

Joint Benefits Committee Report
CUCRA/CUCEA Joint Zoom Meeting at UC San Diego
April 24-25, 2024

Overview:

This JBC Report focuses on issues that continue to be discussed by CUCRA and CUCEA, including: I. Establishment and Initial Meeting of the UC Emeriti/Retirees Advisory Committee (ERAC). II. Progress for Developing Short- and Long-term Principles for ERAC. III. Status of the RASC. IV. Delta Dental. V. Return to Active Duty (RTAD).

I. Establishment and Initial Meeting of the UC Emeriti/Retirees Advisory Committee (ERAC)

The newly formed UC Retirees Advisory Committee has now held three meetings with a fourth scheduled prior to the CUCEA-CUCRA spring conference. This standing committee is scheduled to meet every other month. The committee was appointed in August 2023 by UC Vice President Systemwide Human Resources Cheryl Lloyd. Such a group was requested by CUCEA/CUCRA leadership to provide a means of routine communication in order to better understand upcoming or contemplated changes to benefits administration and, importantly, to provide feedback as to which systems are working well and which need attention to better meet the needs of retirees.

Some of the topics discussed at meetings to date include:

- Future actions to bring UC into compliance with Medicare requirements when retirees “return to active service.”
- Health insurance benefits for out-of-state retirees administered by VIA Benefits. CUCRA/CUCEA leadership has long raised the issue that there has been no COLA for 10 years for out-of-state retirees. UC will be surveying out-of-state retirees to determine if this program is appropriately meeting needs.
- There have been growing concerns that dentists are not accepting Delta Dental insurance.
- Retiree participation be included in coming Request for Proposals (RFPs) for health insurance programs.

CUCRA-CUCEA leadership has been discussing how to best coordinate activities of its Joint Benefit Committee (JBC) with this new Advisory Committee. Amendments to each Council’s bylaws are being drafted which would position the JBC: to submit items for the Advisory Committee and to consider and be briefed on the content of Advisory Committee deliberations.

II. Progress for Developing Short- and Long-term Principles for ERAC

The ERAC Charter published in the Fall 2023 JBC report as Appendix I states that the purpose of the ERAC is to “Engage with University officials (as a part of their stewardship responsibilities to UC annuitants) in a manner to facilitate open communication, clarify program objectives, and promote efficient and effective program administration”.

Furthermore, the Charter specifies the responsibilities of the ERAC are to:

- “Engage with, provide assessment for, and provide counsel to the Vice President Systemwide HR regarding benefits to retirees and emeriti
- Review the suite of medical plans offered to retirees
- Assist with communications and outreach to the retiree and emeriti community”

Some of the JBC and other members of the Retiree and Emeriti community have made some useful suggestions for ERAC principles, and the latest draft of this effort is found in the Appendix. The JBC plans to finalize its recommendation for Principals for the Fall 2024 Joint Meeting. The JBC members want this statement to represent both the interests of the retirees and the University. We welcome comments and suggestions.

III. Status of the RASC

The CUCRA and CUCEA leadership recently met with RASC Executive Director Bernadette Green and her management team, who provided an update on the status of core RASC processes. RASC is reporting marked improvement in the timeliness of retirement benefits confirmation processing, call center and secure messaging responsiveness, and the survivor intake process.

RASC is exceeding its service guarantee (45 business days) for generating confirmation of retirement benefits statements and has reduced the average time from 44 days in 2021 to 31 days in 2024 so far. With the implementation of a fully staffed RASC retirement counseling team, Call Center volume has decreased 38% in January-February 2024 as compared to the same period last year. Wait time for all types of calls (i.e., Tier 1, Tier 2, and Survivor Intake) has declined significantly as well.

Tier 1 calls are those that can be handled relatively easily and have been outsourced to UnifyHR. The wait times on these calls has declined from an average 6-7 minutes in March/April 2023 to 2 ½ minutes in February 2024. Similarly, the more involved Tier 2 call wait time has declined from an average 54 minutes in February 2023 to 3 minutes, 46 seconds in February 2024.

The survivor intake team wait time is now averaging 2 minutes, 34 seconds and RASC has implemented 24-hour voicemail on this line and reports that callbacks are being made within one business day. An area that continues to need improvement is that of survivor processing. The backlog team has made great progress on reducing and almost eliminating the backlog, which should be fixed in April; however, RASC is

reporting that for current survivors who meet the requirements for continuation of monthly benefits, processing remains well over their 30-day service target. Actual average processing time remains 60-70 days in recent months. Similarly, those survivors who are entitled to a one-time death benefit are waiting 70-80 days rather than the 60-day service guarantee. There is a work around whereby they fix things *ad hoc* so that survivors are not cut off from insurance.

Additionally, RASC reported that the retirement counseling team is fully staffed and since its inception in January 2024, has conducted almost 1200 counseling sessions (through March 26) and has another 768 sessions scheduled through May 31. The retirement counseling team has met with all but a few campus and medical center locations and those that remain are scheduled to occur in the next few weeks. Consultants have been engaged to work with the Call Center team to provide additional training that will enhance the customer service experience.

Steps are also being taken by a new Operations Manager who is working in concert with other RASC managers to assist the RASC in developing process improvement recommendations to improve the survivor process.

JBC extends our congratulations to the RASC Executive Director and her management team on the significant progress the organization has made over the past year. While there are ongoing efforts within RASC to make further progress in several areas, JBC would like to highlight some additional opportunities that would further improve processes and communication:

Monitor the scalability of the recently established RASC Retirement Counselor Team to ensure that prospective retirees and those not yet planning for retirement but seeking information receive timely appointments:

The number of retirement counseling sessions conducted (1191) and pending appointments (768) since the inception of the RASC Retirement Counselor Team in January is a very high volume that demonstrates pent up demand. The JBC recommends that the RASC continue to monitor the scalability of the existing team to ensure that adequate resources are deployed so that prospective retirees and employees seeking information receive timely appointments. This is particularly critical during peak retirement periods when prospective retirees need to meet deadlines to ensure continuity of payments.

Provide Location Retirement Counselors and Retiree Center Directors with 'Read Only' Access to Redwood to Assist Retirees:

Currently, the locations do not have access to the Redwood system and must rely on a subset of data in the Roots extract. The inability to access all of the data in Redwood makes it difficult for location retirement counselors and Center Directors to respond to inquiries from their employees and retirees and forces those queries to be funneled to the RASC. As the Redwood system has now been stabilized, JBC strongly

recommends that responsible parties (i.e., local retirement counselors and Retiree Center Directors) at the locations be given ‘read only’ access to Redwood to facilitate being able to respond to inquiries from their local populations thus reducing further the number and length of calls or messages to the RASC. With adequate information, local retirement counselors may be able to take some pressure off the RASC Retirement Counseling team should demand for appointments exceed their capability to provide them in a timely manner.

Continue to Improve Processing for Survivors Eligible for Monthly Payments and Health Insurance:

While improvements have been made and there is a focus within RASC to further improve this process, JBC can’t stress strongly enough how imperative it is that survivors receive timely and compassionate service without interruptions to their health insurance and, in some cases, their only source of income. Currently, small discrepancies in information and/or small amounts of overpayment to the deceased can derail processing a survivor’s claim. Given the time it takes to resolve such discrepancies, it would be more humane to the survivor and more fiscally prudent for the university to proceed and resolve these issues through other means. Since a work around has been developed to prevent eligible survivors from being cut off from health insurance due to processing delays, we suggest a similar work around be developed to ensure continuity of pension payments to survivors.

IV. Delta Dental

The issues regarding problems with Delta Dental PPO insurance were first mentioned in the JBC report of Spring 2023. Since that time there have been discussions with some UCOP staff, but little action resulted. During this past year, within the UC community of employees and retirees, there is an increasing dissatisfaction in the access to care provided by Dental PPO, which is the University’s sole provider of dental insurance. Many dentists are continuing to leave the Delta Dental PPO because the reimbursement rate for the PPO plan is insufficient to compensate them for the current overhead rate for their practices. This dwindling number of dental providers affects not only general dentists but extends to dental specialty care providers as well.

If an employee/retiree decides to seek treatment at a non-Delta “out of network provider”, the individual would be expected to pay for the care and then submit a claim to Delta Dental for reimbursement. Currently, Delta Dental does not give a guarantee of what percentage of the charged fee will be covered. Regardless, it will be much more expensive. This has recognizable limitations for a comprehensive dental care benefit.

There are several potential options that UC could pursue listed below. While none of these options may be likely to reverse the exodus of dentists from the Delta program,

they may help UC and its active and retired employees prepare for further network deterioration:

- Establish a current employees Health FSA that could be utilized for most services provided by an out of network provider. Retirees would not have this option.
- Search for a new PPO carrier. This carrier would need to have an existing network that has an adequate number and geographic distribution of participating dentists to ensure a continuity of care. Insurers (such as Aetna, UHC, Blue Cross, Met Life, Premier Access to name a few) all have dental insurance plans.
- Offer a plan to employees and retirees that have several tiers of service:

Basic Tier Option:

Retain the current Delta PPO plan where UC pays all of the monthly premium.

Advanced Tier Options:

Offer one or more levels of services that employees and retirees could choose from that provide care above the base, but at a cost.

These options could be from one or multiple insurance company-based plan(s). If the monthly premium exceeds the rate of the Delta Dental PPO plan, then the individual selecting this option would be required to pay the difference between the Delta plan and the plan they need. This option would require a careful review to ensure it is superior to the Delta Dental PPO.

In the same way that our UC Medical Plans have a level of variety to meet an individuals' needs and health conditions, the Dental Plans could now do this as well. The benefits survey could be used to assess the need for this type of program. It is clear to many in the retiree community that offering a dental plan like the Delta PPO that dentists are dropping at an alarming rate, cannot be continued.

V. Return to Active Duty (RTAD)

The JBC has become aware of changes in regulations pertaining to return to active duty (RTAD) retirees. It has been the long-time university policy to require a separation of >30 days before commencing recall status, thereby complying with IRS regulations concerning defined benefit plans. We understand that there are newer regulations emanating from Medicare and the ACA that require a separation of six months in order to be eligible for primary insurance coverage under Medicare.

We have heard that there are ~2000 people on recall status throughout the university and that approximately 810 of them were recalled to active duty >one month but <six months after separation. It will be difficult to adjust payroll and benefits for this large group of retirees, if all are subjected to a simultaneous change in their healthcare benefits. Nonetheless, the university should make a good faith effort in moving in this direction for compliance. Thus, we are suggesting a phased approach that will allow the university time to develop the necessary infrastructure in accounting and payroll and the equally necessary infrastructure for communicating the resulting changes in insurance. The JBC as well as leadership of CUCEA and CUCRA should be informed of the university's timetable for these phased in actions.

1. The university should immediately update its files and confirm the number of retirees who separated <six months before returning on recall status. Furthermore, we need to identify the campuses of each individual and the recall function they are pursuing (teaching, research, clinical care or administrative service). Although it is unlikely, some recalled retirees may also live out of state and be covered on VIA benefits. These individuals may need special provisions, other than as suggested below. JBC would like to be informed about these data as soon as they become available.
2. For faculty who will start on recall to teach, the university should immediately require a six-month separation before they are allowed to return for teaching functions. This will satisfy the Medicare regulations and will spare such faculty the complex alterations in health insurance coverage that would otherwise be required. It will also importantly stop further aggravating an already complex situation.
3. There may be a small number of retirees who separated from the university and then returned >43% time, while still listing as Medicare as primary insurance. Such individuals might be notably out of compliance with diverse federal regulations. The university should identify such individuals and immediately regularize their situation (return them to < 43% time and/or immediately transfer them to active employee health insurance status). Furthermore, the university could test out communication strategies on this presumably small number of retirees before disseminating the communications to larger numbers. CUCEA and CUCRA leadership would like the opportunity to review and comment on such communications before they are sent out.
4. For retirees on recall who are performing research or conducting clinical care or administrative activities, it may be infeasible to require a six-month separation. Individuals who will be starting recall should be covered as active employees for health insurance purposes for at least six months before converting to retiree Medicare insurance. The university must identify and pilot test a clear communication strategy to assist such individuals with their unique health insurance needs. Enrolling and disenrolling from Medicare is complex in the best of

circumstances. Again, CUCEA and CUCRA leadership should be given the opportunity to review and comment on such communications before they are sent out.

5. Individuals who have already started RTAD should be converted to active employee health insurance as outlined above. Furthermore, this should be treated as a “period of initial enrollment,” thereby allowing such employees to make a voluntary change in insurance as necessary. For most people, the change from Medicare plan to active employee plan would be clear and without disadvantage. However, under current university practices, individuals on United Medicare Choice PPO might be forced into a Blue and Gold HMO, which is not an equivalent plan. This would be needlessly disruptive. Note that the United plan is currently the most popular of the retiree healthcare options. If the university is requiring individuals to disenroll from Medicare, they should be allowed their choice of active employment plans.

6. In designing and implementing the communications on this complex matter, the university should reach out to CUCEA and CUCRA as well as the healthcare task force to ensure that communications are clear. These interactions should take place far in advance rather than at the last minute.

7. It is unclear what the university should do for people who started RTAD <6 months after separation but who have already ended their RTAD or passed away.

We assume the general counsel's office will ensure that the details of these changes will not result in any penalties for retirees who acted in good faith following university guidelines concerning RTAD.

Respectfully submitted by the Joint Benefits Committee:

Chair, Roger Anderson (UCSC)	Selected by JBC
Lawrence Pitts (UCSF/UCOP)	Selected by JBC
Louise Taylor (UCB)	Selected by JBC
Jack Powazek (UCLA)	Appointed by CUCRA
Eric Vermillion (UCSF)	Appointed by CUCRA
Dan Hare (UCR)	Appointed by CUCEA
Dan Mitchell (UCLA)	Appointed by CUCEA
Sue Abeles (UCLA)	CUCRA Chair-Elect
John Meyer (UCD)	CUCRA Chair
Jo Anne Boorkman (UCD)	CUCEA Chair
Joel Dimsdale (UCSD)	CUCEA Chair-Elect

Appendix

DRAFT 3/18/2024

UC RETIREE HEALTH – STATEMENT OF PRINCIPLES

BACKGROUND

Affordability, accessibility and quality are often used when describing key principles of the UC retiree health program. Maintaining long-term, on-going continuity and stability in the UC retiree health programs, including dental coverage and an optional vision care plan, is a very important additional principle for retirees. Retirees and Emeriti are at a point in life where changes in their health care can disrupt longstanding and ongoing treatment. For many the changes may be difficult to understand and manage given the normal declines that accompany advancing age. At the same time, it is important to recognize that the University is also trying to achieve retiree health plan cost stability, particularly as it relates to UC general fund sources, and needs to maintain an appropriate level of management flexibility. It is also recognized that the University has a long-standing stewardship relationship with its retirees and emeriti aimed at working in their best interests, as well.

In the past decade, a number of de-stabilizing events - for example, the outsourcing to a broker of health benefits for out of state retirees and emeriti and the possibility of eliminating the two UC Medicare supplement PPO plans - have caused disruption and fear among the UC retiree community about losing or dramatically changing and/or reducing their health benefits. As a result, the UC retiree and emeriti associations seek agreement with the University about certain key principles relating to retiree health care plans, particularly the Medicare health plans.

This background outlines the major concerns of retirees and emeriti about health care insurance plans and provides comment on the main issues that retirees and emeriti would like for UCOP to carefully examine before it moves forward in exploring new or revising current retiree health care plans.

AREAS OF CONCERN

1. Anxiety/Concern Over Predictability and Stability of Future Health Plans:

Changes to a retiree's health care plan can be disruptive to longstanding and ongoing treatment. Each year many retirees have considerable anxiety because they do not know whether their plans and providers will be available to them in the next annual insurance cycle. Changes are particularly worrisome to those who have built a group of providers to address the many medical and psychological issues an aging population face. Medical insurance products are complex and, as one ages, it becomes more difficult to understand what critical differences between plans might be. Many retirees do not want

to try to or may be unable to understand the nuances of new plans that may replace existing plans. While understanding that premiums may change, it is still important for UC to do its best to maintain the same basic plan designs and networks, except in unexpected circumstances; doing this will greatly reduce the anxiety and stress that often occurs just prior and during the open enrollment. While it is understood that changes may be necessary, retirees recommend that such changes take place only after detailed consultation with retiree associations and, if changes need to be made, allow sufficient lead time for members, with the assistance of the University, to understand the new plans and how they may impact their current coverage before adoption.

2. Continuity of Choice:

Maintaining the ability to choose between different types of Medicare insurance plans should be a central component of the UC Retiree Health Care Plans. Currently the University offers 2 different plan types: Medicare Advantage (Kaiser Senior Advantage and UC Medicare Choice) and Supplemental Plans to Original Medicare (UC PPO and High Option to Medicare). There are important differences between the two plan types. The Medicare Advantage plans are owned and administered by private, nonprofit or for profit, insurance companies while the Medicare Supplement Plans, are governed by the original Medicare guidelines. Differences in administrative oversight can result in different outcomes. For example, Medicare Advantage plans such as UC Medicare Choice require prior authorization for many Medicare-approved procedures while approval for the same procedures in Supplemental plans is typically post-hoc and, if denied, the patient is not responsible for the payment. Other important differences may result because, in the Medicare Advantage plans, the insurer determines the networks and reimbursement rates, and makes the final determination of coverage. For the Medicare Supplement Plans, the patient may go to any provider in the US that accepts Medicare.¹ These and other differences between the plans can alter perceived or real outcomes in the care the patient receives. Retirees should continue to be able to choose between these different types of plans. An additional reason for maintaining both Medicare Advantage and Medicare Supplement plans is that having different plan types will ensure competition in the health care market, with the benefits that accrue as a result. The provision of multiple plan choices is both a continuation of current practice and a conclusion of the Health Benefit Advisory Committee (HBAC). The HBAC report identified as current principle in administering health plans is that wide choice of plans be available to employees and retirees. The HBAC further recommended that the University retain existing plans, including Kaiser.

¹ Patients in Medicare Advantage plans like Kaiser are limited to its network. Patients in Medicare Advantage PPOs, such as UC Medicare Choice, can in practice go to the vast majority of providers that accept Medicare.

3. Method of applying University's 70% contribution to retiree health: critical for preserving choice

The current method the University uses to apply its 70% contribution to retiree premiums may disadvantage the UC Supplemental Plans. If the current trajectory of the cost of the Supplemental Plans continues, the plans may become unaffordable to many retirees. The University should insure well thought through critical analysis is performed on any cost related changes to the current 70% contribution are considered. Once this information is available, a more informed decision can be made. Additionally, all the plans should be uniformly costed, fully disclosed, and reported on annually with any decisions made to utilize subvention mechanisms concurred with by the CUCEA/CUCRA organizations. There should be full disclosure and discussion of any change strategies to shift the cost balance to annuitants - such strategies would include contracting for new drug formularies that shift costs directly to annuitants and away from the 70% cost floor.

4. Retiree Participation in Retiree Health Benefits Planning (Transparency)

The University will continue to benefit from regular meetings with its recently formed Emeriti-Retiree Advisory Committee and actively seeking its input. Additionally, both would benefit if retirees had earlier and greater participation and input into retiree health coverage planning, primary among the post-employment benefit subject areas. Such participation should include adding one member each from CUCEA and CUCRA on the Executive Steering Committee, (ESC), and including members of CUCRA and CUCEA in preparation and evaluation of all RFPs for retiree health, dental and vision insurance.

5. Role of Medical Centers in Providing Health Insurance

The Medical Centers play a critical role in UC's medical education and patient care missions and when retirees are interested and able to take advantage of the health care services the Centers offer, it is a benefit to the University and the retiree. But not all retirees will want to enroll in a plan supported by the Medical Centers; for example, some will want to continue enrollment in Kaiser, like they did as employees. Also, not all retirees are geographically close to UC Medical Centers and clinics. The Medical Centers, from the standpoint of retiree health insurance, should be considered one possible provider and should continue, as they do now, to strive to provide the best and most effective plans they can to UC retirees, as well as to employees.

STATEMENT OF PRINCIPLES

Given the above set of retiree concerns and interests, the following principles are points of agreement between the University and the UC Retiree and Emeriti Associations.

The provisions of this STATEMENT memorialize a partnership between retirees and the University as follows:

1. For the foreseeable future, the University will continue to provide the current choices in its retiree health plans, including those who are not yet eligible for Medicare. Choice will include offering at least a Kaiser plan for retirees/emeriti, one other Medicare Advantage plan, and at least one Supplemental Plan to Original Medicare for retirees living in California, while recognizing the need for the University to maintain flexibility in the face of future unknowns. The commitment to an ongoing dialogue will allow for stability, robust communication and the ability to pivot as needed.
2. The costs of plans should all be fully disclosed annually to CUCRA and CUCEA, which can then share this information with their member associations.
3. The University will include members of the UC Retiree/Emeriti Associations in health program and insurance planning, including at the working and decision-making levels. This shall include participation of one member each from CUCRA and CUCEA as ex-officio members of the ESC, and participation by one member each appointed by CUCRA and CUCEA in the preparation and evaluation of all RFPs for retiree health insurance, vision insurance and dental insurance.
4. There shall be continued provision of a University-paid dental care program for retirees.
5. The University shall continue to negotiate a voluntarily paid vision plan for retirees.
6. The University will prepare for consideration by ERAC members a review of the current out-of-State retiree health coverage and University contributions to identify whether alternate or additional options are available to insure fair and equitable plan parity with the in-state retirees.