2,949,000</td>
<td>58.0%</td>
</tr>
</tbody>
</table>

5. As with in-patient, out-patient, and office visit costs, there were significant differences among the staffs in principal diagnoses for medical care in FY 1991. These are presented below, though once again it is inappropriate to make sweeping conclusions from one year's data:

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis</th>
<th>Cost</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Administrative staff:</td>
<td>Genital/urinary</td>
<td>$53,000</td>
<td>14.2%</td>
</tr>
<tr>
<td></td>
<td>Pregnancy/birth</td>
<td>88,000</td>
<td>11.5%</td>
</tr>
<tr>
<td></td>
<td>Digestive</td>
<td>80,000</td>
<td>10.5%</td>
</tr>
<tr>
<td></td>
<td>Muscular/skeletal</td>
<td>80,000</td>
<td>10.5%</td>
</tr>
<tr>
<td></td>
<td>Neoplasm</td>
<td>75,000</td>
<td>9.8%</td>
</tr>
<tr>
<td></td>
<td>Neurology</td>
<td>62,000</td>
<td>8.1%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$438,000</td>
<td>64.6%</td>
</tr>
</tbody>
</table>
b. Faculty:

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental</td>
<td>$290,000</td>
<td>18.0%</td>
</tr>
<tr>
<td>Genital/urinary</td>
<td>256,000</td>
<td>15.9%</td>
</tr>
<tr>
<td>Neoplasm</td>
<td>152,000</td>
<td>9.5%</td>
</tr>
<tr>
<td>Muscular/skeletal</td>
<td>127,000</td>
<td>7.9%</td>
</tr>
<tr>
<td>Digestive</td>
<td>125,000</td>
<td>7.8%</td>
</tr>
<tr>
<td>Circulatory</td>
<td>108,000</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

$1,058,000 65.8%

c. Classified staff:

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscular/skeletal</td>
<td>$307,000</td>
<td>11.3%</td>
</tr>
<tr>
<td>Genital/urinary</td>
<td>276,000</td>
<td>10.2%</td>
</tr>
<tr>
<td>Injury/poison</td>
<td>245,000</td>
<td>9.0%</td>
</tr>
<tr>
<td>Digestive</td>
<td>251,000</td>
<td>9.3%</td>
</tr>
<tr>
<td>Circulatory</td>
<td>238,000</td>
<td>8.8%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>230,000</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

$1,547,000 57.1%

Note: The data on costs come from reports on file within the Benefits Office.
APPENDIX B

Marathon Oil
Through a local pharmacy covered at 80%, after deductible for health care is met. Mail
order available for maintenance drugs (generally 90 days) $5.00 cost if generic, $15.00
cost if brand.

Owens Corning Fiberglass
Owens Corning Plan
20% employee copay;
50% copay if fail to
obtain generic when one
is manufactured. 30-90
day supply by mail order
with copay of $13.00

Medical Value Plan
Copay per Rx for
35 day supply $5.00

Paramount Health Care
Copay per Rx for
34 day supply $5.00

Cleveland State University
CIGNA Comprehensive
CIGNA Health Plan
$2.00 Generic
$5.00 Brand Name
Plan Pharmacies
Oral Contraceptives Included
Non-Plan Provider
Deductible
80% Coverage

Kaiser Permanente
HMO
$3.00 Kaiser Ph.
Oral Contraceptives Included

Preferred Cove of Ohio
PPO
$3.00 Generic
Plan Pharmacies
Oral Contraceptives Included

Kent State University
(Comprehensive)
80%*
(Traditional Choice)

Partners HMO
80%*
Partners FPO (Open Choice)
Preferred Plan
80%*
Non-Preferred
80%*

$3.00 Kaiser Ph.
Oral Contraceptives Included

100%/$5 copay
100%/$5 copay

*Individuals with conditions requiring a 90 day supply of medications or other
prescribed materials may use the Mail Order Express Pharmacy service. The individual
pays only 20% of the wholesale price for these materials, not subject to the $200
calendar year deductible. ($200 deductible for all covered services.)

University of Cincinnati*

Option A
Comprehensive Medical Plan
$2 copay/Rx

Option C
U-Care
Network
Non-Network
$2 generic
$2 generic
$4 name
$4 name

Option D
University Health Plan
$3.00 copay/Rx at any UHP participating pharmacy

*There was an Option B, but it was not available to employees.
<table>
<thead>
<tr>
<th>University of Toledo</th>
<th>HMO Health Ohio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross/Blue Shield</td>
<td></td>
</tr>
<tr>
<td>Major Medical*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>*Deductible Ind $100/Fam$330, out of</td>
<td>$5 copay at participating pharmacies</td>
</tr>
<tr>
<td>pocket limit for copay Ind $600/Fam$1,800,</td>
<td></td>
</tr>
<tr>
<td>copay at 20%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Miami University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered under major medical. (Deductible Ind $100/Fam$200, out of pocket limit for copay Ind $400/Fam $800, copay at 20%).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ohio State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buckeye</td>
</tr>
<tr>
<td>Health Plan</td>
</tr>
<tr>
<td>80% after deductible*</td>
</tr>
<tr>
<td>OSU Health Plan</td>
</tr>
<tr>
<td>In-Network</td>
</tr>
<tr>
<td>Generic at 90%</td>
</tr>
<tr>
<td>Out-of Network</td>
</tr>
<tr>
<td>Generic at 90%</td>
</tr>
<tr>
<td>Brand name at 80%</td>
</tr>
<tr>
<td>Brand name at 80% after deductible*</td>
</tr>
<tr>
<td>Traditional Health Plan</td>
</tr>
<tr>
<td>Generic at 90%</td>
</tr>
<tr>
<td>Brand names at 80% (or</td>
</tr>
<tr>
<td>80% after deductible*</td>
</tr>
</tbody>
</table>

*Deductibles are dependent on the plan being used.

<table>
<thead>
<tr>
<th>Bowling Green State University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan pays 100% if generic drug and 80% if name brand drug is used.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ohio University</th>
</tr>
</thead>
<tbody>
<tr>
<td>A $8 deductible for brand name drugs and a $4 deductible for generic drugs through the PCS card. Mail order program is also available through Americas Pharmacies, Inc. The mail order program has a $2 deductible for a brand name and no deductible for a generic.</td>
</tr>
</tbody>
</table>
**APPENDIX C**

**PROPOSED SUMMARY OF BGSU MEDICAL BENEFIT PLAN CHOICES**

**PLAN A**

Hospital charges, in-hospital doctor care, surgical, x-ray and lab are paid 100% of R&C* with no deductible applied. There is no lifetime maximum for these charges.

Other Major Medical expenses are subject to an 80% co-pay after the deductible of $100 per person, to a maximum of $4,500 per year. Additional eligible expenses after the $1,000 out-of-pocket per person is met are 100% of R&C* for the remainder of the calendar year.

Mental illness, chemical dependency, and chiropractic services limited.

Preadmission certification - $200 non-compliance penalty.

Voluntary Second Opinion Surgery.

**COMPREHENSIVE MEDICAL (PLAN B)**

$200/$400 DEDUCTIBLE
$1,000/$2,000 OUT OF POCKET

Diagnostic ex-ray and lab charges have no deductible for the first $500; after the first $500, the deductible applies.

Charges for accidents (physician's office or emergency room) have no deductible for the first $300; after the first $300, the deductible applies.

All other charges are subject to a 80%/20% co-pay of the R&C* after the deductible of $200 single or $400 family is met, to a maximum of $4,000/$8,000. Additional eligible expenses are 100% of the R&C* for the remainder of the calendar year.

Plan maximum is $1,000,000.

Mental illness, chemical dependency, and chiropractic services limited.

Preadmission certification - $200 non-compliance penalty.

Voluntary Second Opinion Surgery.

**COMPREHENSIVE MEDICAL (PLAN C)**

$500/$1,000 DEDUCTIBLE
$1,500/$3,000 OUT OF POCKET

Diagnostic ex-ray and lab charges have no deductible for the first $500; after the first $500, the deductible applies.

Charges for accidents (physician's office or emergency room) have no deductible for the first $300; after the first $300, the deductible applies.

All other charges are subject to a 80%/20% co-pay of the R&C* after the deductible of $500 single or $1,000 family is met, to a maximum of $5,000/$10,000. Additional eligible expenses are 100% of the R&C* for the remainder of the calendar year.

Plan maximum is $1,000,000.

Mental illness, chemical dependency, and chiropractic services limited.

Preadmission certification - $200 non-compliance penalty.

Voluntary Second Opinion Surgery.

**Charges that do not exceed the amount usually charged by most providers in the same geographic area for services, treatment or materials, taking into account the nature of the illness.** Based on reasonable and customary rates after deductible is met.
June 2, 1992

MEMORANDUM

TO: Chair, Administrative Staff Council
    Josh Kaplan

FROM: Paul J. Olscamp
      President

Attached please find a copy of the Health Care Task Force report. I want to express my personal thanks to the committee and to the Chair, Professor Donald Boren for their careful, thorough and diligent work.

The Administrative Council has reviewed the report as have other administrators who have been charged with the responsibility to review it. I am now asking the Administrative Staff Council for comments and suggestions concerning the report. I would like to receive your input no later than October 1, 1992 so that I can forward the report to the Board of Trustees for their consideration of the final recommendations by January 1, 1993.

Thank you for your consideration.

cc: Dr. Donald Boren
WELLNET Proposal: Campus Community Day

WELLNET is a committee that addresses wellness related concerns and has as its mission:

*Increasing the university communities' awareness of the wellness concept; and, achieving an integration of the wellness concept into all areas of the campus.*

Members of the WELLNET Committee firmly believe that this mission statement is congruent with the principles of the collective lives of the members of the university community.

The recent budgetary constraints caused by a faltering economy have had a debilitating and divisive effect on the members of this campus community. In response to this condition that impairs the potential for excellence, the WELLNET Committee presents a proposal aimed to help build a more supportive and constructive work setting and to improve the personal wellbeing of employees at all levels within the community.

The WELLNET Committee proposes that a Campus Community Day be planned as follows: on a given day a time frame be established, i.e. 9am-9pm, during which all members of the university workforce could interface. Classified staff, faculty, administrative staff and student employees could select to participate in planned enrichment activities as their schedule would permit. The Campus Community Day would be comprised of workshops, activities and social interchange programmed around a wellness model incorporating: social, occupational, spiritual, physical, intellectual, emotional, diversity and environmental dimensions.

Before proceeding with this proposal, the WELLNET Committee solicits approval to begin planning a Campus Community Day.

The Professional Development Committee recommends that Administrative Staff Council endorse the WELLNET proposal for Campus Community Day and that a representative from the Professional Development Committee serve on the WELLNET committee to aid in the development of the day.
July 21, 1992

TO: Administrative Staff Constituents  
FROM: Mary Beth Sachary, 2-2054, MACHAR@OPE  
RE: Representation and Health Care Task Force Report

Welcome to the 1992-93 season of activity by the Administrative Staff Council. I will continue to be your representative for the coming year's activities.

Along with the minutes from each meeting of the ASC that you will be receiving, I will be contacting you at various points soliciting input. Because of the busy year ahead, ASC will be meeting all summer. If you have any questions, comments, or suggestions about the minutes, rumors you might have heard, or anything else, please feel free to contact me.

You already have work! Attached you will find two documents. The first is a flyer for the "BG Effect" mentoring program. This program matches a new student, usually a transfer or non-traditional student, to a University staff person. Mentors help new students become familiar with the campus, but do not do academic counseling. Remember what it was like being the new kid on the block not knowing anyone? Remember how good it felt when you finally found a friendly face who took some interest in you? Helped you through a gnatty problem? Introduced you to the people who could really help you? Here's your chance to do some good work. Please contact Joan Morgan, Academic Enhancement, at 2-2677, or JMOGAN@Eadar, if you want more information.

The second document is the Health Care Task Force Report which was submitted to the President last May. Dr. Olscamp requested a formal response to the report from ASC by October 1, 1992. Please review the document carefully and forward your comments/suggestions to me before the AUGUST 6TH ASC Meeting. (FYI--One knowledgeable member of the council has serious reservations about ITEM #16. He is concerned that the long-term effect of this proposal could be detrimental to the employees and the university. If you are interested in his response, I will gladly share his memo with you.

Also, please note that the 125 Plan will be available again this year with expanded boundaries. You will be able to put aside money for health care again. In addition, you will be able to put pre-tax dollars away for dependent care. There will be a cap on the amount of money you may put in the account.

Two things to remember:

Money cannot be shifted from one purpose to another!
If you don't use it, you lose it!
Consider the options carefully.

Thanks for your time. Hope to hear from you.
The B.G. EFFECT program is designed to help you succeed at Bowling Green State University by personalizing your college experience.

Participants are assigned to one University staff person who provides the individual support a new student needs to make the transition to college.

The staff mentor will be available as a single contact point for any questions you might have about the University and will remain in touch with you for as long as you find the relationship necessary—even for your entire college career.

If you want to benefit from this service, complete the form below and return it to the B.G. EFFECT table in the University Union Grand Ballroom or mail to:

Joan Morgan, Director
Office of Academic Enhancement
Bowling Green State University
Bowling Green, Ohio 43403

You will be contacted by your B.G. EFFECT mentor before classes begin so you have an instant friend when you arrive on campus.

Name: __________________________________________________________________

Social Security Number: __________________________________

Address: _____________________________________________________________

City: __________________________ State: ___________ Zip: ________________

Home Telephone: (_________ ) ________________________________

Please return this form to the B.G. EFFECT table in the Grand Ballroom or mail to the address above.
THE DELIVERY SYSTEM

A. Self-Funded vs. Insured Plan

1. THE UNIVERSITY CONTINUE TO PROVIDE FOR HEALTH CARE COSTS THROUGH OUR PRESENT SELF-FUNDED SYSTEM.

Rationale

Employers fund health care costs either by commercial carriers or a self-funded program. Self-funded programs are usually more cost effective since administrative costs are traditionally less [a 1988 survey found that administrative costs for insured plans was 6.6% compared-to 5.2% for self-funded programs, see Foster Higgins, Health Care Benefits Survey (1988)]. The primary advantage of commercial insurance is that costs are more predictable and not as subject to fluctuations in loss experience. The majority of larger employers, who are better able to absorb cost fluctuations, are self-funded. Sixty-five percent of larger employers (1,000 or more employees) are self-funded while the majority of smaller employers (less than 1,000) are insured through an outside source. Most self-funded employers purchase stop-loss insurance to protect against high-cost catastrophic cases.

The University's program is typical of what other large employers are doing. The University is self-funded with stop-loss coverage of $150,000 per claim and an aggregate stop-loss of 125% of expected claims. The University uses a third party administrator (TPA, Didion) to handle claims. Didion is reimbursed on a per employee basis. The current rate of 3% for administrative costs and 2% for stop-loss does not appear excessive when compared to a 1988 average administrative expense of 4.9% for large employers. However, this comparison may be misleading in that the higher dollar amount of claims paid, the smaller will be the percentage paid for administrative expense.

The Task Force did not compare cost between our TPA and insurance. This comparison was made two years ago and the rate for similar coverage under insurance was significantly higher.

B. Preferred Provider Organizations/Health Maintenance Organizations

2. THE UNIVERSITY EXPLORE PROVIDING HEALTH CARE COVERAGE THROUGH AN INTEGRATED PLAN THAT PROVIDES EMPLOYEES THE OPTION OF SELECTING THE TRADITIONAL FEE-FOR-SERVICE ARRANGEMENT, A HEALTH MAINTENANCE ORGANIZATION, OR A PREFERRED PROVIDER ORGANIZATION.

Rationale

There are three kinds of health care delivery plans in the United States today: the traditional fee-for-service plan; health maintenance organizations (HMO); and preferred provider organizations (PPOs). The fee-for-service plan traditionally pays physicians the UCR (usual, customary, and reasonable) price for services rendered. The plan does not limit coverage to any one group of physicians, and in most plans the patient is responsible for fees that exceed the UCR rate.

HMOs provide a fixed, predetermined amount of payment (capitation basis) for each plan participant regardless of the actual number or nature of services provided over a set period of
time. Much of the recent growth in HMO enrollment has been in individual physician associations (IPA). An IPA-type HMO is open to all community physicians who meet the HMO's criteria. Physicians who participate in an IPA maintain their own offices and continue to see non-HMO patients. HMOs appear to be effective in controlling cost. A 1980 study found that total costs for members of HMOs were 20%-40% less than the costs for members of fee-for-service plans. (Employee Benefits, BASICS Third Quarter 1990)

PPOs are hospitals, clinics, and physician groups that contract with employers to provide health care service at a discounted fee-for-service basis in exchange for a greater potential volume of patients. Participants covered by a PPO have the option of deciding at the point of service whether to receive care from the PPO or another provider. Typically, if the patient selects another provider the patient is responsible for additional costs. Employers have reported mixed experiences regarding the cost effectiveness of PPOs. One study found that 24% of employers reported reduced costs; 17% indicated no effect on costs; and 4% reported a sizable increase. (Employee Benefits, BASICS Third Quarter 1990)

The use of HMOs and PPOs is becoming widespread. In 1990, Foster Higgins conducted a study of health care benefits for Ohio colleges and universities. The study found that nationwide 63% of universities over 1,000 employees and 52% of Ohio universities offer either an HMO or PPO. This study also reported mixed results on the effectiveness of controlling costs. Thirty-three percent of respondents from Ohio universities agreed that HMOs were effective in controlling costs compared with 89% of universities in the nationwide survey. The majority of respondents in both the Ohio (67%) and national (57%) surveys agreed that PPOs were effective in controlling costs.

There is insufficient information to decide whether PPOs and HMOs would be effective alternatives to our present indemnity plan. A major problem is that no alternative delivery plans are available in Wood County and none of the Toledo plans have been extended to this area. If the University is to offer these plans as an alternative, a plan would need to be created.

For alternative delivery plans to be successful, there must be sufficient inducements for the physicians and patients to enter the plan. The inducement for physicians to enter into an HMO or PPO is to increase the number of patients. These plans would offer little advantage to physicians if a substantial majority of physicians in the community are members, or if the physician's case load is such that he can not serve additional patients. This indicates that plans would have a greater chance of success in geographic areas with a large number of physicians and patients. A 1991 survey, conducted by Youngstown State University, supports this premise. The survey found that, with the exception of Kent State University, all Ohio universities that offered HMOs or PPOs were located in large metropolitan areas.

Another factor necessary for the success of HMOs and PPOs is that the costs offered by the plan must be sufficiently lower than an indemnity plan to induce employees to join. Hospitals that service the majority of university employees already offer low costs. The most recent survey of hospital costs conducted by the Employers Coalition of Northwest Ohio found that Wood County Hospital and Blanchard Valley Hospital are two of the lowest cost providers in this region. For an alternative delivery plan to be successful, these institutions must be willing to reduce costs even lower.

While HMOs and PPOs do not appear to be viable at this time, potential savings warrant the University continuing to explore these alternatives. The best alternative would appear to be a plan which integrates an indemnity plan and an HMO or PPO. All employees would enroll in the plan at a discounted fee-for-service basis or a capitated rate. The plan would offer a point-of-service option with partial coverage for participants who receive care from outside providers.
PRESCRIPTION DRUGS

3. PRESCRIPTION DRUG BENEFITS CONTINUE TO BE PROVIDED THROUGH THE PRESCRIPTION DRUG CARD PROGRAM (PCS).

Rationale

Prescription drug benefits play an important role in the treatment of illness. Prescription drug card programs are becoming more common with colleges and universities in Ohio and with large employers in Northwest Ohio (see Appendix B).

The prescription drug card program has been widely accepted by employees primarily because of its convenience since no claim form is required when the card is used to purchase prescription drugs. The only drawback to the PCS is that it has been difficult to maintain effective cost management procedures. PCS recently implemented several cost containment procedures to assist employers in maintaining more effective cost management of their prescription drug programs.

4. THE PCS MAXIMUM ALLOWABLE COST BE USED TO DETERMINE PAYMENT LEVELS FOR GENERIC DRUGS.

Rationale

Under the present arrangement, PCS reimburses dispensing pharmacies based on the Average Wholesale Price (AWP) for ingredient costs plus a dispensing fee. Average Wholesale Price is determined by the suggested list price of drug products that pharmacists pay to the drug wholesalers or suppliers. It seldom reflects the costs of the drugs to the pharmacist since it does not take into consideration volume discounts, rebates and other incentives offered by suppliers. PCS has compiled a maximum allowable cost for each of approximately 450 generic drugs which more accurately reflects the actual ingredient cost to the pharmacist. By adopting the maximum allowable cost program, the cost of the program would be reduced by approximately 4% per year. This would result in a savings of approximately $32,000 during the initial plan year.

5. WHEN A BRAND-NAME DRUG IS SELECTED IN LIEU OF ITS GENERIC EQUIVALENT, PCS WILL ONLY PAY THE COST OF THE GENERIC EQUIVALENT.

Rationale

When brand name drugs are dispensed, the individual is required to make a 20% co-payment with the balance being paid by PCS. In some instances, brand name drugs are dispensed when a generic equivalent is available. It is recommended that in these instances the individual be required to pay the difference between the maximum allowable cost for the generic equivalent in lieu of the 20% co-payment. This will encourage the use of generic drugs whenever possible which will result in significantly lower costs for the prescription drug card program.

6. A MAINTENANCE DRUG PROGRAM BE IMPLEMENTED TO PROVIDE FOR THE PURCHASE OF MAINTENANCE DRUGS FOR LONGER TERM MEDICATION THAN THE CURRENT PLAN ALLOWS.

Rationale

Approximately 28% of the total prescriptions purchased under the prescription drug card program for the 12 month period January 1, 1991 through December 31, 1991 were maintenance drugs. Under the current plan the maximum dosage that cardholders can purchase with each prescription is a 34 day supply.
Effective July 1, 1992, PCS will have available a maintenance drug program which will allow cardholders to purchase up to a 90 day supply of maintenance drugs under one prescription. This will significantly reduce the number of prescriptions purchased under the program and will reduce the dispensing fees paid to pharmacists by approximately $10,000.

7. THE UNIVERSITY RENEGOTIATE PRESCRIPTION INGREDIENT COSTS AND DISPENSING FEES.

Rationale

Based on the volume of prescription drug purchases through the Prescription Drug Card Program, PCS has agreed to negotiate a discount of 10% below the average wholesale price for all prescriptions purchased through the PCS network of participating pharmacies. PCS did, however, recommend that the University adjust the dispensing fee paid to the pharmacists. It was recommended that the dispensing fee be increased from $2.60 to $3.23 which is the prevailing fee provided under Medicaid in Ohio.

The above arrangement would result in a net reduction in prescription drug costs of approximately $50,000 per year based on the current annual costs of approximately $862,000.

VISION

8. THE UNIVERSITY OFFER AN OPTIONAL VISION PLAN TO REPLACE THE PRESENT VISION PLAN WHICH WILL NO LONGER BE FUNDED.

Rationale

The Health Care Plan currently provides benefits for vision care on an indemnity basis with specific allowances for each type of service. The current annual claim cost of providing vision care coverage to eligible employees and dependents (classified employees only) is approximately $60,000. The plan offers very limited coverage, paying approximately 1/3 of the costs of typical vision care. The policy pays on a reasonable and customary basis which offers no costs savings over the retail costs.

The Task Force recommends that the University offer to all employees an optional VSP Plan through the Section 125 Plan.

The Task Force explored providing vision care through Vision Service Plan (VSP), a preferred provider arrangement. The VSP Plan would cost approximately $75,000 per year if coverage were provided for the 886 employees and 624 dependent units (classified employees only) covered under the current plan. If vision coverage were expanded to provide benefits to dependents of faculty members and administrative staff, the estimated annual cost would be approximately $121,200.

The Task Force believes that these additional costs are not justified in a period of rapidly expanding medical costs. The approximately $60,000 costs savings in not providing vision care could be better spent in providing coverage in more critical areas.
SECTION 125 PLAN

9. THE UNIVERSITY ESTABLISH A FLEXIBLE SPENDING ARRANGEMENT TO ALLOW EMPLOYEES TO PAY OUT-OF-POCKET HEALTH CARE AND OTHER ALLOWABLE COSTS WITH PRETAX DOLLARS.

Rationale

Last year the University established a 125 Plan that allows employees to pay their share of health care premiums with pre-tax dollars. Expanding this plan to permit employees to pay as much of their health care and other costs (i.e., dependent care, vision, deductibles, and co-pays), as allowed under Internal Revenue Code Section 125, with pre-tax dollars reduces the financial burden on employees and allows them to design a benefit package that best meets their needs.

CHIROPRACTIC SERVICES

10. THE UNIVERSITY’S HEALTH BENEFITS FOR CHIROPRACTIC SERVICES BE LIMITED TO THE FOLLOWING:

SERVICES PROVIDED BY A LICENSED CHIROPRACTOR (D.C.) WOULD BE COVERED BY THE PLAN PROVIDED SUCH SERVICES ARE WITHIN THE SCOPE OF HIS/HER LICENSE.

FOR NEURO-MUSCULOSKELETAL DISORDERS, THE PLAN WILL PAY A MAXIMUM OF 80% OF COVERED SERVICES UP TO $25 PER VISIT WITH A MAXIMUM OF ONE VISIT PER DAY AND 20 VISITS PER CALENDAR YEAR.

X-RAYS WILL BE COVERED IF THEY ARE NECESSARY TO ANALYZE A DISORDER. A MAXIMUM OF $150 WILL BE CONSIDERED FOR X-RAYS AND DIAGNOSIS DURING ANY CALENDAR YEAR. THESE MAXIMUMS WILL APPLY TO EACH COVERED PERSON. ADDITIONAL CHARGES FOR ULTRASOUND, DIATHERMY IN CONNECTION WITH A CHIROPRACTIC VISIT WOULD NOT BE COVERED.

Rationale

The current plan pays 80% of the reasonable and customary charges for chiropractic services. There is no limit to the number of services that can be provided. In reviewing the claims utilization data provided by Didion & Associates, the possible over utilization of these services might be occurring. There were also indications that certain providers are taking some liberties with this benefit in view of the type and extent of services they are providing to their patients.

It is anticipated that the above payment limitations will result in a cost reduction of approximately $43,000 per year for chiropractic services.

MENTAL HEALTH

11. THE FOLLOWING CHANGES BE MADE IN MENTAL HEALTH BENEFITS: SPECIAL DEDUCTIBLES, COPAYMENTS, AND MAXIMUM PAYMENTS BE ESTABLISHED FOR MENTAL HEALTH AS DESCRIBED BELOW.

IN-PATIENT BENEFITS:
THE PLAN PAY 80% OF COVERED SERVICES (DEFINED IN EXISTING PLAN) WITH AN ANNUAL MAXIMUM OF 30 DAYS IN-PATIENT TREATMENT UP TO AN ANNUAL MAXIMUM BENEFIT $30,000.
OUT-PATIENT BENEFITS: THE PLAN PAY FOR COVERED SERVICES (DEFINED IN EXISTING PLAN) UP TO $1,000 PER CALENDAR YEAR WITH A CO-PAYMENT PERCENTAGE OF: VISITS 1-3 80% UP TO $75 PER VISIT; VISITS 4-6 80% UP TO $60 PER VISIT; VISITS 7+ 50% UP TO $40 PER VISIT.

Rationale

The Task Force compared the University's utilization data with industrial standards to identify areas of high utilization. These areas were then examined to determine the cause of the high utilization and what is customarily standard in health care plans.

The Task Force found that the University's utilization of mental health and chemical dependency benefits substantially exceeded the average in health care costs. The Task Force asked Square Lakes Corporation, a medical consulting firm, to compare the University's utilization with industry averages. The University's utilization for the most recent period that data is available (9-1-90 through 8-31-91) was used as the basis of comparison. Square Lakes found that the University's inpatient utilization, of 83 inpatient days per 1,000 group members, is within the industry average of 80 to 100 days per 1,000 members. However, outpatient visits for this period are over three times higher than the industry standard. The University had 916 outpatient visits per 1,000 members compared with the industry standard of 250 to 300 per 1,000 members.

The Task Force further found that the University's coverage for mental and chemical dependency is unique, in that the plan does not provide for special limits on coverage or for utilization review. The most recent Foster Higgins Survey (Health Care Benefits Survey 1991 /Indemnity Plans p. 9) found that 87% of employers now have special limits for mental disorder and substance abuse benefits.

Under the current plan, costs for treatment for mental illness and alcohol and substance abuse is covered under both the basic medical and the major medical benefits. The basic medical benefits, for outpatient treatment, pays for 100% of costs up to $550 per person per calendar year for mental illness, alcoholism, and substance abuse treatment. Once the $550 limit is exhausted, the patient qualifies for major medical coverage with the only limit being a maximum lifetime coverage of $20,000. For inpatient services the plan pays for 120 days per confinement for treatment for both mental illness, and alcohol and substance abuse treatment. Treatment for both mental disorder and alcohol and substance abuse are covered under major medical with a maximum lifetime coverage of $20,000 for these illnesses.

CHEMICAL DEPENDENCY

12. THE FOLLOWING CHANGES BE MADE IN CHEMICAL DEPENDENCY BENEFITS: SPECIAL DEDUCTIBLES, CO-PAYMENTS, AND MAXIMUM PAYMENTS BE ESTABLISHED FOR CHEMICAL DEPENDENCY AS DESCRIBED BELOW.

THE PLAN PAYS 80% OF IN-PATIENT OR OUT-PATIENT BENEFITS ON AN EPISODE OF CARE BASIS. AN EPISODE OF CARE CAN BE A COMBINATION OF IN-PATIENT AND/OR OUT-PATIENT TREATMENT. THE TREATMENT PLAN MUST BE APPROVED IN ADVANCE. NO MORE THAN TWO IN-PATIENT ADMISSIONS RELATED TO CHEMICAL DEPENDENCY CARE WOULD BE COVERED DURING ANY CALENDAR YEAR WITH A MAXIMUM LIFETIME BENEFIT OF $30,000. OUT-PATIENT BENEFITS FOR CHEMICAL DEPENDENCY RELATED CARE BE THE SAME AS OUT-PATIENT MENTAL HEALTH BENEFITS.
July 23, 1992

MEMORANDUM

TO: Ann Bowers  
   Chair, Administrative Staff Council

FROM: Norma J. Stickler  
   Chair, Personnel Welfare Committee

SUBJECT: PWC Meeting

At its meeting of July 23, the Personnel Welfare Committee reviewed the first 13 recommendations of the Health Care Task Force Report. Items one through ten and item thirteen generated very little controversy. Items 11 and 12 were similar in nature and in PWC has the following recommendations.

• Rather than placing cumbersome restrictions on the coverage, there should be a person hired to provide a "gatekeeper" function to assist employees and providers in the best use of the mental health and chemical dependency benefits. It seems possible that the gatekeeper could work in conjunction with the Employee Assistance Program recommended in #13.

• There should be a stated maximum out-of-pocket employee expenditure on mental health coverage.

• All mental health out-patient visits should be covered at the same rate because it is difficult to solve a serious problem in only three visits. Further, there should be no disincentive to people seeking assistance initially.

• There should be sufficient restrictions so that overly expensive/posh facilities can be avoided while still providing competent care.
# CONTRACT EMPLOYEES HEALTH CARE
## MONTHLY COST INFORMATION

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9/1/92
FACULTY WELFARE COMMITTEE RECOMMENDATIONS ON THE HEALTH CARE TASK FORCE REPORT TO THE PRESIDENT

The Faculty Welfare Committee makes the following recommendations on the Health Care Task Force Report to the President dated May 1992. FWC requests that these recommendations be discussed and approved by the Faculty Senate and transmitted to the President and the Board of Trustees for their final approval.

1. Reexamine, for the purpose of removing or increasing, the Plan Maximum of $1,000,000 for all of the BGSU medical benefit plan choices. (See Health Care Task Force Recommendation 16 and Appendix C)

2. The Insurance Committee shall continue the work of the ad hoc Health Care Task Force and engage in strategic long-range planning to contain health care costs and, at the same time, maintain or improve the quality of health care benefits for BGSU employees.

3. Reevaluate the proposed limits on mental health benefits in view of the proposed Employee Assistance Program (EAP) which provides for the monitoring of mental health care benefits. (See Health Care Task Force Recommendations 11 and 13)

4. Health care coverage or benefits and cost to the employee should be the same for all employee groups—faculty, administrators, administrative staff, and classified staff.

5. Access to additional health care coverage, such as family dental care, should be equally available to all employee groups—faculty, administrators, administrative staff, and classified staff. (See Health Care Task Force Recommendation 14)

6. Employee contributions for family and dependent coverage should vary, depending on the number of dependents claimed by the employee. (See Health Care Task Force Recommendation 18)

7. Health care dollar benefit limits, such as "Usual, Customary and Reasonable (UCR)" medical benefit limits, should be reviewed and adjusted annually, in step with changes in the appropriate health care price index.

8. Implementation of the Recommendations of the Health Care Task Force shall not result in any net increase in BGSU administrative costs, nor any net additions to administrative or classified staff.

FWC
9/8/92
August 11, 1992

MEMORANDUM

TO: All Faculty, Administrative and Classified Staff

FROM: Gaylyn J. Finn, Treasurer
       Jim Morris, Benefits Director

RE: 1992-93 Plan Year Section 125 Election

Attached are two documents: a Section 125 information packet and a Benefit Election/Compensation Agreement Enrollment Form for the 1992-93 plan year, which need your immediate attention. The benefit election form requires three elections for the 1992-93 plan year: one for the Health Care Premium Conversion, one for the Health Care Reimbursement Account, and one for the Dependent Care Reimbursement Account. The latter two of these elections are new for 1992-93 and are described in the information packet. The Health Care Premium Conversion election is similar to last year's election and is being requested as required (annual election) by IRS regulations.

The second and third elections, Health Care Reimbursement Account and Dependent Care Reimbursement Account, are being offered at this time in order to provide employees the broadest tax favored treatment possible under Section 125. It is, however, recognized that many individuals may feel insufficiently informed about the benefits and risks associated with a positive election of either of these plans, and a conservative approach to the election is being encouraged. It is expected that many individuals will elect not to participate in one or both of the new programs until they have had an opportunity to thoroughly review the impact on their individual situations.

By law, a continuing employee must make Section 125 elections prior to the beginning of a plan year for the entire year and may not change that election unless there is a change in either family status or in the plan. Current expectations are that the recommendations of the Health Care Task Force and the responses to those recommendations by the Faculty Senate, the Administrative Staff Council, and the Classified Staff Council may result in changes to the existing health care program and the offering of additional health care options in January, 1993. If changes occur in the existing health care program, those individuals electing not to participate in the Health Care Reimbursement Account at this time will have an opportunity to elect to participate in January because of the plan change.

It must be noted that the possibility of a mid-year election does not exist for the Dependent Care Reimbursement Account, as this plan will not be changed during the year. If an individual desires to participate in the Dependent Care Reimbursement Account during the 1992-93 plan year, an election to do so must be made at this time.

While the complexity and limitations of offering the new Section 125 options, effective with the new plan year, are recognized, the benefit to those individuals who will choose to participate at this time could not be ignored. For those individuals who are uncertain about their ability to benefit from the new options, the use of a conservative approach is encouraged.
August, 1992

TO: ALL FACULTY, ADMINISTRATIVE AND CLASSIFIED STAFF

FROM: GAYLYN FINN, TREASURER
      JIM MORRIS, BENEFITS MANAGER

RE: SECTION 125 HEALTH CARE PREMIUM, HEALTH CARE
    REIMBURSEMENT ACCOUNT, AND DEPENDENT CARE
    REIMBURSEMENT ACCOUNT

Enclosed is the following information concerning enrollment in the Bowling
Green State University Section 125 Plan:

1. Explanation about the Health Care Premium Conversion,
   Part A.

2. Explanation about the Health Care Reimbursement Account,
   Part B.

3. Health Care Reimbursement Account, Reimbursement Worksheet
   and explanation of Qualifying Health Care Expenses.

4. Explanation about the Dependent Care Reimbursement
   Account, Part C and worksheet.

5. Section 125 Benefit Election/Compensation Agreement
   Enrollment Form (Blue).

Informational meetings concerning the additional options available in the
Section 125 Plan will be held at locations indicated on the attached
schedule.

Please review all Section 125 information and plan to attend one of the
informational meetings to learn more about Section 125 Plan Benefits and
receive assistance in the enrollment process.

All employees MUST complete the attached Section 125 Enrollment Form
(Blue) to indicate whether you elect to participate in the Health Care
Premium Plan pre-tax or after-tax option and whether you elect or decline
to participate in the Health Care Reimbursement Account Plan or Dependent
Care Reimbursement Account. These forms must be received by the Benefits
office no later than Monday, August 31, 1992 to assure a September payroll
deduction. Forms received after August 31 but prior to September 18, the
final acceptance date, may result in an initial payroll deduction in
October.

After the informational meetings, if you have any questions concerning
this information, please feel free to contact the Benefits office,
372-2112.
Part A

Prior to July 1, 1991, you paid your portion of medical and/or dental premium costs, if applicable, with after-tax dollars. Since that time, through Section 125 of the Internal Revenue Code, you have had the opportunity to pay for your premiums with pre-tax dollars.

Paying premiums with pre-tax dollars means your take home pay will increase since your premium payments are subtracted from your gross salary before Federal and State taxes are applied. Therefore, your salary dollars will stretch farther for you than if you paid premiums with after-tax dollars.

Additionally,

- Your annual tax withholding statement (W-2) reflects your reduced taxable income;
- Participating in the Section 125 Health Care Premium Conversion does not affect your Health benefits.

Bowling Green State University will again deduct any required premium contributions for your health care coverage, on a pre-tax or after-tax basis, starting with your pay(s) in September, 1992.

You should be aware your election cannot be changed during a Plan Year unless you have a "change in family status" which affects your benefits or unless there are significant changes in the health care plan. A "change in family status" is defined as:

* Marriage or divorce;
* Birth or adoption of a child;
* Death of a dependent spouse or child;
* Loss of a dependent’s eligibility for coverage;
* Gain or loss or your spouse’s group health coverage;
* Change in spouse’s employment status.

Currently, we are considering making the changes to our existing health care plan recommended by the Health Care Task Force. The changes being considered which would be effective in January 1993 at the earliest may allow you to select optional coverages based upon your needs. Should you decide to select an alternative plan, you will have the right to change your election for the Health Care Premium Conversion and Health Care Reimbursement Account only at that time.
Part B

The Bowling Green State University Health Care Reimbursement Account allows you to spend tax-free money on expenses not reimbursed by your health care coverages.

HOW THE PLAN WORKS

You decide how much you want to deposit into your account for the 1992-93 Plan Year, up to a maximum of $2,400. Consider only predictable expenses you or your family members will have during the year that are not covered by any health care plan.

A worksheet is included on the following page to help you estimate these expenses.

Some common eligible expenses for reimbursement are:

* deductibles;
* co-insurance or co-payments;
* eye exams or glasses;
* contact lenses;
* hearing exams;
* immunizations;
* routine physical.

Some common ineligible expenses are:

* cosmetic surgery;
* weight loss programs;
* fitness program;
* nonprescription drugs;
* stop smoking programs.

The amount you elect to deposit will be spread equally over all your pay periods between September 1, 1992 and August 31, 1993. Starting with your September, 1992 pay(s), this amount will then be deducted from your paycheck before your taxes are calculated. The amount will then be deposited into your personal reimbursement account. The plan year for this program will be September 1, 1992 thru August 31, 1993. If you do not receive pay for one or more of your scheduled pays, the amount deducted for your Health Care Reimbursement Account will be increased in subsequent pays in order to achieve your annual deferral, as required by law.

FILING A CLAIM

The IRS requires that benefits from any other health care coverage must be paid prior to payment from your reimbursement account. For instance, if you have dental coverage through the Bowling Green State University and your spouse's employer, you must file any dental expenses incurred with both plans before filing for reimbursement under this Plan. You will be required to provide proof the other plan(s) have considered the expenses in question by providing copies of the payment or denial worksheets. Claim forms are available through the Benefits office, please call 372-2112.
You will be reimbursed for the eligible portion of these expenses up to the maximum amount you have elected. You are never taxed on this money. The total amount you elect to deposit during the year is available anytime during the year.

Remember, you can only claim expenses incurred during the Plan year for reimbursement. If you are in the midst of ongoing treatment that is not completed in one year, such as orthodontia, you can claim only those services which have been incurred in that Plan year.

**HOW THE HEALTH CARE REIMBURSEMENT PLAN CAN BENEFIT YOU**

You can decrease your taxes and increase your take home pay. Your base income will remain the same, but since you pay less tax, you have more money to spend.

**EXAMPLE:**

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**Increase in Spendable Income**

$214

**"USE IT OR LOSE IT" RULE**

The Health Care Reimbursement Account can result in a real savings to you, but it is not for everyone. Only predictable expenses should be considered since your election cannot be changed during the year unless the plan or your family status changes. You should be aware the IRS Code requires that any amount(s) remaining in your account at end of the Plan year must be forfeited and therefore, cannot be returned to you. Unused amounts will remain in the Plan. You have ninety (90) days after the end of the plan year to file a claim, however, the expense must have been incurred during the plan year.

If you terminate employment, you can still claim reimbursement for expenses incurred prior to your date of termination. You are also able to exercise COBRA (Consolidated Omnibus Budget Reconciliation Act) after termination for the remainder of the plan year.
HEALTH CARE REIMBURSEMENT ACCOUNT REIMBURSEMENT WORKSHEET

The Health Care Reimbursement Account enables you to pay for eligible health care expenses that are not reimbursed by any other plan for yourself and your dependents with pre-tax dollars.

This worksheet is designed to help you estimate those expenses to determine how much, if any, to deposit in your Health Care Reimbursement Account. Please see the reverse side of the worksheet for additional information on the types of expenses which qualify for reimbursement under this Plan. Estimate conservatively, as any unused amount(s) in your account at the end of the plan year must be forfeited.

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<td>IMMUNIZATIONS</td>
<td>$___________</td>
</tr>
<tr>
<td>GLASSES</td>
<td>$___________</td>
</tr>
<tr>
<td>CONTACT LENSES</td>
<td>$___________</td>
</tr>
<tr>
<td>OTHER</td>
<td>$___________</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$___________</td>
</tr>
</tbody>
</table>

Divide the TOTAL by your number of pay periods in this plan year.

This will be the amount deducted from your paycheck on a pre-tax basis and deposited into your Health Care Reimbursement Account.
This is a partial listing only of the types of expenses which could be eligible under your Health Care Reimbursement Account.

* Alcoholism, treatment of
  Ambulance hire
  Attendant to accompany blind student

Blindness, special educational aids to mitigate condition
Braille books and magazines, excess cost of regular editions

* Chiropractors
  Christian Science treatment
  Contact lenses
  Contraceptives, prescription
  Crutches

Dental fees
  *Doctor's charges, office calls, surgery, etc.
  Drug addiction, recovery from

Eye examinations and glasses

Glasses
  Guide animals, cost and maintenance

Hearing aids
  *Hospital care, inpatient
  *Hospital services

* Insulin
  *Limbs, artificial

Mattress, prescribed alleviation of arthritis

Nurse's fees, including board if paid by taxpayer
  Nursing home, medical reasons

* Obstetrical expenses
  Oxygen equipment, breathing difficulty

Plumbing, special fixtures for handicapped
  *Psychiatric care
  *Psychologists
  Psychotherapists

Teeth, artificial
  Telephone, specially equipped for the deaf
  Transportation, cost incurred essentially and primarily for medical care

Vitamins, prescribed
  Wheel chair

*The only portion of these expenses eligible to be reimbursed under a Health Care Reimbursement Account is the part which is not payable under your Medical Insurance.
DEPENDENT CARE REIMBURSEMENT ACCOUNT

Part C

The Dependent Care Reimbursement Account provides a mechanism for the pre-tax payment of eligible dependent care expenses. You decide how much to "budget" for anticipated dependent care expenses and authorize your employer to reduce your salary by that amount. You are then reimbursed for eligible expenses from the reimbursement account as expenses are incurred.

Eligible expenses are those which could otherwise be claimed for the Dependent Care Tax Credit on your Federal income tax. It must be for a dependent child who is under 13 years old (or a dependent who is disabled and unable to care for themselves), and it must be for care which enables you to work. In other words, you must be at work during the hours your eligible dependent receives the care.

You can not claim expenses for tuition (even for preschool), for overnight camping, residential programs, or nursing homes. There are also limits on how much you can claim. The maximum amount that a couple filing jointly can claim is $5,000, for an individual filing singularly - $2,500. Also, you can not claim more than you earn - if you are married, the maximum amount is the lower of either of your incomes.

In order to submit for reimbursement, you need to submit a receipt from or a copy of a cancelled check to the care giver showing that you have paid for the care and how much you paid. You need to include the dates the service was rendered (you can not pre-pay) and the social security number or tax ID number of the care giver. This must be included on every claim!

Claim forms are available through the Benefits office. Please call 372-2112. As always, if you have any questions about a claim, or about an eligible expense, please call Didion & Associates for assistance. Their Toll-Free number is 1-800-282-3920.
WORKSHEET

Determine the amount you will spend for child care from September 1, 1992 - August 31, 1993.

Divide the total by your number of pay periods between September 1, 1992 and August 31, 1993.

"USE IT OR LOSE IT" RULE

Once again, you should be aware that IRS Code requires that any amount(s) remaining in your account at the end of the plan year must be forfeited, and therefore, cannot be returned to you. You have 90 days after the end of the plan year to file a claim, however the expense must have been incurred during the plan year.

TAX CREDIT ALTERNATIVE

You should be aware that you may be able to take a federal tax credit of up to 30% of the amount you pay for dependent care expenses instead of participating in the dependent care reimbursement account.

You may use up to $2,400 of dependent care expenses to figure your credit if you have one qualifying dependent and up to $4,800 if you have two or more qualifying dependents.

You should consult with your tax advisor as to whether the tax credit may be more favorable for you than participating in the dependent care reimbursement account. You may also wish to obtain IRS Publication 503 for more information about the federal tax credit.

A copy of the current Federal Tax Credit Allowance is attached for your review.
CHILD CARE CREDIT

The figures below show the maximum child care credit available at various levels of adjusted gross income. The maximum child care expenses to which the applicable credit percentage may be applied are $2,400 for one child, and $4,800 for two or more children. Beginning in 1989, the credit is only available for children age 12 and younger.

<table>
<thead>
<tr>
<th>Adjusted Gross Income</th>
<th>Credit %</th>
<th>One Child</th>
<th>Two or More Children</th>
</tr>
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<tbody>
<tr>
<td>$10,000 and less</td>
<td>30%</td>
<td>$720</td>
<td>$1,440</td>
</tr>
<tr>
<td>10,001 to 12,000</td>
<td>29</td>
<td>696</td>
<td>1,392</td>
</tr>
<tr>
<td>12,001 to 14,000</td>
<td>28</td>
<td>672</td>
<td>1,344</td>
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<tr>
<td>14,001 to 16,000</td>
<td>27</td>
<td>648</td>
<td>1,296</td>
</tr>
<tr>
<td>16,001 to 18,000</td>
<td>26</td>
<td>624</td>
<td>1,248</td>
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<td>18,001 to 20,000</td>
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<td>20,001 to 22,000</td>
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<td>22,001 to 24,000</td>
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<td>24,001 to 26,000</td>
<td>22</td>
<td>528</td>
<td>1,056</td>
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<td>26,001 to 28,000</td>
<td>21</td>
<td>504</td>
<td>1,008</td>
</tr>
<tr>
<td>28,001 and over</td>
<td>20</td>
<td>480</td>
<td>960</td>
</tr>
</tbody>
</table>
SCHEDULE OF SECTION 125 WORKSHOPS

The following workshops have been scheduled to discuss the expanded Section 125 Plan.

The workshops will review the election and enrollment forms and options available under the Health Premium, Medical Spending and Dependent Care accounts.

The workshops will be repeated several times in order to enable as many employees as possible to attend one of the workshops. The date, time and location of each workshop is indicated below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, August 17</td>
<td>10:00 a.m.</td>
<td>West Hall, Room 121</td>
</tr>
<tr>
<td></td>
<td>1:30 p.m.</td>
<td>West Hall, Room 121</td>
</tr>
<tr>
<td></td>
<td>3:00 p.m.</td>
<td>West Hall, Room 121</td>
</tr>
<tr>
<td>Tuesday, August 18</td>
<td>10:00 a.m.</td>
<td>Life Science Bldg., Room 112</td>
</tr>
<tr>
<td></td>
<td>1:30 p.m.</td>
<td>Life Science Bldg., Room 112</td>
</tr>
<tr>
<td></td>
<td>3:00 p.m.</td>
<td>Life Science Bldg., Room 112</td>
</tr>
<tr>
<td>Wednesday, August 19</td>
<td>10:00 a.m.</td>
<td>Business Adm. Bldg., Room 116</td>
</tr>
<tr>
<td></td>
<td>1:30 p.m.</td>
<td>Business Adm. Bldg., Room 116</td>
</tr>
<tr>
<td></td>
<td>3:00 p.m.</td>
<td>Business Adm. Bldg., Room 116</td>
</tr>
</tbody>
</table>

ja
8/4/92
TO:       Dr. Paul J. Olscamp  
         President  

FROM:    Ann Bowers  
         Chair, Administrative Staff Council 

RE:      Health Care Task Force Report  

DATE:    September 24, 1992  

Please find enclosed Administrative Staff Council’s recommendations on the Health Care Task Force Report. We appreciated the opportunity to review the Report and the Task Force’s recommendations regarding changes in health care benefits. All administrative staff were offered the opportunity to provide input into this review and the enclosed recommendations are reflective of their concerns and questions.

We will be happy to respond in more detail if any questions arise regarding these recommendations.

AB: swf  

Enclosure
MEMORANDUM

TO: President Olscamp

FROM: Christine Stock, Chair

Subject: Classified Staff Council

MEMORANDUM

TO: President Olscamp

FROM: Christine Stock, Chair

Subject: Classified Staff Council

In response to your request that Classified Staff Council review the Health Care Task Force recommendations, we submit the following recommendations and comments:

1. Indexing deductibles and copayment levels based on salary regardless of type of employment (contract vs. hourly). The number one concern voiced by Council members is that the cost of medical care not be out of reach for the people at the lower end of the pay scale.

2. The present difference in contribution levels between classified and contract employees should be maintained unless compensation is given to classified to offset this loss in benefits.

3. If a PPO is the most cost effective way to provide health care, then more emphasis must be placed on securing such an organization in the Bowling Green area.

4. The health care package should provide more measures for preventive medicine (i.e. pap tests, mamograms, blood pressure and cholesterol screening).

5. The development of "wellness" programs here on campus, with each employee group provided the same accessibility (i.e. Rec Center membership, stop smoking programs, weight control).

6. Expansion of the 125K plan to include participation by part-time employees.

7. Allowance be made when a physician specifies that a particular drug cannot be replaced by a generic. There is potential that some employees may be seriously harmed if forced to use the generic due to financial restrictions.
2. "Usual and customary" charges should be available to the employee upon request. This would help in the case of sheltering money for planned surgeries or procedures.

9. Cost information on the three plans needs to be developed and shared as soon as possible.

10. Informational meetings and training sessions be started as soon as possible with Firelands having the same training, in the same timely fashion as main campus. Employees need as much information as soon as possible to make an educated decision on their health care purchase.

Classified Staff Council wishes to express our gratitude to all the members of the Task Force for the fine job they did. We realize that many hours of effort were spent and many concerns were addressed.

We also would like to thank you, Dr. Olscamp, for allowing us participation on the Task Force and input into the final recommendations.

cc: CSC
FACULTY WELFARE COMMITTEE COMMENTS AND SUGGESTIONS ON THE HEALTH CARE TASK FORCE REPORT TO THE PRESIDENT

Last summer, President Olscamp sent a copy of the Health Care Task Force Report to the Faculty Welfare Committee with the charge to make "... comments and suggestions concerning the report." FWC has examined the report, makes the following comments and suggestions concerning it, and requests that they be adopted by the Faculty Senate and transmitted to the President and the Board of Trustees for their final approval.

1. We do not approve of the policy of shifting health insurance costs to employees; it results in cutting their take-home pay. The Central Administration should develop more creative and effective strategies to control health care costs without reducing benefits. Examples include consumer education, early detection, wellness programs, better purchasing and utilization of health care services, PPO's, HMO's, and the like.

2. The Central Administration should reexamine, for the purpose of removing or increasing, the Plan Maximum of $2,000,000 for all of the BGSU medical benefit plan choices. (See Health Care Task Force Recommendation 16 and Appendix C)

3. The Insurance Committee should continue the work of the ad hoc Health Care Task Force and engage in strategic long-range planning to contain health care costs and, at the same time, maintain or improve the quality of health care benefits for BGSU employees.

4. The Central Administration and Insurance Committee should reevaluate the proposed limits on mental health benefits and reexamine the proposed Employee Assistance Program (EAP) as a gatekeeper and monitor of mental health care benefits. (See Health Care Task Force Recommendations 11 and 13)

5. Health care coverage or benefits and cost to the employee should be the same for all employee groups-- faculty, administrators, administrative staff, and classified staff.

6. Access to additional health care coverage, such as family dental care, should be equally available to all employee groups-- faculty, administrators, administrative staff, and classified staff. (See Health Care Task Force Recommendation 14)

7. Employee contributions for family and dependent coverage should vary, depending on the number of dependents claimed by the employee. (See Health Care Task Force Recommendation 18)

8. Health care dollar benefit limits, such as "Usual, Customary and Reasonable (UCR)" medical benefit limits, should be reviewed and adjusted annually, in step with changes in the appropriate health care price index.

9. Implementation of the Recommendations of the Health Care Task Force shall not result in any net increase in BGSU administrative costs, nor any net additions to administrative or classified staff.

FWC 10/13/92
FACULTY SENATE COMMENTS AND SUGGESTIONS ON THE HEALTH CARE TASK FORCE REPORT TO THE PRESIDENT

Last summer, President Olscamp sent a copy of the Health Care Task Force Report to the Faculty Welfare Committee with the charge to make "... comments and suggestions concerning the report." The FWC examined the report, made the following comments and suggestions concerning it, and requested that they be adopted by the Faculty Senate and transmitted to the President and the Board of Trustees for their final approval.

At its on-call meeting on October 20, 1992, the Faculty Senate approved and adopted the following comments and suggestions of the Faculty Welfare Committee on the Health Care Task Force Report and hereby transmits them to the President and the Board of Trustees for their final approval and implementation.

1. We do not approve of the policy of shifting health insurance costs to employees; it results in cutting their take-home pay. The Central Administration should develop more creative and effective strategies to control health care costs without reducing benefits. Examples include consumer education, preventive medicine, early detection, wellness programs, better purchasing and utilization of health care services, PPO's, HMO's, and the like.

2. The Central Administration should reexamine, for the purpose of removing or increasing, the Plan Maximum of $1,000,000 for all of the BGSU medical benefit plan choices. (See Health Care Task Force Recommendation 16 and Appendix C)

3. The Insurance Committee should continue the work of the ad hoc Health Care Task Force and engage in strategic long-range planning to contain health care costs and, at the same time, maintain or improve the quality of health care benefits for BGSU employees.

4. The Central Administration and Insurance Committee should reevaluate the proposed limits on mental health benefits and reexamine the proposed Employee Assistance Program (EAP) as a gatekeeper and monitor of mental health care benefits. (See Health Care Task Force Recommendations 11 and 13)

5. Health care coverage or benefits and cost to the employee should be the same for all employee groups -- faculty, administrators, administrative staff, and classified staff.

6. Access to additional health care coverage, such as family dental care, should be equally available to all employee groups -- faculty, administrators, administrative staff, and classified staff. (See Health Care Task Force Recommendation 14)

7. Health care dollar benefit limits, such as "Usual, Customary and Reasonable (UCR)" medical benefit limits, should be reviewed and adjusted annually, in step with changes in the appropriate health care price index.

8. Implementation of the Recommendations of the Health Care Task Force shall not result in any net increase in BGSU administrative costs, nor any net additions to administrative or classified staff.

10/20/92
MEMORANDUM

TO: Paul J. Olscamp
President

FROM: Marilynn F. Wentland
Secretary, Faculty Senate

DATE: October 26, 1992

RE: Faculty Senate Comments and Suggestions on the Health Care Task Force Report to the President

Attached is a copy of the comments and suggestions of the Faculty Welfare Committee on the Health Care Task Force Report approved and adopted at the Faculty Senate On-Call Meeting of September 20, 1992.

Please let me know if you have questions about any of the items on the list.
BOWLING GREEN STATE UNIVERSITY
Review of Health Care Task Force Recommendations
and
Plan Design Review

• PLAN DESIGN AND COST MANAGEMENT CONSIDERATIONS

• TASK FORCE RECOMMENDATIONS

• CONSTITUENCY GROUP RECOMMENDATIONS
  o Faculty Welfare Committee
  o Administrative Staff Council
  o Classified Staff Council

• FINANCIAL/ADMINISTRATIVE CONSIDERATIONS
PLAN DESIGN AND COST MANAGEMENT CONSIDERATIONS

- Fundamental problems with the current health care plan relate to the current reimbursement methodology for hospitals and physicians and the lack of any significant cost management programs.

- The University has been a payor rather than purchaser of health care services.

- In order to pro-actively manage its health care costs, the University must redirect its thinking to becoming a purchaser of health care services.

- The current plan reimburses hospitals based upon the hospital's average semi-private room rate and reasonable and customary fees for certain ancillary services. This provides no meaningful control over the cost of services and subjects the University to cost shifting from other third party payors.

- The current plan reimburses physicians according to reasonable and customary fee levels. This also provides no meaningful control over the cost of services and subjects the University to cost shifting from third party payors.

- The use of employee contributions as a cost control mechanism does not reduce the group's total health care costs, but only impacts the allocation of costs between the University and the employee.

- Reasonable levels of employee contributions should be encouraged for all coverages to control duplicate coverage and to involve the employee in the cost equation.

- The University must pursue either plan design (i.e. dollar limits, scheduled benefits) or purchasing strategies (i.e. direct contracting, purchasing coalitions, PPOs or HMOs) in order to bring its reimbursement levels under control. See attached Exhibit I on the increase in per diem hospital costs from 1991 to 1992.

Note that the average cost per day at the University’s top three hospitals increased by 35.9%, 29.9%, and 43.4% respectively. The average cost per day at the University’s fourth largest volume hospital increased by over 200%.
Average length of stay also increased in each of the top three hospitals and remained the same in the fourth ranked hospital.

- Efforts at introducing managed care strategies into the University's benefit plans must address not only price, but quality and utilization management issues as well. Evaluation and selection of health care providers as participants in a managed care program must be made on the basis of quality and commitment to long term cost management. Selection of health care providers on the basis of price alone exposes the University to significant potential liability from negligent actions by these health care providers. Objective criteria must be established and appropriate due diligence must be able to be demonstrated to insulate the University from potential liability.

Third party liability issues associated with contracting with health care providers should be reviewed with the University's legal counsel before proceeding.

- Consideration should be given to re-orienting the current or proposed plan designs to provide for early intervention in the disease process through the use of fixed dollar co-pays in lieu of increasing deductible and co-insurance levels, in regards to primary care services.

**TASK FORCE RECOMMENDATIONS**

1. The current system of self-insurance lacks controls necessary to manage costs in today's environment. The health care plans need to be re-oriented to introduce significant management of care methods in order to continue a self-insured funding approach. Failure to introduce controls on the current self-insured plan will result in continued unchecked increases in cost.

2. The use of alternative plan choices can be effective in maximizing employee satisfaction. The University should target its contribution level based upon the most cost effective plan and allow employees to "buy up" to more costly plans, if desired.

3.-7. These recommendations should be pursued, however, a co-pay requirement should be instituted for generic drugs.

8. Based upon the data reviewed by Burns-Wender & Company, we have no recommendation regarding an optimal vision program for the University.

9. The use of a flexible spending account to permit employees to pay out-of-pocket health care costs with pre-tax dollars represents no design or technical problems for implementation and should be expected to be well-received by employees.
deductibles for primary care intervention is appropriate as noted in our earlier recommendations but must be balanced with other cost considerations and affordability at this point in time for the University.

The Administrative Staff Council also recommended that the plans should have a low percentage co-payment with a high limit so that employees have an incentive to limit the costs of most levels of care. We believe the utilization of a co-pay requirement for primary care services can adequately address the access/early intervention objectives of the Task Force and constituency groups. For other services, however, we believe the use of a co-insurance percentage lower than the current 20% requirement does not provide adequate participation by the employee in the cost of services.

The other recommendations of the Administrative Staff Council have been addressed through our comments on the Task Force Recommendations or represent policy considerations for the University which are outside of the scope of this review.

Classified Staff Council

The Classified Staff Council recommended indexing deductible and co-payment levels based upon salary. The indexing of deductibles and co-pays is a cost allocation issue. Employee benefits have traditionally been provided equally to employees regardless of salary levels. Indexing deductibles and co-payment levels based upon salary does, however, present significant administrative complexities and can be expected to increase the administrative cost of the program.

The Classified Staff Council also recommended that the University's health care plan should provide more benefits oriented towards "wellness" and prevention. We are supportive of efforts to cover wellness and prevention oriented benefits such as well baby care, well child care, and health screenings such as pap tests, mammograms, blood pressure and cholesterol. Short term cost implications may, however, force a delay in the implementation of these programs.

The other recommendations of the Classified Staff Council are either covered by our comments on the Task Force Recommendations or represent policy considerations for the University which are outside of the scope of this review.
CONSTITUENCY GROUP RECOMMENDATIONS

Faculty Welfare Committee

- The Faculty Welfare Committee recommended that employee contributions should vary based upon the number of dependents; i.e., the University should utilize multi-tier rates in lieu of the current single/family rating methodology. We believe this begins to more accurately allocate the cost among employees based on a closer approximation of actual utilization. However, in order to be cost neutral to the University, a movement to three or more tiers in the rating structure will require an increase in the current family rate.

- The Faculty Welfare Committee also recommended increasing or removing the current $1,000,000 maximum benefit. Raising this cap above $1,000,000 limits the accessibility of adequate reinsurance to the University based upon the availability of stop loss reinsurance protection. Reinsurance amounts in excess of $1,000,000 up to $2,000,000 per person are available although from a limited market. The accessibility of reinsurance amounts in excess of $2,000,000 per person are even more limited and further restrict the University's ability to obtain reinsurance coverage at affordable rates.

It is our understanding that the University administration has already increased its individual plan maximum from $1,000,000 to $2,000,000 through the plan's current reinsurer.

- The Faculty Welfare Committee recommended that UCR limits should be adjusted annually in step with changes in the appropriate health care price index. UCR limits are a reflection of the charge patterns of providers in a specific region. UCR limits are currently updated at least every six months by the University's third party administrator.

- In general, the remaining recommendations of the Faculty Welfare Committee have been addressed in our comments on the Task Force Recommendations or represent policy considerations for the University which are outside of the scope of this review.

Administrative Staff Council

- The Administrative Staff Council recommended that the plans should apply no deductible at all to encourage employees to seek early treatment. We believe that the employee must remain part of the "cost equation" in order to be a valid participant in the purchasing of health care services. We believe the waiver of
participation in this plan due to the lower contribution requirement. While this effectively protects the employee in large claim situations, it also places a financial barrier ($500 deductible) on the employee's access to primary care.

We would also urge under Plans B and C that the emergency accident benefit be modified from a first dollar benefit to provide for a $50 co-pay for hospital emergency room services and a $25 co-pay for urgent care and physician office visits resulting from an emergency accident or illness, up to a maximum benefit of $300 - 500.

Diagnostic, x-ray, and lab services should continue to apply to the deductible and co-insurance under Plans B and C, rather than provide a $500 first dollar benefit. In the alternative, the University may provide for an outpatient diagnostic benefit at the Plan's 80% co-insurance level without application of any deductible requirement. This benefit should be applied to the first $500 in diagnostic charges after which the Plan's deductible and co-insurance limits would apply.

Consideration should also be given to the introduction of a primary care physician co-pay (i.e., Pediatrician, Ob-Gyn, Family Practice, Internal Medicine) in lieu of applying the plan's deductible and co-insurance requirements for these services. This benefit could be priced to provide an equivalent value to a targeted cost level in Plan A, Plan B, etc.

The implementation of wellness and prevention plan design features (i.e., well baby care, well child care, and health screenings) may be considered in conjunction with the other plan design changes proposed. The cost of these additional benefits should be evaluated in light of the cost savings requirements of the University.

17.-20. These recommendations are primarily policy decisions for the University, however, we encourage all of the University's efforts to educate its employees about their current health care plans and support a health promotion program.
There will be an additional cost which typically will range from $2.50 to $3.50 per employee per month for administration of the flexible spending account which needs to be factored into projected 1993 costs.

10. The proposed changes in chiropractic services are reasonable and consistent with appropriate management of chiropractic services and costs.

11.-13. The proposed changes in mental health benefits are reasonable and appropriate in regards to management of inpatient and outpatient mental health services. We would recommend that all three recommendations be combined into an integrated program and that outpatient benefits be expanded from their current $550 maximum only through the use of a gatekeeper model.

14. We have assumed no changes in the present dental plan. Enclosed is Exhibit II, which shows the cost of extending family dental coverage to contract employees as well as the reduction in cost associated with the elimination of family coverage for classified employees.

15. Pre-certification of hospital admissions should be implemented as a defensive mechanism. More important is the development of a case management program to be operated in concert with the pre-certification program. Note that the quality and effectiveness of pre-certification and utilization management programs can vary significantly. Considerations regarding third party liability of the University should also be taken into account in selection of a utilization management vendor. Criteria should be established and alternative vendors evaluated before entering into an agreement for utilization management services.

16. The use of three plans under a flexible benefit plan scenario is appropriate and provides a greater range of choice to employees. We would, however, urge that the proposed Plan B maintain the same deductible and co-pay requirements as Plan A to ease the transition from the basic major medical Plan A to the comprehensive major medical Plan in Option B.

The use of a $200 deductible under a comprehensive major medical plan design as proposed under Plan B will significantly discourage employees from participating in Plan B and also limits the employee’s access to primary care services due to the $200 deductible. We find this inconsistent with the task force’s general recommendations regarding early intervention and prevention.

Consideration should also be given to modifying Option C to represent the $200 - $250 deductible plan alternative. The current Option C, which is designed to be a “catastrophic” plan may also appeal to lower paid employees who may elect
FINANCIAL/ADMINISTRATIVE CONSIDERATIONS

- Administrative costs for period ended 8/31/92 which totalled 2.36% of claims are within a relevant range for group of BGSU's size and reflect the efficiency of the current administrative arrangements.

- Reinsurance costs for period ended 8/31/92 totalled 2.17% of claims and are within a relevant range for group of BGSU's size. Note that reinsurance costs will vary among employers based upon level of risk transference/assumption.

- Savings associated with change from a basic major medical to a comprehensive major medical plan were "modeled" at 11.0%. This included a change in deductible from $100 to $200, representing approximately 4.0% in savings. Net savings attributable to a change to a comprehensive plan should be 6.0%-7.0%.

- Net savings attributable to a change in deductible should be 4.0%.

- No review of efficiency of the prescription drug plan was undertaken (i.e., ingredient reimbursement levels, dispensing and administrative fees).
### Exhibit I

**Bowling Green State University**

**Major Hospital Inpatient Facility Charges**

<table>
<thead>
<tr>
<th>Location</th>
<th>Total Hospital Days</th>
<th>Total Charges Paid</th>
<th>Average Charge/Day</th>
<th>ALOS</th>
<th>Total Hospital Days</th>
<th>Total Charges Paid</th>
<th>Average Charges/Day</th>
<th>ALOS</th>
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</thead>
<tbody>
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<td>Wood County</td>
<td>828</td>
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<td>$627</td>
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<td>699</td>
<td>$595,301</td>
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<tr>
<td>Toledo</td>
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<td>232,401</td>
<td>1,086</td>
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<td>490,963</td>
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<td>615</td>
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<td>1,171</td>
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<tr>
<td>St. Charles</td>
<td>37</td>
<td>32,824</td>
<td>887</td>
<td>4.63</td>
<td>107</td>
<td>84,752</td>
<td>792</td>
<td>9.73</td>
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<tr>
<td>Flower</td>
<td>39</td>
<td>31,134</td>
<td>798</td>
<td>4.33</td>
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<td>NA</td>
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<tr>
<td>Blanchard Valley</td>
<td>28</td>
<td>29,503</td>
<td>1054</td>
<td>2.55</td>
<td>32</td>
<td>25,662</td>
<td>802</td>
<td>3.2</td>
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</table>
EXHIBIT II
BOWLING GREEN STATE UNIVERSITY

Dental Coverage Options
Cost/Savings

Projected 1993 Rates

<table>
<thead>
<tr>
<th>Assumed Employee Census Breakdown</th>
<th>Premium Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract S = 563 F = 567</td>
<td>$24.53</td>
</tr>
<tr>
<td>Classified S = 285 F = 593</td>
<td>68.44</td>
</tr>
</tbody>
</table>

Cost to provide family dental protection to all contract employees (Administration and Faculty):

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<thead>
<tr>
<th></th>
<th>Projected</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per Month</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>Cost</td>
<td>Cost</td>
</tr>
<tr>
<td>S = 479</td>
<td>$11,750</td>
<td>$140,998</td>
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<td>F = 609</td>
<td>41,680</td>
<td>500,160</td>
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<tr>
<td></td>
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<td>$641,158</td>
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Projected additional cost = $308,531

Savings projected if only single dental coverage offered to all classified employees:

<table>
<thead>
<tr>
<th>Actual Dental Cost</th>
<th>Projected Dental Cost</th>
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</thead>
<tbody>
<tr>
<td>Per Month</td>
<td>Per Month</td>
</tr>
<tr>
<td></td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>S = 285</td>
<td>$ 5,723</td>
</tr>
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<td></td>
<td>$ 68,674</td>
</tr>
<tr>
<td>F = 593</td>
<td>33,172</td>
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<tr>
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<td>398,069</td>
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</table>

Projected Savings = $255,180
EXHIBIT 3

COMPREHENSIVE MEDICAL (PLAN B)

DEDUCTIBLE (calendar year) $100 Individual
$300 Family

ANNUAL OUT OF POCKET LIMITS $1000 Individual
$3000 Family

Co-insurance 80%/20%: Plan pays 80% of usual, customary and reasonable charges.

All charges would be subject to deductible and co-insurance with the following exceptions:

Charges for emergency treatment for accidental injury (physician's office or emergency room) are paid at 100% of UCR after following co-payments are made by insured:

- $50.00 Hospital emergency room
- $25.00 for physician's office or urgent care center

Lifetime maximum $2,000,000 (per individual)

Benefits limited for mental illness, chemical dependency and chiropractic services.

Pre-admission notification required

Voluntary second surgical opinion benefit

11/19/92

ja
MEMORANDUM

TO: Paul J. Olscamp  
    President

FROM: Chris Dalton  
    Vice President for Planning & Budgeting

Bob Martin  
    Vice President for Operations

Gaylyn Finn  
    University Treasurer

John Moore  
    Executive Director Personnel Services

Jim Morris  
    Manager, Benefits

RE: Proposed Restructuring of University Health Care Benefit Plan

March 8, 1993

As you know the report of the Health Care Task Force presented a series of recommendations for restructuring the BGSU Employee Health Care Benefit Plan (see Appendix I for a full copy of the Task Force Report). Their recommendations have subsequently been reviewed by Faculty Senate, Administrative Staff Council, and Classified Staff Council and their respective welfare committees. The Task Force recommendations along with the comments on the recommendations provided by the constituent groups were then forwarded to an outside benefits consultant, Craig Burns of Burns-Wender, for his evaluation. Finally, the University Insurance Committee reviewed the Health Care Task Force report and the comments of all three constituents groups and the external consultant. The written feedback from all of these on-campus groups as well as from Mr. Burns can be found in Appendix II.

All the materials noted above have most recently been carefully reviewed by an ad hoc group consisting of the authors of this memo. That ad hoc review has resulted in the development of the enclosed BGSU Health Care Proposal (Exhibit A) which recommends a significant restructuring of the current health care benefit plan for BGSU employees. Our proposal follows the basic thrust and in many cases the specifics of the Health Care Task Force recommendations. In several cases, however, we have modified Task Force recommendations, primarily in response to comments and concerns provided by the constituent groups, the Insurance Committee and Craig Burns. Specific cases where our recommendations differ significantly from the Task Force recommendations will be noted below.
Beginning with efforts to reduce plan costs, we recommend adopting in their entirety four of the five cost savings steps recommended by the Health Care Task Force. These four recommendations include (with the projected annual savings in parentheses): changing the prescription drug plan ($90,000); replacing the current university-funded vision plan with an optional vision plan covered by employee premium contributions ($60,000); implementing a cap on mental health and substance dependency, an employee assistance program, and utilization review ($85,000); and implementing a cap on chiropractic care ($43,000). The estimated annual savings from these changes total $282,000, approximately 3% of the cost of our total health care costs for 1991-92. We are recommending some modification of the fifth cost savings step recommended by the Health Care Task Force, which was an increase in employee coinsurance and deductibles projected to reduce claims costs paid by the program by more than $720,000 per year.

The Task Force proposed that our current first dollar coverage health care plan be replaced by a program under which employees would have the option of choosing from three different health care plans. Quoting from the Task Force report, "The plans will vary as to the type of deductibles and coinsurance; the types of coverage will be the same for all three plans. Plan A will have the current deductibles and coinsurance for major medical. Plan B and C will be comprehensive plans with an 80% coinsurance on most medical costs. Plan B will have a $200/$400 (individual/family) deductible with a maximum out-of-pocket cost of $1,000/$2,000. Plan C will have a $500/$1,000 deductible with a maximum out-of-pocket cost of $1,500/$3,000."

It was the Task Force's hope that Plan B (their "base plan") could be offered to employees without an increase in the existing employee premium contribution. Employees selecting Plan A would pay all of the additional costs of receiving this coverage through higher employee premium contributions. Employees selecting Plan C would benefit through lower employee premium contributions (or contributions to their 125 Plan) from the savings to the plan associated with the higher deductible and coinsurance. The Task Force report noted that there was disagreement among Task Force members on whether or not Plan C "should be offered as an alternative."

The enclosed BGSU Health Care Proposal (Exhibit A) retains the three plan option approach recommended by the Task Force, including one option which would retain the first dollar coverage features of the current system (Plan I which corresponds to Plan A in the Task Force recommendations). Our Plans II and III differ from Plans B and C recommended by the Health Care Task Force primarily in the level at which the deductible and out-of-pocket maximum contribution limits are set. These differences reflect the recommendation of the external consultant that employees would be much more likely to make the desired shift from the existing first dollar coverage plan to a comprehensive medical plan if the comprehensive plan maintained the same deductible and out-of-pocket maximum payment limits as the existing plan. For this reason, our Plan II retains the $100 per person annual deductible and $1,000 per person annual maximum out-of-pocket limits that are part of both our current plan and the Plan I option.
Plan III is, in one sense, similar to the Task Force's Plan C in that it offers an option with higher deductible and out-of-pocket maximum levels than the other two options and thus features the lowest employee premium contribution. The deductible proposed in Plan III is $200 per person or $600 per family, with the out-of-pocket maximum payment being $1000 per person and $3000 per family. (Our current plan, and Plans I and II above, do not have a family deductible limit or a family maximum out-of-pocket payment limit.) There is another feature of Plan III, however, which was strongly recommended by the health care consultant and which makes Plan III quite different from the Task Force's Plan C. That feature is the elimination of the deductible for primary care (e.g. visits to a family practice, internal medicine, OB-GYN, or pediatric physician). Instead of the deductible in these cases there would be a $15 per visit co-pay by the employee. Thus an employee (or covered dependent) opting for Plan III would pay only $15 for a visit to their primary care physician with the plan covering all the rest of the charges up to the reasonable and customary limit. This might reduce the reluctance of some covered individuals to visit a physician in cases where they have not yet paid their deductible. Under our current plan the employee is required to pay the first $100 in eligible charges per covered individual. Under Plan III even the first visit each year to a primary care physician would be covered by the plan except for the $15 co-pay. (This assumes that the total physician charges for the visit don't exceed the reasonable and customary limit.)

As noted in the materials in Exhibit A (BGSU Health Care Proposal), Plan III is recommended to be the "base plan" option with employee premium contributions that are at or below their level with our current plan. As in the Health Care Task Force proposal, employees wishing to retain the first-dollar payment features of our current plan would have to pay the significantly higher employee premium contributions (single and family) in order to cover the cost differential between Plan III and Plan I. Plan II employee premium contributions would be expected to be modestly higher than Plan III premiums, but significantly lower than the employee premium contributions for Plan I.

In one area, our BGSU Health Care Proposal recommends taking a bold step to resolve a problem which continues to be the cause of much divisiveness among employee groups - the differences in health care coverage and employee premium contributions between contract and classified employees at BGSU. Many of the comments of the constituent groups regarding the Task Force recommendations concerned this issue, which was one for which the Task Force did not propose a solution. Our proposal is to move to a university health care program where all full-time employees have the same health care coverage and plan options available to them with no differential between contract and classified staff in their employee premium contributions for single or family coverage.

Accomplishing that goal will require two significant changes. (First, contract employees need to be provided with the same family dental coverage enjoyed by classified staff. (We are assuming that the Task Force recommendations regarding the dropping of our current vision plan and the adoption of an optional vision plan will be implemented, eliminating the difference in vision plans for classified and contract staff.) (Second, the difference
(currently $713 per year) between employee premium contributions for family coverage paid by classified staff ($866) and contract staff ($1579) needs to disappear so that classified and contract staff experience the same premium contribution for family health care coverage.

Equalizing family rates clearly needs to be accomplished, however, in a way which does not disadvantage either employee group. Our proposal is to increase the classified staff employee premium contribution for family coverage so that it equals the premium paid by contract staff, while simultaneously increasing the annual salary paid to full-time fiscal year classified staff members by a comparable amount. (Since this will be done by adjusting the classified pay tables, this will also result in salary increases for part-time and temporary classified staff.) Thus full-time fiscal year classified staff who carry family coverage through the University would experience comparable increases in their salary and their annual health care premium contributions, leaving their “take-home” income approximately the same (assuming their premium contributions are paid through a 125 plan).

A preliminary model of employee premium contributions for Plans I, II and III for 1993-94 assuming the proposal outlined above is adopted is given in Exhibit B (“Health Insurance Costing for 1993-94 - Projections for Plans I, II and III (Assumes Equal Employee Family Rates)”). This model assumes that program claims costs for 1993-94 will increase 10% under Plan I, 4.6% under Plan II and 1.9% under Plan III. The increases are lower for Plans II and III because of the projected savings associated with the changes proposed in these plans. Given an estimated increase of 3% in the University’s contribution next year to the employee health care benefit program, employee premium contributions for 1993-94 for Plans I, II and III are projected to be $516, $369, and $293, respectively for single coverage and $2099, $1735, and $1549 respectively for family coverage. This compares to rates under our current plan, after adjustment for equalization of classified and contract family rates, of $315 for single coverage and $1579 for family coverage.

For the university, the increase in salary for classified staff carrying family health care coverage would presumably be matched by a decrease in the University’s contribution to the cost of providing family health care coverage for these classified staff. That does not mean, however, that there will be no increase in cost to the University aside from the cost of providing family dental coverage for full-time staff. The university will incur additional costs to cover the increased retirement contributions that would accompany the increased salary for classified staff. Also, the increased salary costs for full-time classified staff who do not opt for family health care coverage, as well as part-time classified staff, will increase university wage costs. On the other hand, the incentive to switch family health care coverage to their spouse’s employer would have been significantly increased for classified staff who have that option. Such switches would reduce our health care plan costs.

According to the most recent count from the Benefits Office, BGSU currently employs 922 full-time classified staff who are eligible to participate in our employee health care benefit program. The annual cost of providing a $0.35
per hour increase in wages ($723 per year for full-time fiscal year employees) to these 922 employees would be $671,216. Taking into account PERS contributions (13.31%) increases the projected additional compensation costs to $760,555. However, if we assume that the 585 full-time classified staff members opting for family health care coverage continue to do so, the University's share of family health care premium cost would be reduced $417,105 (585 x $713). (If some classified staff drop their family coverage the savings will be greater.) This reduces the net increase in University compensation costs associated with the proposal to equalize employee premium contributions for family health care coverage to $343,450 ($760,555 in increased salary and retirement costs - $417,105 in savings on employer health care premium contributions). Given a preliminary estimate of approximately $192,000 as the cost of providing family dental coverage for contract staff, the total projected cost for moving to identical health care programs for contract and classified staff is estimated to be approximately $535,000. It should be emphasized that at this point this is a rough estimate involving a number of approximations which will need to be fine-tuned if we decide to move forward with this proposal.

Clearly this proposal is not without cost to the University. It may increase compensation costs by more than $500,000 for the university as a whole, including both educational and auxiliary budgets areas. In the case of the educational budget, which incurs the majority of all university employee compensation costs, the funds currently budgeted for "health care adjustment" costs are more than sufficient to cover the projected increased cost. Although this is a significant cost, we believe that at this point in time, when we are proposing a major restructuring of the University's health care benefit program, we have a unique window of opportunity to accomplish a "leveling of the playing field" with respect to employee health care benefits. Such an action would lead to significantly reduced divisiveness among employee groups while enhancing the environment in which the University and its faculty and staff will deal with future health care issues.

Since our proposal differs in some significant ways from the recommendations of the Health Care Task Force, we recommend that you send our proposal to the Task Force for their review and comment prior to any final decision on implementation.

We would be pleased to respond to any questions or requests for additional information that you might have.
BGSU HEALTH CARE PROPOSAL

The attached documents provide a summary of the plans being proposed for the health care program at BGSU and the costing approach being recommended along with selected other approaches which were considered. The major change from the historical health care benefits package offered by BGSU is the opportunity for the employee to select one of three plans with varied employee contributions based on the option selected. Four significant benefit changes are being proposed, all of which were recommended by the Health Care Task Force and cross all three plans -- the replacement of the current vision benefit with an optional vision insurance program; the modification of the mental health/chemical dependency coverage; the limitation of chiropractic benefits; and the implementation of a non-compliance penalty of $200 where pre-admission certification does not occur. All three plans have a $2,000,000 lifetime maximum per individual as recommended by the constituency groups. The individual characteristics of the three plans are as follows.

Plan I, replicates the current first dollar plan except for the four universal changes noted. Hospital charges for in and out patient services, in-hospital doctor care, surgery, diagnostic tests and lab work would be paid at 100% of reasonable and customary (R&C) with no deductible applied. Other charges would be paid at 80% up to the R&C limit after an individual deductible of $100. The maximum employee expense would remain at $1,000 per person, for charges not exceeding R&C, for the calendar year. As under the existing plan, an employee with three covered dependents could experience up to $4,000 in covered health care cost in a year.

Plan II, is a comprehensive plan where all benefits would be paid at 80% of R&C after a calendar year deductible of $100 per individual. The maximum out-of-pocket per covered individual, for the calendar year, would be $1,000 for charges not exceeding R&C. Employees would pay the first $100 of charges plus 20% of the next $4,500 of charges at or below R&C for a maximum of $1,000. In addition any charges above the R&C limits not subsequently waived by the provider would be the responsibility of the individual. Co-pays would be used instead of deductibles to pay for emergency treatment with a charge of $25 for services at an urgent care center and $50 at a hospital emergency room. Charges above the co-pay would be paid on an 80/20% basis up to R&C.

Plan III, is a comprehensive plan coupled with a primary care program. Primary care services by a primary care physician would be paid in full, with no deductible, up to R&C limits after a $15 per individual co-pay for each visit. Covered services would include charges for the office call, office lab work, injections, and minor in office surgery up to $100. All other benefit charges would be paid at 80% of R&C after a calendar year deductible of $200 per individual. An additional benefit of Plan III would be the implementation of family maximums. The maximum family deductible would be $600. The maximum out-of-pocket expenses per covered individual, for the calendar year would be $1,000 for charges not exceeding R&C. Employees would pay the first $200 of charges and 20% of the next $4,000 of charges (for each covered family member) at or below R&C for a maximum of $1,000 ($3,000 for a family) plus any charges above the R&C limits not subsequently waived by the provider. Co-pays would be used instead of deductibles to pay for emergency treatment with a charge of $25 for services at an urgent care center and $50 at a hospital emergency room. Charges above the co-pay would be paid on an 80/20% basis up to R&C.

Based on the benefit cost of each of the three plans, Plan I would require the highest employee contribution while Plan III would require the lowest contribution. The University's contribution to the cost of each of the plans would be the same.
### PROPOSED SUMMARY OF BGSU MEDICAL BENEFIT PLAN CHOICES
March 5, 1993

#### PLAN I
(Similar to Existing Plan)

**First Dollar Coverage**
- Benefits for hospital charges (inpatient and outpatient), in-hospital doctor care, surgery, diagnostic tests and lab work are payable at 100% of reasonable and customary (R&C)* with no deductible applied.

**Major Medical**
- Other expenses are subject to an 80/20 co-insurance after the calendar year deductible of $100 per person to a maximum out-of-pocket expenditure to the employee of $1,000 per covered family member ($4,500 in eligible charges at 20% plus the $100 deductible; no family limit)
- Additional eligible charges after the initial $1,000 out-of-pocket per person maximum is met are paid at 100% of R&C for the remainder of the calendar year.

Mental illness, chemical dependency, and chiropractic services are limited.

A voluntary second opinion for elective surgery is an eligible expense.

Pre-admission certification non-compliance penalty equals $200

**Estimated 1993-94 Employee Premium Costs**
- Single $516 per year
- Family $2,069 per year

No vision coverage (all three plans)

Lifetime maximum per individual $2,000,000

#### PLAN II

**Comprehensive Medical**
- 80/20 Co-insurance
  - $100 Deductible Per Person (no family maximum)
  - $1,000 Out-of-Pocket Maximum Per Person

All charges are subject to an 80/20 co-insurance of the R&C, after the deductible of $100 is met, until a maximum of $1,000 per family member is paid by the employee ($4,500 in charges at 20% plus the $100 deductible). Eligible expenses beyond the $1,000 out-of-pocket per person maximum is met are paid at 100% of R&C for the remainder of the calendar year.

**Emergency Treatment**
- Charges for accidental injury or the sudden onset of illness are paid at 80/20 after the following co-pays are made by the insured for treatment. Deductible is waived for these services.
  - $50.00 Hospital emergency room
  - $25.00 Urgent care center

Mental illness, chemical dependency, and chiropractic services are limited.

A voluntary second opinion for elective surgery is an eligible expense.

Pre-admission certification non-compliance penalty equals $200.

**Estimated 1993-94 Employee Premium Costs**
- Single $369 per year
- Family $1,735 per year

Lifetime maximum per individual $2,000,000

#### PLAN III

**Comprehensive Medical**
- 80/20 Co-insurance
  - $15 Co-pay for Primary Care (No Deductible)
  - $200/300 Deductible for Other Care
  - $1,000/3,000 Out-of-Pocket Maximum (Per Person, Per Family)

Coverage same as Plan II, except for Primary Care

Primary Care (Office call, office lab, injections, minor in office surgery up to $100)
- $15.00 co-pay/visit to primary care physician (Family practice, internal medicine, pediatrician, and OB/GYN physicians) with no deductible or co-insurance for charges (including the co-pay) up to the R&C limit. Co-pay does not apply to deductible.

**Emergency Treatment**
- Charges for accidental injury or the sudden onset of illness are paid at 80/20 after the following co-pays are made by the insured for treatment. Deductible is waived for these services.
  - $50.00 Hospital emergency room
  - $25.00 Urgent care center

Mental illness, chemical dependency, and chiropractic services are limited.

A voluntary second opinion for elective surgery is an eligible expense.

Pre-admission certification non-compliance penalty equals $500.

**Estimated 1993-94 Employee Premium Costs**
- Single $230 per year
- Family $1,549 per year

Lifetime maximum per individual $2,000,000

---

*Reasonable and Customary (R&C) charges are charges that do not exceed the amount usually charged by most providers in the same geographic area for services or materials taking into account the nature of the treatment or illness. The co-insurance percentage is applied to the reasonable and customary charges after the deductible is met.*
HEALTH INSURANCE COSTING FOR 1993-94

PROJECTIONS FOR PLANS I, II AND III (Assumes Equal Employee Family Rate)

<table>
<thead>
<tr>
<th>1992-93 Rates (Adj.)</th>
<th>CLASSIFIED</th>
<th>CONTRACT</th>
<th>TOTAL ACCRUAL</th>
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</thead>
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<td>Single</td>
<td>Family</td>
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<tr>
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<td>282</td>
<td>585</td>
<td>521</td>
</tr>
<tr>
<td></td>
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<td>1,428,582</td>
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</table>

Projected Costs 1993-94 Assumes University Contribution Increase Is 3.00%

| Aggregate | 860,598 | 4,346,843 | 1,571,440 | 4,153,650 |
| Headcount | 282     | 585       | 521       | 559       |

Project Increase for 93-94

|            | 9,929.5 |

Plan I (Base & Major Medical)

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<th></th>
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<th>Employer</th>
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<th>% Increase</th>
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<td>516</td>
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<tr>
<td>% Increase</td>
<td>63.9%</td>
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<td>63.9%</td>
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Plan II

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</tr>
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<td>% Increase</td>
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<td>9.9%</td>
<td>17.0%</td>
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Plan III

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<tr>
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<td>-1.9%</td>
<td>-6.9%</td>
<td>-1.9%</td>
</tr>
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</table>

BGSU Current

|                      | 684,414    | 3,027,960| 1,264,467         | 2,893,384  |
| BGSU Plan I          | 704,946    | 3,118,799| 1,302,401         | 2,980,186  |
| BGSU Plan II         | 704,946    | 3,118,799| 1,302,401         | 2,980,186  |
| BGSU Plan III        | 704,946    | 3,118,799| 1,302,401         | 2,980,186  |

Employee Current

|                      | 86,830     | 923,715  | 164,115           | 882,661    |
| Employee Plan I      | 145,622    | 1,228,044| 269,039           | 1,173,464  |
| Employee Plan II     | 103,944    | 1,015,048| 192,039           | 969,935    |
| Employee Plan III    | 82,680     | 906,377  | 152,753           | 866,094    |

Prop B 3/3/93 3/8/93
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<tr>
<td>Dental</td>
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<td>Vision</td>
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<table>
<thead>
<tr>
<th>SAVINGS:</th>
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<tbody>
<tr>
<td>PCS - MAC (AWP - 10%)</td>
<td>90,000</td>
<td>90,000</td>
<td>90,000</td>
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<tr>
<td>Vision</td>
<td>67,000</td>
<td>67,000</td>
<td>67,000</td>
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<tr>
<td>Comprehensive 80/20 (6.0%)</td>
<td></td>
<td>429,000</td>
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<tr>
<td>Mental Health (Net of EAP $60,000)</td>
<td>85,000</td>
<td>85,000</td>
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<td>Chiropractic limitations</td>
<td>40,000</td>
<td>40,000</td>
<td>40,000</td>
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<tr>
<td>Increased Deductible (4.0%)</td>
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<td></td>
<td>286,000</td>
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<tr>
<td>$15 co-pay Primary Care</td>
<td></td>
<td></td>
<td>-72,000</td>
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<tr>
<td><strong>Total Savings</strong></td>
<td><strong>282,000</strong></td>
<td><strong>711,000</strong></td>
<td><strong>925,000</strong></td>
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<table>
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<th>Net savings off of revised basic plan</th>
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<tr>
<td></td>
<td>429,000</td>
<td>643,000</td>
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<th>Revised Costs</th>
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<tr>
<td></td>
<td>8,718,000</td>
<td>8,289,000</td>
<td>8,075,000</td>
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Net savings off of revised basic plan: 429,000 (4.9%) 643,000 (7.4%)

Revised Costs:

- BASIC: 8,718,000
- COMPI: 8,289,000
- COMP II: 8,075,000

Prop B 3/3/93 3/3/93
May 4, 1993

Dr. Paul Olscamp
McFall Center

Dear Dr. Olscamp:

We write this letter upon the recommendation of Mr. John Moore, Executive Director of Personnel Services.

We understand that the proposed changes in health care options for university employees will soon be presented to the Board of Trustees. In conjunction with that process, we ask that appropriate persons review what appears to be a matter of inequity with regard to the university's contribution to employee health costs. Explicitly, we are concerned that the university discriminates against contract employees where both work at EGSU (see attached partial list) in the level of its financial support for health care coverage.

Prior to the change in employee contributions in 1991, the University was equitable in its contributions for families in cases where both spouses were employed at EGSU. Rather than insure each partner as a single employee, couples were treated as a family (regardless of whether or not they had children). One spouse was named 'head of household' and the other spouse was listed as the 'dependent.' The University's contribution for employees in this situation recognized each person as a separate employee and gave the benefits due any single employee, even though the University treated them administratively as a family.

For the past two years, however, the University's level of contribution to medical coverage for dual-career EGSU couples has been reduced. Married EGSU employees currently pay the same for family coverage as single employees carrying family coverage. The attached cost sheet from the Benefits Office bears this out. Every employee at EGSU pays the same for family medical coverage, even when two parties in the family are employed here. If the University were to contribute the same dollar amount for family coverage based on the number of persons employed at EGSU, then the dual-career EGSU couple would receive double the university contribution it is now receiving and would no longer be treated inequitably because of their marital status. As long as this situation is allowed to continue, a number of university employees are being disadvantaged, and the university could quite innocently be guilty of discriminating in fringe benefits based on marital status.

We ask that attention be paid to the issue described above. Discussion with Mr. Moore and Mr. Morris and subsequent discussions of this matter with the Task Force on Health Care led to the recommendation that it be addressed to you.

Sincerely,

Deborah Vetter
Career Planning and Placement Services

Diane Regan
College of Arts and Sciences

Michael Vetter
Assistant Vice President for Student Affairs

Scott Regan
Professor of Theatre

Enclosures

c: Mr. J. Moore
## EXAMPLES*

### CURRENT Single Contract Employee
- Estimated Annual BGSU Cost of Single Medical Care Insurance Coverage: $1,000
- BGSU Benefit Contribution Per Employee: 500
- BGSU Employee Contribution: 500

### CURRENT Family Coverage (1 BGSU Contract Employee)
- Estimated Annual BGSU Cost of Family Medical Care Insurance Coverage: $2,000
- BGSU Benefit Contribution Per Employee: 500
- BGSU Employee Contribution: 1,500

### CURRENT Family Coverage (2 BGSU Contract Employees)
- Estimated Annual BGSU Cost of Family Medical Care Insurance Coverage: $2,000
- BGSU Benefit Contribution for One Employee Only: 500
- BGSU Employee Contribution: 1,500

### EQUITABLE Family Coverage (2 BGSU Contract Employees)
- Estimated Annual BGSU Cost of Family Medical Care Insurance Coverage: $2,000
- BGSU Benefit Contribution Per Employee ($500 each employee): 1,000
- BGSU Employee Contribution: 1,000

*These dollars amounts are hypothetical and are used for illustrative purposes only. The examples apply to medical coverage only and do not apply to vision or dental costs.
BGSU Full-time Contract Employees

Behling, Orlando and Dorothy
Bissland, James and Joan
Blinn, Elliot and Joyce
Browne, Neil and Kubeck, Nancy
Brownell, Greg and Nancy
Bunce, Mark and Tina
Campbell, Don and Kathy
Champion, Ernest and Peace
Colvin, Wayne and Cindy
Crocker, Ken and Petroshius, Susan
Darrow, Art and Susan
Gerwin, William and Elaine
Grant, Bill and Crowell, Claudia
Gromko, Mark and Eastlund, Joyce
Gruber, John and Susan
Jones, Eric and Akiko
Keeley, Stuart and Barbara
Kepke, Allen and Joyce
Kim, Kyoo and Younghee
King, Timothy and Patricia
Kisabeth, Scott and Denise
Lab, Steven and Susan
Lancaster, Ron and Ann-Marie
Locey, Michael and Lenita
McRoberts, Conrad and Gail
Midden, Robert and Suzanne
Mohr, Steven and Kennedy, Ann
Morgan, Ed and Joan
Navin, Leo and Joanne
O'Donnell, Ed and Amy
Olscamp, Paul and Ruth
Parmer, Jess and Coleen
Paul, Jeffrey and Ellen
Peper, Richard and Christine
Pinto, Peter and Lorna
Porter, Adam and Jakobs, Elizabeth
Pugh, Med and Susan
Ragusa, Don and Yarris, Betty
Redmond, William and Merritt, Nancy
Ritts, Blaine and Mary Helen
Reed, Robert and Patricia
Regan, Scott and Diane
Swanson, Kory and Margy
Thomas, Jack and Darlene
Tisak, John and Marie
Veitch, Russell and Janet

Vetter, Mike and Deborah
Wahrman, Ralph and Judy
Whitmeyer, Duane and Diane
Wood, Florida and Bess
Yon, Paul and Bowers, Ann
MEMORANDUM

TO: Bob Martin, Vice President of Operations

FROM: Bob Kreienkamp, Chair

RE: New Health Care Option #3

After carefully reviewing the insurance plan information distributed to all employees and called to my attention by many people, I want to pass along some areas of concern that need to be addressed by the powers that be.

It was my understanding that plans 2 and 3 were included to provide some incentive for employees to switch from the more expensive present first dollar plan. Since I have been on the Health Task Force since its inception, I also believe that the rest of the Task Force has labored under this assumption. The late changes made in the alternatives, in particular plan 3, have had the exact opposite effect and I believe forces the employee to remain in plan 1.

Example 1: **EMERGENCY CARE.** The changes for ER or the urgent care treatment in plan 3 indicates these charges are only paid if the $200 deductible has been previously met. If you take your dependent to the emergency room on January 3, 1994 under plan 3, you will have to pay $250 out of pocket before the policy covers 80% of additional R & C charges. That alone pretty much wipes out any cost incentive to change from our present plan. This was not originally in the plan. Why was it changed and by whom???

Example 2: **MATERNITY CARE.** Does the $15 co-pay apply to each visit (12 visits at $15 per visit = $180) and is the remainder of the bill paid at 80% or 100% since it is primary care? It is possible for an employee to have to spend an additional $650 on maternity care in plan 3 as opposed to plan 1. (This figures an average bill of $1,600 maternity charge.) Once again, we have destroyed any incentive for employees to change from the more expensive plan 1.

Example 3: **PREVENTIVE CARE.** The information seems to say that the employee pays the $15.00 co-pay and the rest is paid for by insurance. Apparently this is not the case. In plan 3 the employee has to pick-up the entire cost of the office visit (approximately $40 plus $15 toward the cost of the mammogram and the pap smear or the colon cancer test). There is no monetary incentive to get any of these tests done until it is labeled as a diagnostic test and a much bigger share of it will be covered.
I am also concerned with the explanation of the cost of vision care for family coverage. The information sheets state the policy is $21.98 per month, but if employees are going to have to pay the total of $263.76 in 8 months, the cost goes to $32.97 a month. If employees who sign up for the VSP plan (which I happen to think is a good plan for most families) and realize their paycheck deductions are higher than they had planned it will cause a great deal of concern. I know the Benefits Office telephones will be ringing with employees with the question WHY???

These are just some of the many examples of problems associated with the changeover to the new plan that should have gone much smoother given the amount of time we had to do it right. In many cases I am afraid it will just cause the faculty and staff to look suspiciously at the administration, again just the exact opposite effect of what we would hope for when future changes are looked at during phase two of the Task Force.

Now we are rushing around to provide some answers that should have been answered quite awhile ago and employees are making a decision based on incomplete and inaccurate information. Again, I am concerned that these changes have totally destroyed any incentive for employees to change plans away from the most expensive insurance plan we now have.

These problems would never have occurred if late changes were not made and proper explanations for questions concerning these changes had been prepared by those who made the changes. The lack of proper foresight on the part of somebody seems very evident.

Due to the approaching November 15th deadline, I would appreciate your immediate attention to this matter. I am available to further discuss this issue in a timely manner.

cc: President Olscamp
    Ad Council
    Board of Trustees
    Health Care Task Force
TO: Members of the Insurance Committee, Faculty Senate Welfare Committee, Norma Stickler, Chair, Personnel Welfare Committee and Randy King, Personnel Welfare, Classified Staff Council

FROM: Don Boren, Chair

RE: Health Care Goal Setting

DATE: November 23, 1993

Perhaps the only certainty in employee health plans is that the plans will change; and if cost continue to escalate at twice the rate of inflation, the change will be painful. I believe that the best plans, in both quality and cost, will be provided by employers who establish long range goals and are structured to accomplish these goals. In an institution, such as the University, this requires a broad consensus as to the goals and plans for achieving them.

The Task Force hopes to take the first step in university-wide goal setting by engaging in a very intense awareness building session. This session will be held from 9:00-3:30 on December 15th & 16th in the College Park classroom.

Mr. Bill Hembree, the Director of the Health Research Institute, will be helping us in this endeavor. As you can see from the attached biographical profile, Mr. Hembree, is a recognized authority in this area.

Since this subject is of such importance to all of us, we are inviting all members of the Insurance Committee, the Faculty Senate Welfare Committee, and representatives of the Administrative Staff and Classified Staff Councils to participate.

In order to assure proper seating, please RSVP to the Department of Legal Studies by December 10, 1993. Please contact me if you know of other individuals or groups that you believe should be invited.

DB:pw

Encl:

xc: Paul Olscamp, President
    Chris Dalton, Vice-President
    Planning & Budgeting
    Bob Martin, Vice-President
    Operations
    Ben Muego, Chair
    Faculty Senate
    Greg Jordan, Chair
    Administrative Staff Council
    Bob Kreienkamp, Chair
    Classified Staff Council
BIOGRAPHY

William E. Hembree

William E. Hembree is the Director of Health Research Institute in Walnut Creek, California. He has held this position since founding HRI in 1978.

HRI is a non-profit, independent and objective, research-based organization providing health care cost containment and health improvement policy planning and implementation assistance, research, health education, data collection and analysis, and communications services to major private and public employers, unions, and coalitions.

Mr. Hembree received his BA and MBA from California State University at Long Beach. Since his graduation, he has held management positions with a major group insurance company, the nation's oldest Health Maintenance Organization, and Hewitt Associates, a compensation and benefits consulting firm.

As Director of HRI, Mr. Hembree is responsible for overall direction, development, and management of Health Research Institute's activities. He was instrumental in developing the nation's only 1,500 largest U.S. employers biennial survey of health care cost containment actions. Also, under his guidance HRI has developed an analytic process used to help focus employers' scarce resources on their specific cost and utilization problems, health education newsletters, and employers' NEWS service, various workshops on cost containment, and a cost-benefit approach to health promotion, prevention, and wellness.

His work includes assessments of alternative delivery systems, evaluation of results of specific cost containment/health improvement actions, innovations in the use of health care anti-economics to control costs, and the development of coalitions and other joint employer- and community-based efforts to halt spiraling medical care costs.

During Mr. Hembree's nearly 25 years of experience in the health and employee benefits field, he has advised major employers and coalitions across the U.S., served as a director for public service and private industry organizations, and has conducted legislative review and extensive research into the most cost-effective ways to contain costs and improve employee health.

In recognition of his accomplishments, Business Insurance magazine named Mr. Hembree as one of twenty individuals who have had the most significant influence on employee benefits in the U.S. over the past twenty years (1968-1988).

Mr. Hembree is an active writer and frequent speaker on innovative and cost-effective health care cost containment and health improvement techniques. His most recent book is entitled Breakthroughs in Health Care Management: Employer and Union Initiatives.
Administrative Staff Council Recommendations on
the Health Care Task Force Proposal

Overall recommendations:
1. Health care coverage, cost to employee, and cost to the University should be the same for all employee groups.
2. Access to additional coverage (such as family dental care) should be the same for all employee groups.
3. There should be differential employee cost based on whether the employee takes single, dual, or family coverage.
4. Modest co-payments rather than benefit curtailment should be used as a cost reduction strategy.
5. The Plans described in appendix C of the Task Force Report include a plan cap of $1,000,000. We recommend that there be no cap, and that the University investigate the purchase of additional catastrophic insurance coverage.
6. The implementation date of the new plan is of concern because employees have been hired for the year under the current plan and have just completed 125 Plan registration.
7. The University contributions to the cost of each employee's health care plan should be equally applied regardless of marital status.

Mental Health Coverage
1. While the Administrative Staff Council acknowledges that BGSU's mental health coverage costs have risen above the industry norm, it is recommended that the coverage not swing too far in the opposite direction. Mental health coverage is as important as physical health coverage.
2. The per year limit covered by the plan for out-patient care should be raised from $1000 to $2000.
3. To assist in controlling costs, the University should have a "gatekeeper" who would assist employees in finding the most appropriate mental health care for their particular needs. A gatekeeper is defined as a mental health professional, paid by the University's health care plan, who would be located off campus and who would provide confidential consultation.
4. The phase in period should accommodate patients already in treatment.
5. Mental health professionals on campus must be included in draft.
Generic Drugs

1. There appears to be a short list of generic drugs (such as some anti-convulsants, anti-arythmics, and anti-coagulants) which are in fact not the equivalent of the brand name drugs.
   
   It is recommended that an up-to-date list of such drugs be maintained by the Benefits Office.

2. Accommodations should be made for instances involving non-equivalent generic drugs.

Health Care Options (Task Force Recommendation 16)

1. The Administrative Staff Council recommends that there be no deductible at all to encourage employees to seek early treatment.

2. There should be a co-payment that has a low percentage but a high limit, so that employees have an incentive to limit the costs of most levels of care.

3. Whichever options are made available, there must be a thorough and timely education program to acquaint employees with the ramifications of each choice.

Preventative Care

1. The Administrative Staff Council applauds the task force recommendations on health promotion and information. We urge the inclusion of additional measures to encourage early detection of health problems; namely, the health care program should cover the costs of mammograms, pap tests, prostatic cancer detection tests, and colon cancer tests.

2. The University should have a Health Care Educator to work with staff in such wellness activities as smoking cessation, weight loss, nutrition, and fitness.
MEMORANDUM

TO: Bob Martin, Vice President of Operations

FROM: Bob Kreienkamp, Chair
       Classified Staff Council

RE: Changes Health Care Option #3

Since it has been almost a month from the time I wrote you about the changes in Health Care plan 3, that took most of the incentive away from using that plan, I thought it was time to remind you that I am waiting for your reply to my memo that we also discussed on the telephone the next week.

First, I would like to say that I appreciate (a) the immediate attention given to this subject, (b) that President Olscamp followed up on my memo in directing that attention, and (c) that Plan 3 was ultimately returned to the original intent of the Task Force and made a much better option for employees to choose from than was originally presented.

The confusion that all these last minute changes caused was apparent by the number of people who contacted me and asked me to explain what the changes really meant. I even suggested that we use WBGU-FM to have a radio call-in show that all employees on campus could listen to in their offices and not have the major disruption in work schedules that additional informational sessions would have caused. This suggestion to Jim Morris was not followed up due to the time constraints and the Thanksgiving holiday. However, I believe we should consider doing this again next spring, even if we make no additional changes (which is unlikely). Most people just simply don't understand the packages, and if they don't understand, they will stay with what they have and pay the additional premium contributions.

Now, let's turn our attention to the question I asked in my original memo -- WHO MADE THESE CHANGES AND WHY???

I checked the minutes from the Board of Trustees meeting when these health care plans were approved by the Board and the motion states "these plans be accepted as submitted to the Board." I again looked closely at the material that was submitted to the Board, particularly plan 3, and the material that was handed out to the employees. These are the changes I pointed out in my original memo last month and certainly could not be classified as different interpretations of the plan adopted by the Board, but a complete change in the plan.
This brings me to the question of whether changes can be made by an individual or small group of people to an official Board of Trustees adopted policy without the Boards' previous knowledge and/or approval?

Another question is why weren't these changes brought back to the Health Care Task Force. At least two members of the Task Force were aware of these changes before they were announced publicly, yet it was not brought up for discussion from the time the Task Force reconvened in September to the time of the first information session when the changes were first slipped into the plan.

If the Task Force is to achieve its charge, it must be kept up to date and not in the dark about any administrative questions or changes to its recommendations in the future.

I await your reply to my original question - who made these changes and why???

cc: President Olscamp
    Ad Council
    Board of Trustees
    Health Care Task Force
    Administrative Staff Council
    Faculty Senate
To: Senate Welfare Committee Members, Insurance Committee Members, Norma Stickler, Chair, Personnel Welfare Committee, Administrative Staff Council & Randy King, Personnel Welfare, Classified Staff Council

From: Don Boren, Chair HCA Task Force

Re: Managed Care Presentations

Date: January 5, 1994

The Health Care Task Force is in the process of determining if existing managed care programs in Northwest Ohio meet the University's needs. As part of this process, we have invited the following managed care organizations to make a presentation on their programs:

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<th>Organization</th>
<th>Representative(s)</th>
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<tr>
<td>1:00 p.m.</td>
<td>Blue Cross/Blue Shield of Ohio</td>
<td>Timothy Smith</td>
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<tr>
<td>2:00 p.m.</td>
<td>Wood Health Network, Inc.</td>
<td>Kipp Miller</td>
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<td>Wood County Hospital</td>
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<td>3:00 p.m.</td>
<td>Western Lake Erie Employer's Coalition (WLECC)</td>
<td>Gaylyn Young</td>
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<td>4:00 p.m.</td>
<td>CoreSource/Burgett &amp; Deitrich</td>
<td>Eddie Choat</td>
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<td>Primary Care Network</td>
<td>Vice President</td>
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The meeting will be held on Wednesday, January 12th, in the McFall Assembly Room. As a member of a committee who will ultimately be providing input into the nature of the University's health care program, we would like for you to attend if possible.
January 21, 1994

MEMORANDUM

TO: Donald Boren, Chair of Health Care Task Force
John Moore, Executive Director of Personnel

FROM: Norma J. Stickler, Chair, Administrative Staff Personnel Welfare Committee

SUBJECT: Health Care Management

The Personnel Welfare Committee appreciated the opportunity to hear the presentations on January 12 from the four health care management organizations. We are fully supportive of efforts to save money through managed health care. Our overall impression was that the Wood County Hospital plan had little to offer us; it was not clear what the Western Lake Erie Employer's Coalition could offer; the Blue Cross/Blue Shield and the CoreSource/Burgett & Deitrich plans seemed acceptable enough to obtain further information.

The larger issue for our committee focuses on the following questions.

On what basis are the plans being evaluated? What is the overall philosophy being used, e.g., what portion of health care should be paid by the employee? We feel the goal should be to maintain some employee contribution, but keep it as low as possible.

What is the overall plan being developed by the consultant hired by the University, and how does this plan fit into the managed care plan?

Are there data from CoreSource that could help in making this decision?

Are there other managed health care providers being considered? How were these four selected?

xc: Greg Jordan