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Practical Research for Employers

Fall 2018

How Competitive Are Your Institution's Benefits?

Use Sibson's 2018 *College and University Benefits Study* to See the Latest Trends and Discover How Your Programs Stack Up

Benefits play a key role in colleges' and universities' constant quest to attract and retain top talent. Benchmarking how your benefit plans compare to what your peer institutions offer can provide invaluable insights. Sibson Consulting's latest *College and University Benefits Study* (CUBS) reports detailed information about higher education institutions' benefits, including differences among the benefits offered to faculty, administration and clerical staff. Institutions can use the study, which covers 2017 offerings of more than 450 private and public institutions, to identify the benefits that could be added, changed or simply promoted to stay competitive.

This report presents an overview of the results and highlights program trends. It includes observations and draws attention to potential opportunities for consideration.

What CUBS Covers

To go directly to the sections of this report that interest you most, choose from these links:

Key Findings

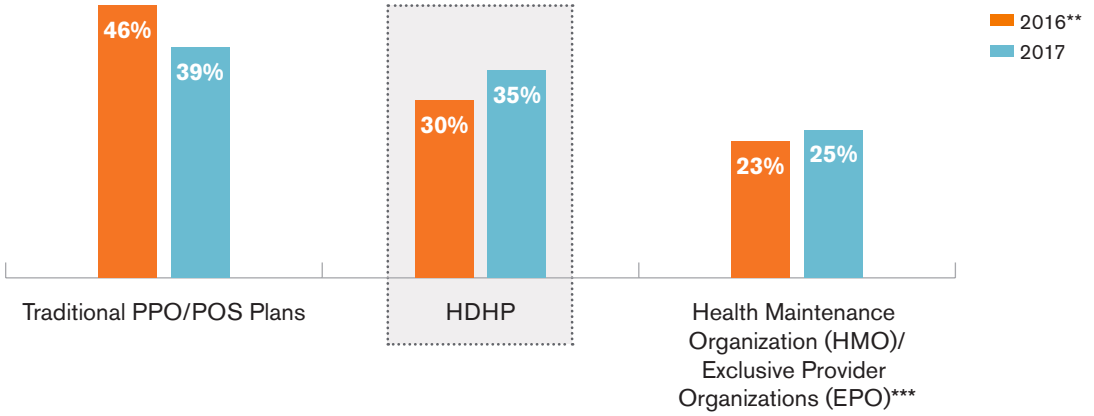
These are among Sibson's key findings about how benefit offerings have changed:

- In only one year, there were dramatic increases in both the number of institutions offering high-deductible health plans (HDHPs) and the percent that HDHPs represent of all plans offered.
- The offering of Health Savings Accounts (HSAs), which allow for employee and/or employer contributions, far exceeds the offering of Health Reimbursement Arrangements (HRAs), which are funded only by employers, or HDHPs without either account.
- The traditional medical cost-sharing features — deductibles, copayments, coinsurance and employee contributions — continued to be adjusted, and, in most cases, there were increases.
- The percentage increase in employee payroll-contribution requirements for medical coverage was greater than the increase in total medical/prescription drug costs (after taking into account design changes).
- The prevalence of pharmacy cost-management programs, such as step-therapy programs and mandatory use of generic drugs, increased significantly.
- The trend of institutions reducing or even eliminating their retiree health benefit offerings continues (although slowly).
- Among institutions that still offer retiree health and welfare plans to new hires, there continues to be steady movement to account-based defined contribution (DC) health plans as the vehicle to fund the cost of coverage.
- The percentage of DC retirement plans moving away from immediate vesting continues to increase.
- The use of voluntary/non-traditional benefits has increased.
- In 2017, fewer tuition reimbursement plans offered immediate eligibility than in 2015; more institutions required coursework to be job-related for employees, and more required minimum grades for any reimbursement.

Dramatic HDHP Growth Continues

Growth in offerings of HDHPs, which are defined in the study as having annual deductibles of $1,000 or more, continues to be significant. HDHPs, which now represent more than one-third of all medical plans offered, are the second most prevalent offering behind the traditional preferred provider organization (PPO)/point-of-service (POS) plans with deductibles less than $1,000.

Significant Year-Over-Year Growth in HDHP Offerings Compared to Other Plan Types*



* Note that the totals for both years do not equal 100% because the 1% that indemnity plans represent are not shown.

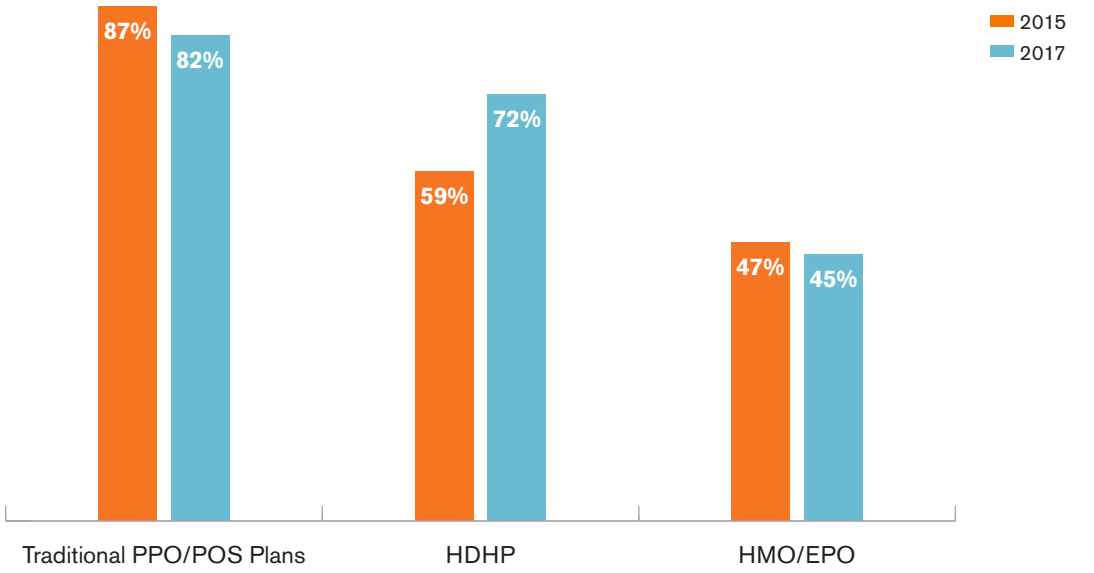
** Changes in benefit offerings over only one year tend to be modest. Consequently, we compare 2017 data to 2015 data throughout this report. This graph is an exception to that practice because the one-year changes were significant.

*** Like HMOs, EPOs require participants to seek care from within a network of providers. An EPO is similar to an HMO by design, however it is not bound by the legislation of one state, only national mandates.

Source: Sibson Consulting, 2018

Moreover, HDHPs are now offered by nearly 72 percent of institutions, a dramatic increase of 13 percentage points in only two years. These plans have become an integral part of institutional strategy, to encourage better health care consumerism. In contrast, the percentage of institutions offering PPO/POS plans and health maintenance organization (HMO)/exclusive provider organizations (EPOs) declined slightly over that period.

Most Institutions Offer PPO/POS Plans and HDHPs



Source: Sibson Consulting, 2018

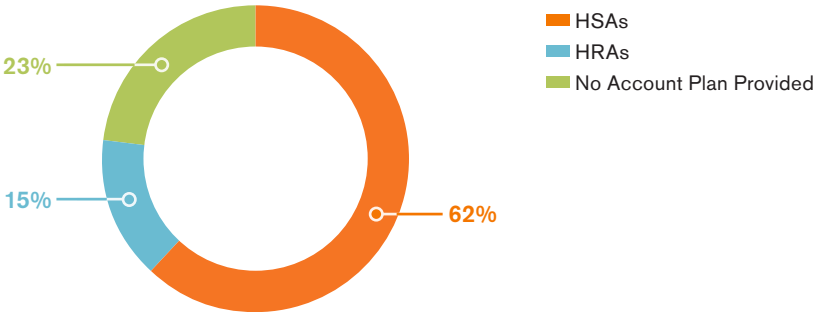
Sibson Observations Historically, higher education medical plans have tended to be somewhat more valuable to the employee than plans offered by corporate employers. Changes over the years have narrowed the gap. Health benefit cost trends continue to exceed the Consumer Price Index for All Urban Consumers (CPI-U), which is used as an estimate for cost-of-living increases.[1] The financial strains that institutions continue to face have led more of them to offer HDHPs.

> "Higher education institutions understand that they can no longer afford to simply maintain a traditional approach to employee health care benefits and that they must now proactively address rising costs for their institutions and for their employees. The dramatic increase in HDHPs is a direct result of institutions' desire to engage faculty and staff in the health care purchasing process to promote consumer awareness of the high cost of medical services."

Norman J. Jacobson
Senior Vice President, ASA, MAAA
Higher Education Benefits Practice Leader

HDHPs can be designed with an associated health savings account—either an HSA or an HRA.[2]

A Majority of HDHPs Have HSAs



Source: Sibson Consulting, 2018

[1] See the 2019 *Segal Health Plan Cost Trend Survey* conducted by The Segal Group of which Sibson is a member.

[2] As noted at the beginning of this section, CUBS defined HDHPs as having deductibles of $1,000. Under federal government rules for 2018, an HDHP must have a deductible of at least $1,300 in order to offer HSAs. For a comparison of key elements of HSAs, HRAs and flexible spending accounts, see Sibson's summary graph.

Sibson Observations HSAs are the account most often paired with an HDHP because they offer a unique triple-tax savings opportunity to employees. Employee contributions can be made on a pre-tax election from payroll. The investment earnings are not taxed. They can be used tax-free for qualified health plan expenses. HSAs also offer the most portability (or flexibility on what they can be used for by employees) and are the easiest to promote because employee and institution contributions belong to the employee at all times — even after leaving employment. The employer can contribute or "seed" money into these accounts[3] or choose to simply set it up for employees without seeding. HRA plans only allow employers to deposit money into them for the employees' use; they do not allow employee contributions. Consequently, all of these HRA accounts have "seed" money.

Employer Initial Contribution Amounts Are Lower for HSAs Than for HRAs But Allow Employee Investment*

	Average	Median
HSAs		
Tier 1: Those Electing Employee-Only Coverage	$631	$528
Tier 2: Those Electing Employee +1/Family Coverage	$1,155	$1,000
HRAs		
Tier 1: Those Electing Employee-Only Coverage	$962	$600
Tier 2: Those Electing Employee +1/Family Coverage	$1,693	$1,250

* Excludes institutions that do not contribute to HSAs.

Source: Sibson Consulting, 2018

Sibson Observations HRAs tend to have more money initially provided by the employer because the employee cannot contribute to the account. Thus, outside of employer-provided incentives/bonuses for healthy behaviors, these "seed" levels are the most the employee will get to use towards meeting their HDHP annual deductible or paying for other out-of-pocket health care expenses.

While HRAs are owned by the university (so funds left over after employment revert to the institution), HSAs are owned by the employees (so, under current law, any money seeded is kept by the employee permanently). Promoting the ownership (and portability) of these accounts to employees, and the triple-tax advantage of these accounts, provides significant advantages for employees, even if the accounts are funded at lower levels than HRAs.

[3] Employer contributions are generally made through the employer's Section 125 plan, but if not are subject to the HSA comparable contributions rules.

Cost-Sharing Features Differ by Plan Type

Deductibles vary significantly by plan type. PPO/POS plans have deductibles of less than $1,000 whereas HDHPs, as defined by the study, have deductibles of $1,000 or more. In contrast, most HMO/EPOs (68 percent) do not require a deductible. For those that do (32 percent), the deductible has been increasing steadily to an average of about $369 in 2017 (it was $316 in 2016).

For Employee-Only Coverage, Annual Deductible for HMO/EPOs Increased by More than One-Third, on Average; Increases Minor for Other Plan Types*

	2015		2017	
	Average	Median	Average	Median
PPO/POS Plans: In Network	$341	$300	$342	$300
PPO/POS Plans: Out of Network	$756	$500	$787	$500
HDHPs: In Network	$1,806	$1,500	$1,820	$1,500
HDHPs: Out of Network	$2,905	$2,500	$3,005	$2,600
HMO/EPOs: In Network Only	$85	$0	$117	$0

* Includes plans where the deductible is $0 or does not exist.

Source: Sibson Consulting, 2018

Coinsurance has not changed much for traditional PPO/POS plans since Sibson's last report. Institutions' median in-network coinsurance for PPO/POS plans is higher than that of HDHPs for all service types.

Median In-Network Coinsurance by Type of Service Is Similar for PPO/POS Plans, HDHPs *and* HMO/EPO Plans

	PPO/POS Plans	HDHPs	HMO/EPO Plans
Physician Visits	None (Copayment Only)	90%*	None (Copayment Only)
Inpatient Services	90%	80%	100%
Outpatient Services	90%	80%	100%

* Although it is not common, some HDHPs have 100% coinsurance where copayments exist for physician visits, therefore this is not 80%, the coinsurance for inpatient and outpatient visits.

Source: Sibson Consulting, 2018

The median out-of-network employer coinsurance applicable to most services is 70 percent in PPO/POS plans, and is 60 percent in HDHPs.

Sibson found that 52 percent of PPO/POS plans differentiate between copayments for office visits to primary care physicians (PCPs) and specialists. A majority of HMO/EPOs (58 percent) also have different PCP and specialist copayments. Only 28 percent of institutions' HDHPs have office-visit copayments, and very few have per-hospitalization, in-network copayments. That is because HDHPs tend to use coinsurance as the cost-sharing mechanism for those plan provisions, after the high deductible is met.

The table below shows the median copayments, which are identical for PPO/POS plans and HMO/EPOs. The averages are very similar to the medians. For example, PPO/POS plans' copayments for PCP in-network office visits average $21 while specialist in-network office visits average $31 (both were the same amounts in 2015).

Median In-Network Copayments for Physician Visits Are Identical for PPO/POS Plans and HMO/EPOs

	PPO/POS Plans	HDHPs	HMO/EPO Plans
PCP Visits	$20	$25, But Coinsurance Is More Typical	$20
Specialist Visits	$30	$40, But Coinsurance Is More Typical	$30

Source: Sibson Consulting, 2018

PPO/POS plans' emergency room (ER) copayments shown in the table below continue to rise from 2015 (*e.g.*, average HMO copayment is up over 10 percentage points). In our experience with higher education clients, this increase is partially attributable to plan sponsors' interest in discouraging employees who have non-emergency service needs from visiting the ER. Additionally, 33 percent of PPO/POS plans and 61 percent of HMO/EPOs have a per-hospitalization, in-network copayment.

Average In-Network Copayments for ER Visits Virtually Identical for PPO/POS Plans and HMO/EPOs; Differences Greater for Inpatient Stays

	PPO/POS Plans	HDHPs	HMO/EPO Plans
ER Visits	$127	$165, But Coinsurance Is More Typical	$125
Inpatient Stay (Per Admission)	$272	None, (Typically Coinsurance Only)	$313

Source: Sibson Consulting, 2018

While out-of-network out-of-pocket maximums continue to be between 1.5 and 2 times their in-network counterparts, the in-network out-of-pocket maximums have remained relatively close to what they were two years ago.

Out-of-Pocket Maximum Total Exposure (Including Deductibles) Is Greatest for HDHPs, Least for HMO/EPOs

	Average	Median
PPO/POS Plan In-Network Services	$3,159	$2,550
PPO/POS Plan Out-of-Network Services	$4,332	$3,500
HDHP In-Network Services	$4,188	$3,500
HDHP Out-of-Network Services	$6,953	$6,100
HMO/EPO In-Network Services (Only)	$2,962	$2,000

Source: Sibson Consulting, 2018

Sibson Observations As more HDHPs are created, we see that the out-of-pocket maximums (including the deductibles) have realigned with PPO/POS plans and HMO/EPOs. When combined with institution-funded accounts and lower employee contribution requirements, having the employees' out-of-pocket exposure for the HDHPs at levels more in line with the traditional plans has made them more attractive to employees.

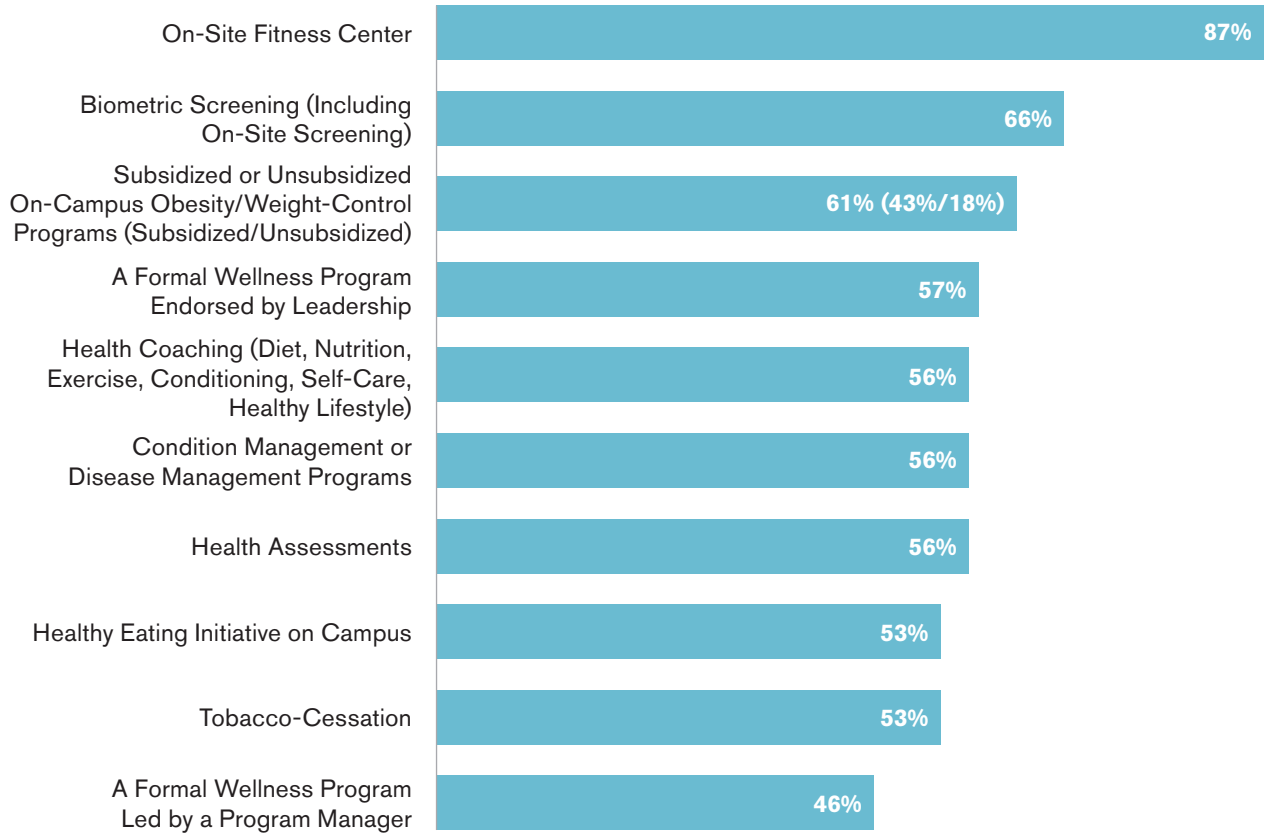
> "Institutions should consider incorporating health plan design features that encourage employees to be aware of costs and efficient plan use. An example of this is ensuring that medical copayments align properly with the cost of care at the place of service. This means making the ER copayment more expensive than the urgent care copayment, which is more expensive than the PCP office visit copayment, which is more expensive than telemedicine web/phone visits."

Leonard J. Spangher, CEBS, MHP
Vice President and Senior Consultant

Wellness Initiatives and Health Plan Strategies

To supplement CUBS, Sibson conducted an online survey in late 2016 focusing on wellness initiatives and health plan strategies. These strategies can help institutions with cost-management and staffing. Healthier employees have lower health claims. Moreover, a focus on employees' well-being can help attract and retain talent.

All But One of the Top 10 Wellness Initiatives and Health Plan Strategies Are Being Used by More Than Half of Institutions

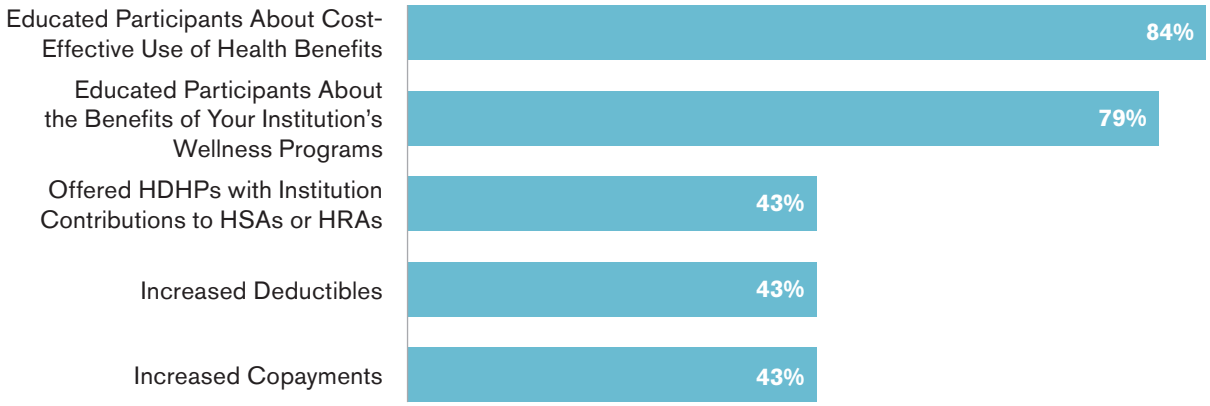


Source: Sibson Consulting, 2016

Sibson Observations Colleges and universities that have made a commitment to create a healthier workforce can use this as a recruiting tool. Wellness initiatives are generally viewed as enhancements that help reduce medical spending in a positive way that also demonstrates care for employees by improving their health, well-being, and the plan's claims experience. By focusing on the well-being of faculty and staff, institutions are able to reduce health risk in the population, which leads to reduced health claims. This helps make their campus a more desirable place to work.

In terms of strategies used in 2016 to control health plan cost increases, most institutions stressed wellness program education and employee education about the cost-effective use of their health benefits. These two strategies were clearly the top choices, with various cost-sharing strategies and HDHP account plans rounding out other prevalent methods used.

Two of the Top Five Strategies for Managing Health Plan Cost Increases Involve Educating Participants



Source: Sibson Consulting, 2016

In addition to continuing to use what they were using in 2016, most institutions (71 percent) said that the "use of data analytics to inform program and plan design" was among the Top Five Future Strategies to be used to control health plan cost increases for 2017, behind wellness programs education, educating participants about cost-effective use of health benefits, and educating employees about the benefits of an institution's disease management programs.

The survey also revealed an increase in prevalence of certain disease-management programs: programs for depression[4] and hypertension both increased by about 2.5 percentage points, and programs for diabetes and lower back pain both increased by close to 2 percentage points. All four of these disease-management programs are important because they target diagnoses that are co-morbidities to obesity.

> "Obesity tends to be a significant part of the root cause of Type II diabetes, hypertension and lower back pain. While prevalence of the four disease-management programs mentioned above has increased, what was surprising to find was that the prevalence of obesity-management programs has not. This tells us that higher education institutions have an opportunity to shift their focus from simply treating the diseases after they occur to addressing obesity before it *leads* to high-cost health issues."
>
> **Sadhna Paralkar, MD**
> Senior Vice President,
> National Health Practice

[4] Disease management programs for depression must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Sibson Observations Institutions continue to focus on educating the educators (and staff) about the most cost-efficient use of health and wellness programs. Communications campaigns play a vital role in how health benefits programs are positioned, explained and understood. High-quality, clear and frequent communications and educational tools can all help increase engagement and participation in wellness and disease-management programs. That can lead to a healthier campus in general. It also increases the odds that, if educated properly, employees catch billing errors (which are far more common than one might expect) and understand the cost of care.

> "Educating employees about how to use their health plans can make utilization more efficient and cost-effective, and give employees a greater sense of security when they need to use their plans — a time when they may not always be able to think rationally."

Randolph B. Carter
Senior Vice President,
National Communications Practice Leader

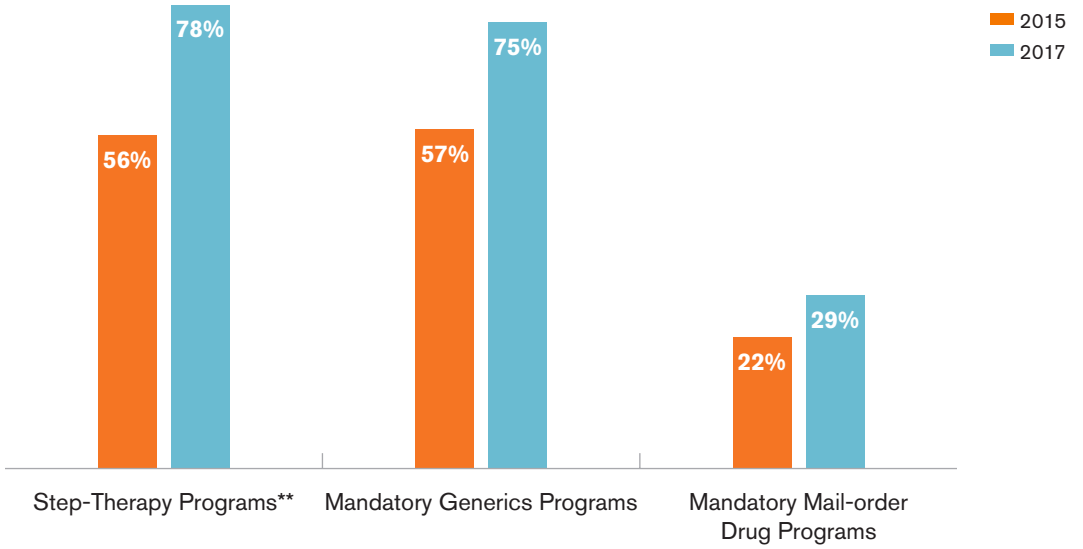
The most successful strategies integrate the medical, disease management and wellness programs. In Sibson's experience, some institutions are achieving a wellness program participation rate as high as 90 percent.

Growth in Use of Prescription Drug Cost-Management Programs

Sibson found the following about institutions' prescription drug coverage:

- **Deductible** — Relatively few prescription drug plans (15 to 20 percent, depending on plan type) had a stand-alone (independent of medical coverage) deductible in 2017 (unchanged from 2015).
- **Coinsurance** — There was a consistent percentage of plans that include coinsurance for at least some brand-name drugs from 2015 to 2017. Approximately 26 percent of plans overall include coinsurance to pay for at least some brand-name drugs. The average institution coinsurance level was 74 percent for brand-name, formulary drugs (same as in 2015) and 67 percent for brand-name, non-formulary drugs (was 68 percent in 2015).
- **Copayments** — The weighted average three-tier copayments across PPO/POS plans, HMO/EPO plans and HDHPs collectively are $10 for generic drugs, $30 for brand-name formulary drugs and $51 for brand-name non-formulary drugs. The average and median 90-day mail-order copayments continue to be very close to two times the 30-day retail copayments (for all three plan types).
- **Out-of-Pocket Maximums** — Over the past couple of years, Sibson's CUBS found the prevalence of stand-alone, out-of-pocket maximums remained fairly consistent: 35 percent in 2015 to 34 percent in 2017.
- **Prescription Drug Cost-Management Programs** — The two most prevalent prescription drug cost-management programs, which are used by at least three-quarters of institutions, experienced dramatic growth since 2015.

Notable Two-Year Growth in Use of Three Prescription Drug Cost-Management Programs*



* This data is for prescription drug plans that are part of PPOs/POS plans, HMO/EPOs and HDHPs.

** Step-therapy programs require that, for certain drug classes, attempts at using alternative solutions (such as lower-tiered, effectiveness-equivalent drugs) and/or generic drugs must first be made before using a more expensive tier of drugs, such as the specialty drug class.

Source: Sibson Consulting, 2018

Sibson Observations Mandatory mail-order drug programs are not as prevalent as the others. This is because major pharmacies have created the "90-days script at retail" pharmacy benefit, giving employees the same drug quantity and price at retail as for mail-order, coupled with the convenience of drug store pickup. Step-therapy programs continue to expand and evolve as the need grows to cover additional drug therapies under these programs with the advent of new, specialty pharmaceuticals.

Prescription drug costs continue to soar and are now typically between 25 percent and 33 percent of total health plan costs. Institutions have taken many steps to help mitigate future increases. In addition to the steps mentioned above, institutions have been:

- Joining a higher education prescription drug coalition;
- Considering alternative formularies, which provide significant savings with minimal employee disruption;
- Educating faculty and staff about the drivers of prescription drug costs;
- Providing transparency tools and apps that allow for on-the-spot cost comparison of alternatives when physicians are writing the prescription; and
- Conducting pharmacy benefit manager claim audits and contract reviews to ensure competitive pricing.

Quantity (day) limits on scripts, and prior authorizations on specialty drugs are also becoming commonplace. Additional controls to combat opioid addiction are beginning to be used, too.

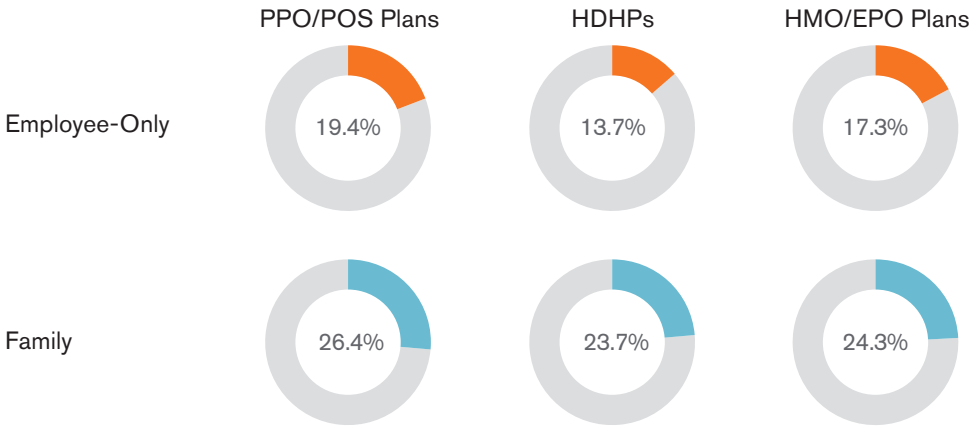
> "Institutions will need to look for other creative ways to combat pharmacy claims trend, particularly the specialty drug trends. Institutions may want to consider further management measures such as quantity limits, site-of-care cost optimization, partial/split fill programs, more comprehensive prior-authorization rules, and performing fraud waste and abuse analyses."

Nick Taylor, RPh
Vice President,
National Pharmacy Practice Leader — Consulting Services

Institutions Are Incenting the Election of HDHPs Through Comparatively Lower Employee Contributions

Sibson found that the percentage of medical plan premiums paid by employees for their health coverage (medical and prescription drug coverage) is lowest for those covered by HDHPs for employee-only coverage. Employee contributions are lowest for HDHPs and highest for PPO/POS plans, in general, as illustrated below. Employee contributions for HMO/EPO plans are generally 1 to 4 percent higher than that for HDHPs, and PPO/POS plans are generally 2 percent higher than that for HMO/EPO plans. Also, note that clerical staff[5] pay as much as 2 percent to 3 percent less than faculty or administrative staff, on average.

Employee Contribution Requirements Continue to Favor HDHPs, but the Gap Is Not Wide*



* Note that for this comparison, only 4-tier rates and contributions were used to reflect these two tiers (as a vast majority of the plans use 4-tier rates and contributions).

Source: Sibson Consulting, 2018

Sibson Observations Higher education institutions continue to subsidize family benefits more generously than those offered by employers in other industries. Additionally, with the rising cost of health care (particularly pharmacy trend), employee appreciation for this generous benefit has eroded as the cost to participate steadily increases and becomes harder to afford. As a result, institution initiatives to educate and enable consumerism, as well as stressing wellness and disease management programs (to combat obesity, among other things), have become prominent and will continue to be emphasized going forward.

[5] The "clerical staff" employment group can often include security, maintenance, food services and transportation staff.

Year-Over-Year Increases in Medical/Prescription Drug and Dental Premium Rates and Employee Contributions

The table below shows the increase between 2016 and 2017 in medical/prescription drug premium rates and employee contributions. This data is for only those plans in CUBS for both years. For details about the analysis that generated this data, see the methodology section on page 34.

Contribution Increases for HDHP Outpaced Other Plans While Rate Increases Did Not

Medical/Prescription Drug Increase 2016 – 2017	PPO/POS Plans	HDHPs	HMO/EPO Plans
Total Premium Rate*	7.1%	5.6%	4.8%
Employee Contributions	7.7%	9.7%	7.5%

* Unlike pure medical/prescription drug trend, the premium rate reflects plan design changes.

Source: Sibson Consulting, 2018

Data from the above table shows that:

- Medical (including prescription drug) rate increases, after plan design changes and excluding plan replacement where identifiable, are less than 7 percent on average, (lower by about 1 percentage point than in 2015). This is true across the higher education industry and is consistent with what employers in other industries are experiencing. While many plans make minor design changes, there are also a significant number of plans that have converted from PPO/POS plans to HDHPs; several converted from HMO/EPOs to HDHPs.
- Employee contribution increases are, on average, higher than the medical/prescription drug premium rate increases for all plans. This trend illustrates the financial pressure institutions are facing. Therefore, cost shifting to employees, even at a slow rate, continues.

Note that increases in HDHP employee contributions appear higher as a percentage than those of the PPO/POS plans and HMO/EPOs because these contribution amounts are starting off at a much lower dollar amount. (In other words, the percentage increase may seem more significant than it actually is because a high percentage of a lower dollar amount can still be a lower dollar increase.)

Sibson Observations Institutions, on average, have increased employee contributions at a somewhat higher rate than the overall health premium rate increases (after design changes) for medical and prescription drug plans. This occurred for HDHPs because as the popularity of the plan type increases, there is less need to lower employee contributions as an incentive to join. (Nevertheless, contribution requirements for HDHPs are still substantially lower than for traditional PPOs, as shown on page 14.)

> "Cost shifting has not gone away. Increasing contributions is one lever among many used to manage costs. As utilization management and wellness programs grow in use and effectiveness, the hope is fewer costs will need to be shifted to faculty and staff through payroll contributions."

Christopher Calvert
Senior Vice President,
Corporate Health Practice Leader

The table below shows the increase between 2016 and 2017 in dental premium rates and employee contributions by the faculty and staff groups combined. As with the increase data about medical/prescription drug plans presented on page 15, the increase data about dental plans is only for dental plans in CUBS for both years.

Dental Contribution Increases Kept Pace with Rate Increases

Dental Increase 2016-2017	PPO/DPO Plans	HMO Plans	Indemnity Plans
Total Premium Rate*	3.3%	2.0%	2.6%
Employee Contributions	3.2%	1.7%	2.1%

* Unlike pure medical/prescription drug trend, the premium rate reflects plan design changes.

Source: Sibson Consulting, 2018

Dental premium rate increases, after plan design changes and excluding plan replacement where identifiable, remain very low and in the realm of 2 percent to 3.5 percent. However, what cannot be accounted for within these low premium rate increases is that dental contracts are often multi-year contracts where premiums and/or administration costs are held flat for two or three years. For all plans, the employee contribution increases match closely to the premium rate increases (as they all fall just below those premium rate increase levels). This is common among renewal increases, where there can often be rounding down to the nearest dollar for such small increases, making contribution increases lower than the rate increases themselves, even though the intent was to pass along an even share of the increase to the employee.

Continued Steady Decline in Retiree Health and Life Insurance Coverage

Many institutions appear to be exploring alternatives to retiree health and life insurance coverage. Each year, some institutions make one of the changes noted below. The most prevalent changes (which are still the same options considered two years ago) institutions have adopted include:

- Eliminating eligibility for new hires;
- Introducing defined contribution accounts for retiree health care coverage;
- Offering retiree post-65 medical coverage through a private Exchange;
- Limiting the institution contribution to a fixed-dollar or capped amount; and
- Capitalizing on the expanded prescription drug benefits available to Medicare-eligible participants as a result of health care reform. (Many institutions have already eliminated prescription drug coverage for Medicare-eligible participants beginning January 1, 2020, when the changes to the Medicare program introduced by the Affordable Care Act will be fully phased in. It will be at this time that the Medicare-provided benefit will usually be equivalent to or better than the benefit institutions are offering today. In 2020 and thereafter, the coverage gap, which begins after the deductible is paid and ends when catastrophic coverage starts, will require participants to pay 25 percent of the cost share — down from 100 percent when Medicare Part D was first introduced.)

Sibson found there has been a steady decline (of 2 percentage points over two years) in offering retiree health benefits to new hires. There was little difference in the decrease percentage between public and private institutions.

Prevalence in Retiree Health Benefits Offered to New Hires Continues Its Steady Decline Among Higher Ed Institutions

	2017	2015
Public	71%	74%
Private	47%	49%
Overall	57%	59%

Source: Sibson Consulting, 2018

Sibson did find some dramatic differences in the retiree health coverage that public and private institutions offer to new hires. Although a large majority of public institutions still offer a defined benefit retiree health benefit plan to new hires, there has been a decline in that offering (83 percent in 2017, down from 93 percent in 2012). In contrast, a much smaller percentage of private institutions—57 percent—offer defined benefit retiree health plans to new hires (and there was a similar significant decrease of 14 percent over that same timeframe, compared to 71 percent offering DB health benefits in 2012).

Among private institutions that offer coverage to new hires, 43 percent use an account-based DC plan (a significant increase compared to 29 percent in 2012) whereas only 17 percent of public institutions offer a DC health option (also a significant increase, up from 7 percent in 2012). The CUBS data had been showing slow, but consistent, movement away from DB retiree health coverage and movement towards DC account-based retiree health coverage. Private institutions have been moving towards defined contribution retiree health plans at a quicker pace than public institutions.

Movement to DC Retiree Health, Away from DB, However Many Public Institutions Continue to Offer DB Plans

	2017		2012*	
	DB	DC	DB	DC
Public	83%	17%	93%	7%
Private	57%	43%	71%	29%

* This 2012 data from Sibson's first *College and University Benefits Study* is shown to illustrate how these offerings have changed since the study's inception five years ago.

Source: Sibson Consulting, 2018

The table below shows variation in 2017 cost sharing by coverage tier and pre- and post-Medicare for retiree health coverage among institutions that still offer subsidized defined benefit retiree health.

Retiree Contributions In the 20 to 30 Percent Range

	Average	Median
Pre-Medicare		
Retiree-Only	22%	20%
Spouses and Dependents	31%	26%
Post-Medicare		
Retiree-Only	20%	20%
Spouses and Dependents	33%	27%

Source: Sibson Consulting, 2018

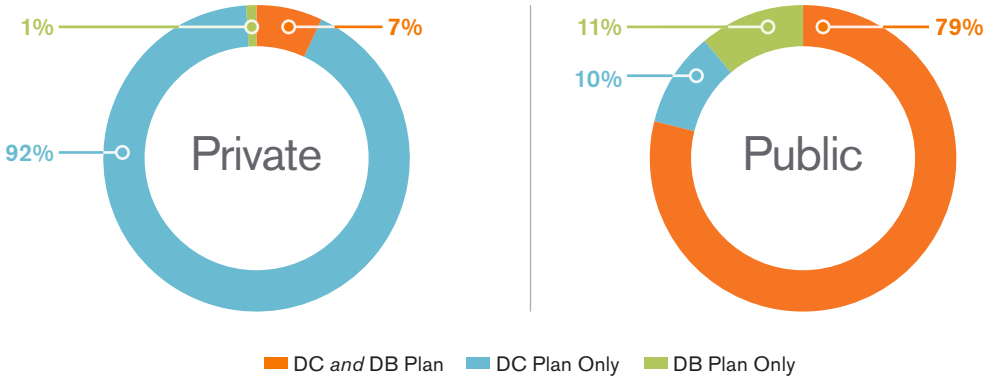
Sibson found that relatively few institutions offer either retiree dental coverage (18 percent), which are mostly retiree-pay-all programs, or retiree life insurance (31 percent).

Sibson Observations The study data suggests that due to the continued high cost of providing retiree health programs, an increasing number of institutions have come to view their DB retiree health programs as unsustainable. We expect the trends towards defined contribution account-based programs, which allow for greater cost control while still offering retirees medical coverage, and/or elimination of coverage for new hires, will continue to increase over the next several years. The data has shown this pattern over the past few years.

Retirement Plans: Dramatic Differences Between Private and Public Institutions

Sibson continues to find differences in retirement benefits offered by private versus public institutions. Very few private institutions (close to 8 percent) offer defined benefit (DB) plans in 2017. In contrast, a majority of public institutions offer a DB plan (close to 90 percent).

Private Institutions Almost Completely Exit DB Space, While Public Institutions Are Evenly Split



Source: Sibson Consulting, 2018

Practically all (100 percent when rounded[6]) private institutions with retirement plan data in CUBS offer a defined contribution (DC) plan. Moreover, close to 88 percent of public institutions that offer a DB plan also offer a DC plan. It is common for state retirement plans to offer a DB plan with the ability for some groups to opt out and select the state DC plan (Optional Retirement Plan) as an alternative.

Among all DC plans, 77 percent include an employer match. For institutions where the primary retirement plan is a DC plan, Sibson found that the median institution contribution to their DC plans is 9 percent of compensation, and with a mean contribution of 8.7 percent of compensation. This continues to be close to two-and-half to three times greater than the corporate contributions to 401(k) plans.[7]

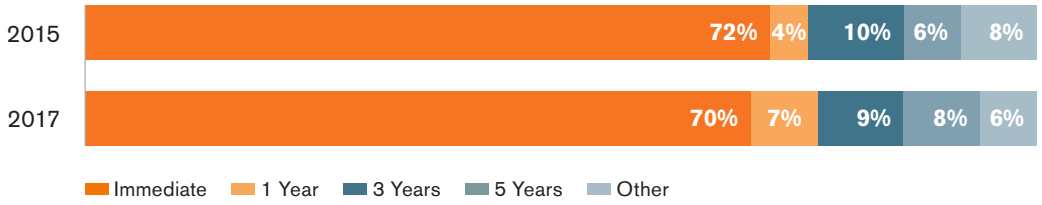
Sibson Observations In Sibson's experience, in recent years, some institutions have redesigned their DC plans to reduce or eliminate their non-contributory retirement funding and replace it with an employer match based on employee contributions to encourage shared responsibility for building retirement savings. Institutions are also placing a greater emphasis on retirement planning through employee education.

[6] This did not apply to one institution.

[7] According to the Bureau of Labor Statistics' *2015 Employee Benefits Survey*, the median match for all private sector employees is 50 percent of the employee contribution up to 6 percent, and the median maximum employer contribution is only 3 percent. See Table 58a and Table 55a.

Sibson's study continues to see movement away from immediate vesting in DC retirement plans. Approximately 30 percent of institutions now have a service requirement for vesting in employer contributions, most requiring three or more years of service. The graph below compares DC retirement vesting schedules for 2017 to 2015.

After Several Years of Vesting Slowly Lengthening, 2017 Saw Little Change

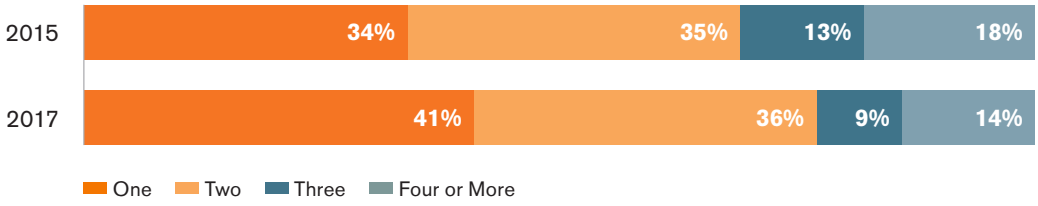


Source: Sibson Consulting, 2018

Sibson Observations We continue to see a consistent pattern of institutions slowly moving away from immediate and one-year vesting and towards vesting in three to five years. Every institution should consider extending vesting to three-year cliff vesting or five years graded vesting, as it has a low impact on employee retention while potentially offering significant cost savings. Turnover in the first five years of employment continues to be commonplace in higher education. This makes three-year cliff or five-year graded vesting schedules a good way for institutions to manage their DC plan costs while still rewarding employees who stay beyond those time frames. Overall, there was a shift away from immediate vesting since 2015 (and earlier). This is a low-impact, high-value savings opportunity.

Vendor consolidation continued further between 2015 and 2017. As shown in the graph below, Sibson found that more than three-quarters of institutions have only one or two DC plan administration vendors (this was less than 70 percent in 2015).

Consolidation of DC Plan Administration Vendors Continues



Source: Sibson Consulting, 2018

Sibson Observations Vendor consolidation often allows for reduced expenses while still offering employees significant investment options. Vendor consolidation will continue particularly at institutions with more than four active vendors. When consolidating investment options, some institutions add a mutual fund brokerage window to give faculty and staff access to almost any mutual fund.

> "Adding a brokerage account can mitigate the misconception that vendor consolidation is a reduction of choice."

Rick Reed, CEBS, AIF
Vice President,
Defined Contribution Practice Director

Institutions may want to provide counseling for employees about retirement planning to get them ready to retire. Recordkeepers may provide on-campus counseling, but often employees that need it most do not take advantage of the service. Coordinating these educational efforts with your recordkeeper can significantly improve success and overall employee outcomes. This approach, in combination with bank/credit union programs and group legal services, can help promote fiscal responsibility of both personal and institutional resources, while reducing employees' stress about their financial wellbeing. Additional avenues may include retirement-readiness reports and incorporating behavioral economics by adding a new or enhanced matching feature and improved communications. Behavioral economics (nudging employees towards making optimal choices) can assist in sending the "right message" subtly to employees, to help them make the best choices for their families. Data available from your DC plan recordkeepers can be helpful in developing a behavior change and communications strategy.

> "Institutions, like most employers, have no idea how financially prepared their employees are for retirement. Yet it's important to understand what constitutes retirement readiness and where all employees — not just those nearing retirement — stand on the readiness spectrum. This requires knowing what savings employees need to attain a secure retirement, gathering financial and other data on all employees and then 'running the numbers' to determine how each employee stacks up."

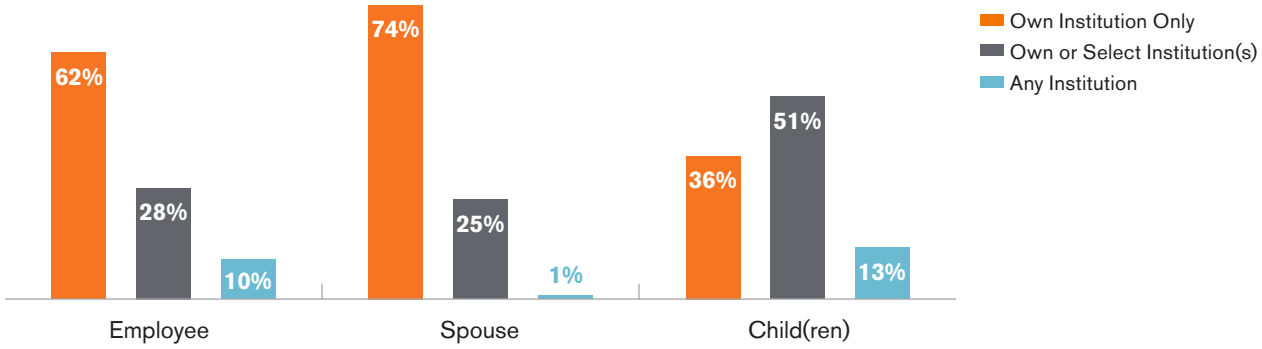
Jonathan Price
Vice President,
Strategic Defined Contribution Analytics

Tuition Benefits Continue to Be One of Higher Ed's Most Valuable Recruiting Advantages

Tuition benefits align with the institutional teaching mission, are far more prevalent in higher education due to the "business" they are in and are commonly viewed as one of the most valuable benefits offered by institutions. As a result, it is one — and perhaps the most significant — of many incentives that draw employees to work in higher education. Tuition benefits can play an important role in the intellectual health of each employee and his/her family.

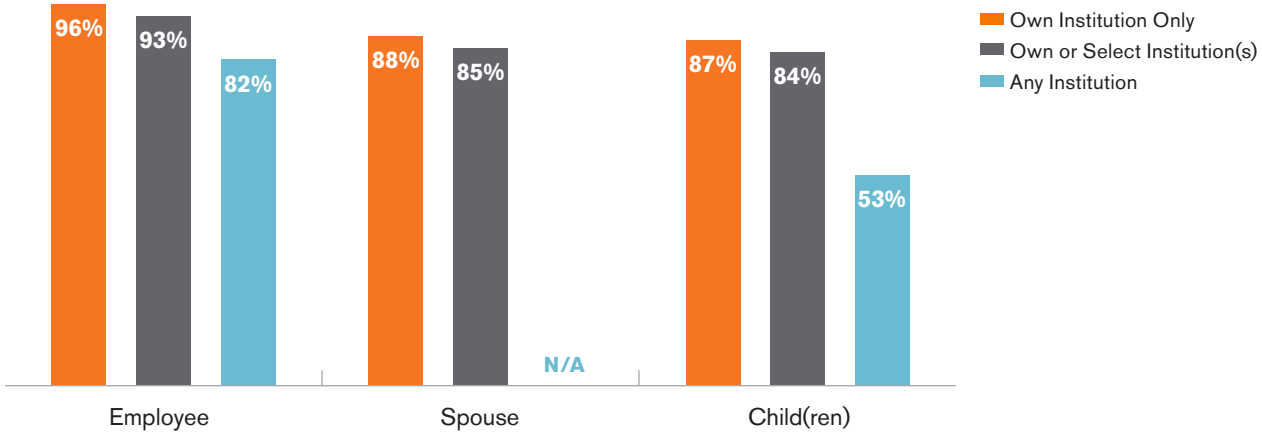
Virtually all institutions offer tuition benefits to employees. About 95 percent offer them for dependent children. Approximately 88 percent offer tuition benefits for dependent spouses. The first graph below shows to where employees, spouses and children can use tuition benefits. The second graph shows how the average percentage of tuition reimbursement varies by family member and where the benefit is used.

Where Can Tuition Benefits Be Used by Family Members?



Source: Sibson Consulting, 2018

How Does the Level of Reimbursement Vary by Family Member and Location?



Source: Sibson Consulting, 2018

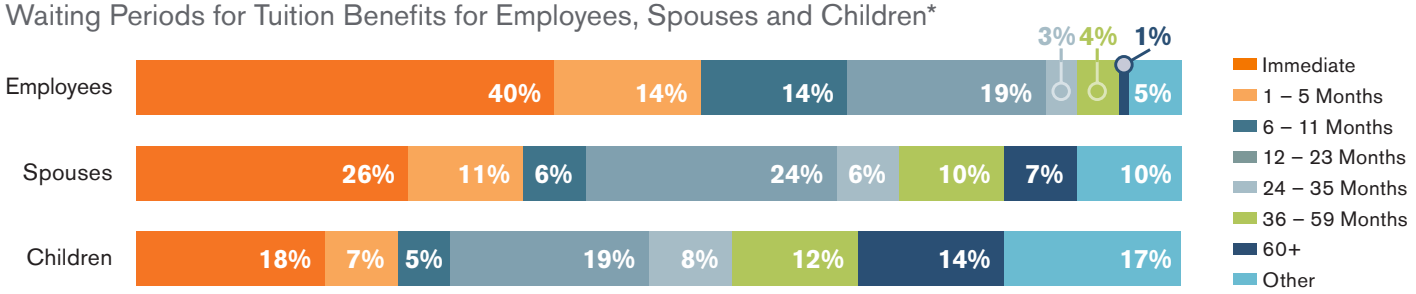
Sibson Observations While there are some minor variations from what was seen two years ago, these tuition reimbursement levels are consistent with what CUBS has seen historically.

On average, after health and retirement, tuition benefits are the third largest benefit value (or cost, if the institutions book the payment or reimbursement of the tuition amounts) as a percentage of operating budget, with most of the cost subsidized by the institution. To keep this cost down, there are usually credit-hour, or sometimes dollar, benefit limits, particularly when used by an employee or spouse. Sibson found that the median credit hour limit for employees is 16 hours per year; spouses, it is 18 hours per year. When the limit is based on credits per semester, it was found that employees are limited to 6 credit hours per semester; spouses were limited to 8 credit hours per semester. When used by a dependent child, however, the median limits are much greater: 24 credits per year and 16 credits per semester. As shown in the graph on the prior page, employees and spouses are usually required to use this benefit at their own institution. In contrast, dependent children usually have more options.

Sibson found that the waiting period among the institutions is significantly spread out, particularly for dependent children. This indicates that institutions place a different emphasis on the role tuition benefits play in employee retention. It also found slight differences among the average waiting periods for faculty, administrative staff and clerical staff.

Of the three groups, faculty have the shortest waiting periods. A large percentage of this group (42 percent for employees, 28 percent for spouses and 20 percent for children) have immediate access or no waiting period. (See the first set of bars in the graph below.) This is 2 percentage points higher than those with no waiting period who are administrative staff, and 3 percent higher than those with no waiting period who are clerical staff. The graph below shows the average waiting periods for tuition benefits for administrative staff, which is representative of all employees.

Waiting Periods for Tuition Benefits for Employees, Spouses and Children*



* The data shown is for administrative staff. The data was similar for faculty and clerical staff.

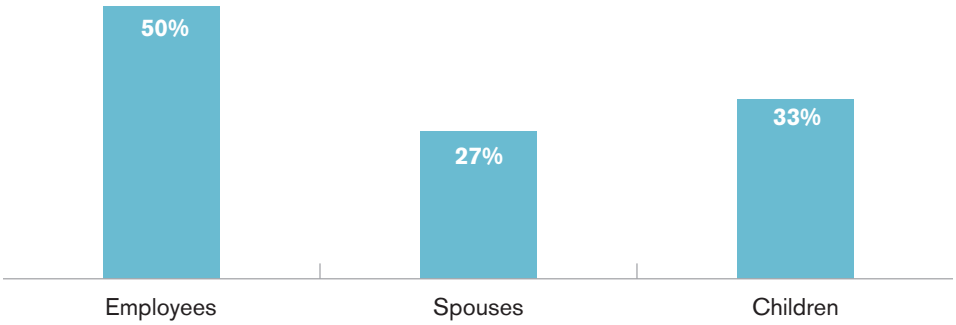
Source: Sibson Consulting, 2018

Sibson found a slight decline (of 1 to 2 percent) for the immediate waiting period since 2015. This was the only consistent pattern change across all three family member types. Very little movement has been seen in any one particular waiting period range over the past two years.

Twenty-nine percent of the institutions require coursework to be job-related for faculty tuition reimbursement. This is significantly higher than the 22 percent reported in 2015, and reflects another way institutions have changed tuition benefits with an eye on controlling cost.

The graph below shows how the percentage of institutions with a minimum grade requirement differs depending on who is requesting reimbursement. These percentages are all higher by 2 to 7 percentage points across each tier from what Sibson's CUBS reported for 2015.

Requirements to Achieve a Minimum Grade as Method to Moderate Cost Approach 50 Percent Level



Source: Sibson Consulting, 2018

Sibson Observations Consideration must be given to whether the investment in tuition benefits is optimal as part of total compensation expenditures and, if so, how to communicate its value to current and prospective employees. Is this benefit drawing the talent your institution seeks, or adding significant cost without building a noticeably distinctive workforce?

Tuition benefits can include features that preserve the value of this very rich and attractive benefit while reducing program costs. Commonly used ways to keep the cost of this benefit from growing too quickly include longer service requirements, credit or dollar limits, making the employee benefit tied to job-related coursework for eligibility, and requiring minimum grades to receive reimbursement. We continue to see a shift, albeit slight, away from immediate eligibility towards having some form of waiting period. There continues to be sizable increases in the percentage of institutions requiring the classes to be related to the employee's job, and towards requiring a minimum grade to receive reimbursement. Of course, institutions must consider the impact of any of these changes on recruitment and retention.

> "Tuition assistance has long been a recruitment and retention differentiator for higher education institutions. The new challenge is how to maintain that advantage as a growing number of employers from other industries start to offer this popular benefit."

Kelly Jones
Senior Vice President,
National Higher Education Practice Leader

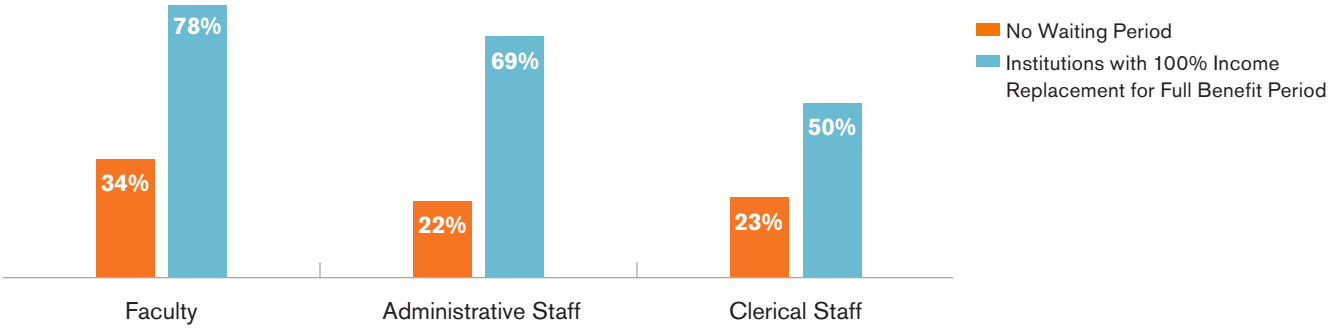
Offerings of Leave Programs Differ by Employment Groups

Leave programs play an important role in protecting faculty and staff from financial hardship and in promoting personal and professional renewal. At colleges and universities, leave programs tend to be a grouping of benefits that might include some or all of the following: salary-continuance plans, holiday leave, vacation time, personal days, sick leave, short-term disability plans, long-term disability plans, maternity/paternity leave, and sabbatical leave. Some institutions also offer bereavement and military leave.[8] (Formal paid time-off programs[9] are not common in higher education).

Sibson found some differences in leave programs offered to the three employment groups studied, as noted below:

- **Vacation Time** — On average, administrative staff at the institutions in the study receive three to six more days of vacation time than clerical staff receive in the first 10 years of employment. This difference diminishes as service increases. By 15 years of service, the difference in time off becomes negligible. Similar differences were also reported by Sibson's CUBS for 2015. Administrative staff accrue a median of 20 to 22 days of vacation per year, depending on service. Clerical staff accrue 12 to 22 days per year, also depending on service.
- **Sabbatical Leave** — Faculty are much more likely than other employees to be eligible for sabbatical leave. Among the institutions in CUBS, 87 percent offer fully-paid sabbaticals to faculty, compared to 31 percent that extend it to administrative staff and a smaller percentage (22 percent) that offer it to clerical staff. Faculty receive a median of 16 weeks, or 1.0 semester, of fully paid sabbatical leave. Since the majority of institutions don't offer sabbatical leave for administrative and clerical staff the mean and median for those groups is zero. When sabbatical leave is offered to administrative and clerical staff, CUBS reflects that they are almost always the same length of sabbatical offered to faculty.
- **Salary-Continuance Plans vs. Short-Term Disability Plans** — Salary-continuance plans[10] are not typically offered to all employment groups. Sibson found that 61 percent of institutions offer this benefit to faculty and 49 percent offer it to administrative staff, but only 32 percent offer it to clerical staff. Instead, clerical staff are offered short-term disability at a higher rate than faculty (by 6 percentage points) and administrative staff (by 1 percentage point). Where faculty do not receive salary-continuance plans, they often have unlimited sick leave. A majority of institutions require a waiting period before employees can participate in salary-continuance plans, but among those that do not, faculty are more likely than administrative staff or clerical staff not to have a waiting period.

Salary Continuance Is a Benefit Primarily Given to Faculty and Administrative Staff



Source: Sibson Consulting, 2018

[8] Institutions should be aware of any state or local mandatory leave programs that apply to them.

[9] Paid time-off programs combines any of the following paid leave plans into a single pool of paid time-off to be used at the employee's discretion: sick, vacation, holiday, personal and bereavement. They can often include rollover accumulation of time and banking of time that can be converted into time used for any purpose.

[10] Salary-continuance plans provide 100 percent reimbursement for employees who are unable to work for an extended period due to illness. Before benefits commence, there is sometimes a requirement for the employee to take unused sick and/or vacation days. Salary-continuance plans are often used in place of short-term disability plans. In some rare cases, they are used in combination with short-term disability plans.

Virtually all institutions offer long-term disability (LTD) insurance, with 49 percent integrating their LTD insurance programs with their short-term disability insurance program.

The 25th, median and 75th percentile benefit percentages were all 60 percent, with the median monthly maximum of $8,000/month and a 180-day elimination period. There have been little to no changes regarding LTD benefits over the past few years.

Sibson Observations Variation of leave benefits for faculty and administrative and clerical staff is most prevalent in institutions' paid time-off policies. Most faculty do not get vacation leave, but have salary-continuance programs that often protect their income before LTD insurance benefits begin. Some institutions have gaps in their paid-leave programs where employees may not have salary protection if they are out of work for an extended time due to illness or injury. These institutions may want to consider providing voluntary short-term disability insurance plans to help employees fill these gaps and protect their income, while not adding cost for the institution. Most clerical staff do not get salary-continuance. Rather, they receive sick leave in combination with short-term disability insurance. However, the cost of some short-term disability insurance plans is paid by the institution and some are voluntary—that is, employee-pay-all. A number of institutions offer sick leave with provisions for the rollover of a large total of unused time. This time can be used until the individual's LTD insurance plan begins paying benefits. For these institutions, there is an opportunity to bridge a gap in clerical staff income protection by offering a subsidized or unsubsidized short-term disability insurance plan. This way, an employee who has not accrued enough sick leave to continue all or a portion of his/her income until his/her LTD insurance plan begins paying benefits will not be without income during an extended illness.

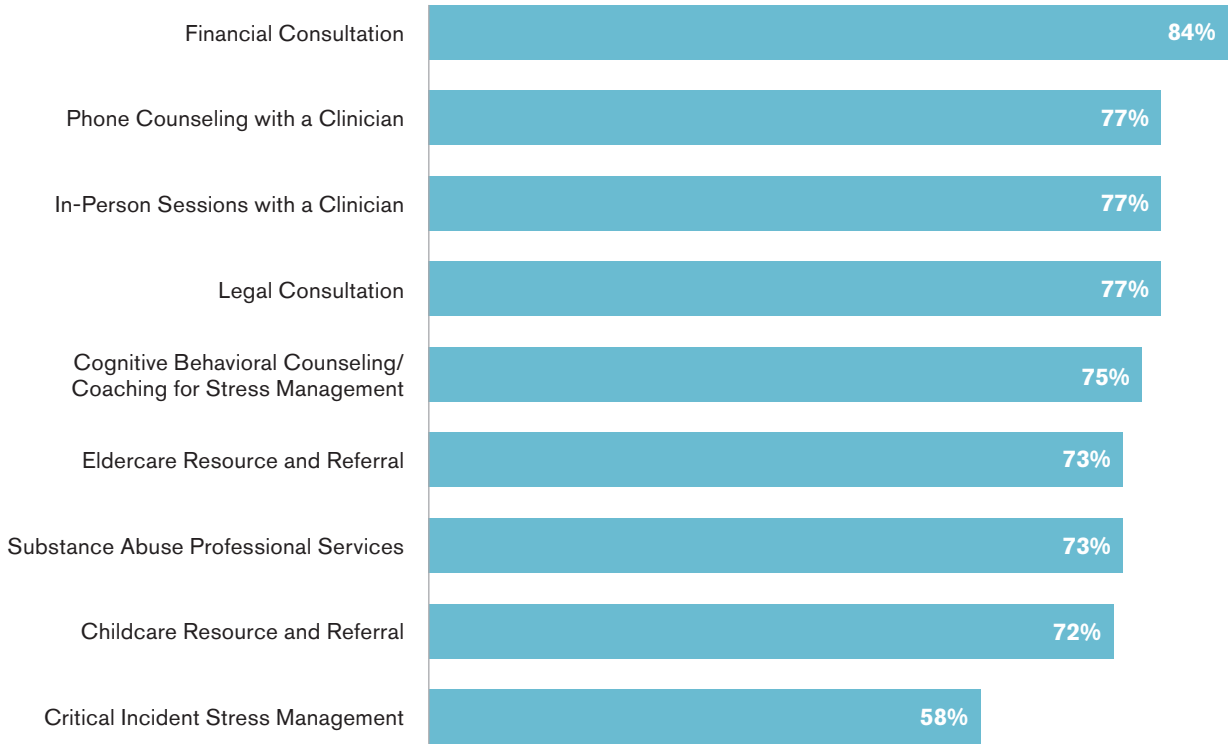
> "Integrating short-term disability and LTD insurance programs could save 10 to 15 percent of LTD insurance premium costs. Yet many institutions haven't taken advantage of this savings opportunity."

Norman J Jacobson
Senior Vice President, ASA, MAAA
Higher Education Benefits Practice Leader

Institutions Offer Many Employee Assistance Program Services but May Not Adequately Promote the Use of this Benefit

Sibson found that in 2017, at least 50 percent of institutions in the study offer the nine employee assistance program (EAP) services listed in the table below. EAPs can vary in value based on how many face-to-face sessions an employee can schedule, and how connected the EAP is to other benefit plans, such as the wellness plan or the medical plan. EAPs offered by institutions allow for nearly five in-person visits each year, on average.

Financial Consultation Leads EAP Services Offered, as Financial Wellness Needs Boom for All Employees



Source: Sibson Consulting, 2018

Sibson Observations EAPs can play an important role in supporting the wellbeing of a workforce, but they are often not promoted and communicated effectively. Most EAPs are often underutilized, particularly if they are designed to only support those in distress. Employee education about the services EAPs provide and how best to use them is vital to ensuring faculty and staff get the most of this often-overlooked benefit.

Optional Plan Maximums for Life Insurance Rise

Sibson found that basic group term life insurance does not often vary by employment group, and most institutions include similar provisions tied to this benefit. These benefits are typically fully subsidized by the institution.

The graph below lists the provisions that are part of group term life insurance at more than half of the institutions in the study.

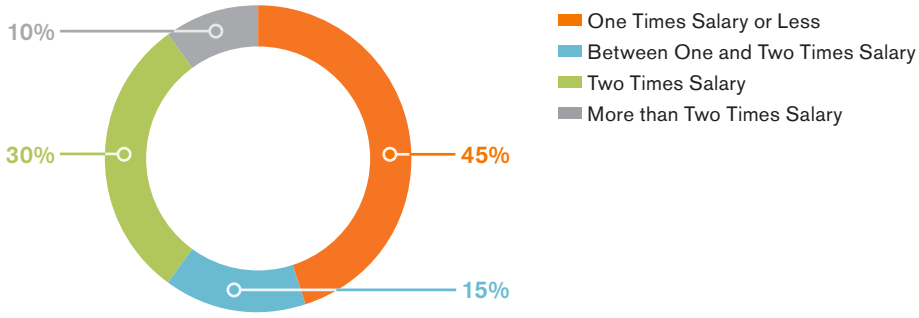
Premium Waivers and Accelerated Death Benefits Have Almost Become As Widely Used as AD&D Insurance

* Under this provision, benefits are paid when the employee is diagnosed with a terminal condition.
** Under this provision, no premium payment is required during the period of disability.

Source: Sibson Consulting, 2018

The graph below shows the breakdown of the salary multiples used by the nearly three-quarters of institutions that calculate the basic level of life insurance by using a multiple of salary.

Benefit Multipliers Have a Mean and Median of 1.5 Times; However One Times and Two Times Remain Most Prevalent

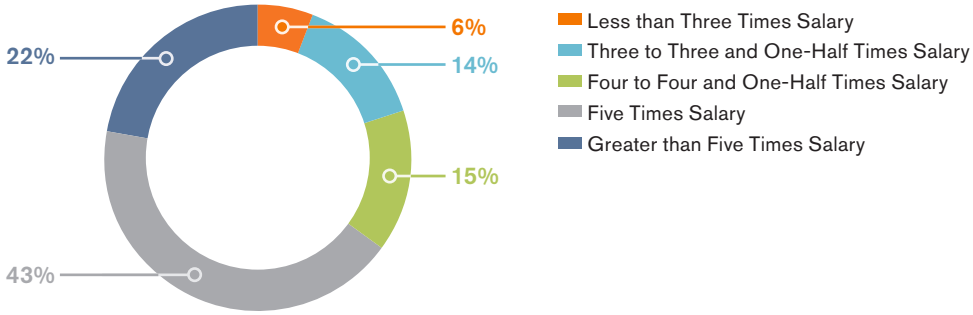


Source: Sibson Consulting, 2018

Note that these multipliers are consistent with what was reported by CUBS in 2015.

Eighty-five percent of the institutions for which information about life insurance benefits was captured reduce those benefits when employees reach a specified age. The median age at which this reduction takes place is 65. Of those with benefit reductions by age, 83 percent of the reductions are by some percentage of the benefit; the other 17 percent are reductions by or to a particular dollar amount.

Optional Life Insurance Maximums Trend with the Times



Source: Sibson Consulting, 2018

The maximum multiplier, on average, is higher than what was reported for 2015. Those with five times salary or greater than five times salary have increased in prevalence by 3 to 4 percent; all other multipliers (lower ones) have decreased in prevalence.

Non-Traditional Benefits: Creative Offerings

Non-traditional and/or voluntary benefits are a great way to enhance a benefits package at low or no cost to the employer. Historically, non-traditional benefits have focused on benefits that save employees money or provide additional financial security. Such resources, which can support the financial well-being of faculty and staff, continue to be among the most prevalent non-traditional benefits, as shown in the table below, in which those types of non-traditional benefits are indicated with a wallet. Other symbols in the table indicate which non-traditional benefits can play an important role in a healthy campus initiative (look for an apple) and/or support work/life balance (look for the person meditating).

Financial Wellness Continues to Be the Growing Theme, with Local Business Discounts and Banking Programs Now Offered by More than Half of Institutions Studied

Campus Wellness Initiatives*	88%
Access to Campus Fitness Center(s)	87%
Long-Term Care Insurance	87%
Day Care and Eldercare Referral Services	80%
Group Home and Auto Insurance	78%
On-Site Day Care/Eldercare (or Reimbursement)	78%
General/Local Business Discounts	66%
Group Legal Services	65%
Relocation Assistance (for Non-Clerical Staff)	59%
Banking/Credit Union Programs	54%
Transportation and Parking Benefits**	52%

Key to Symbols:

- Benefits that Save Employees Money or Provide Additional Financial Security
- Benefits that Can Play an Role in a Healthy Campus Initiative
- Benefits that Support the Personal Development of Faculty, Staff and their Dependents
- Benefits that Support the Work/Life Needs of Faculty and Staff

* These often include the initiatives mentioned on page 9.
** Examples include discounts for chiropractor services and acupuncture.

Note: An expanded version of this table showing other non-traditional benefits is available as a supplement to this study report.

Source: Sibson Consulting, 2018

Sibson Observations Voluntary benefits, such as group home and auto plans and bank/credit union programs, offer significant value for little to no additional cost to the employer. This list contained only six benefits in 2015 but has expanded to 11 for 2017. This increase, in part, may be that institutions are seeing the value of adding these often low/no cost benefits to attract and retain talent and, in part, may be due to greater visibility and promotion of these benefits (now being captured in CUBS when they were not visible previously).

We anticipate a few more moving up the list to break the 50 percent prevalence barrier in coming years, as they become more popular and institutions look for additional ways to attract and retain talent. Non-traditional benefits that build affiliation among employees, the institution, and the surrounding community can be particularly attractive. Benefits such as internet and phone discounts, discounts to local businesses/vendors, and discounts to local museums, performing arts and sporting events all tie the employee to the institution's culture and environment. However, to reap the rewards of offering low-cost, non-traditional benefits, it is critical that they be wrapped into a broader total rewards strategy and communicated clearly, consistently and frequently to employees and in recruiting and retention materials. Institutions are promoting what they can offer to attract and retain talent.

> "Making it financially easier and more convenient for new faculty and staff to move their lives to an institution's campus and surrounding town or city is what non-traditional benefits are all about. They help build affiliation between the individual and the institution for which they work. These benefits, together with all other benefits provided by the institution, can make the difference in attracting talent and retaining it."

Leonard J. Spangher, CEBS, MHP
Vice President and Senior Consultant

Opportunities

Institutions may wish to consider adopting the following strategies to attract and retain the desired talent for their workforce:

- Focus on well-being and its integration with all health and welfare benefits. Each benefit has a place in helping employees achieve happiness, through physical, mental and financial well-being.
- Enhance the benefit package at little or no cost through the promotion of non-traditional and voluntary benefits.
- Continue to review generous tuition, medical, time-off and retirement benefits as part of their total compensation offerings.
- Implement prescription drug trend management programs to keep program costs from growing too rapidly, even as the rate of trend increase is slowing.[11]
- Close gaps that will improve the perceived value of your overall benefits package, such as closing an income protection gap by adding a voluntary short-term disability insurance plan where short-term disability insurance coverage is not provided by the institution (giving employees the option to select and pay for this protection).
- Emphasize retirement-income investment assistance and retirement-planning tools and services.
- Determine benefit competitiveness as part of total compensation offerings.

It is essential to measure how well current benefits meet employees' needs. Peer comparisons and employee satisfaction surveys/focus groups can help determine need and satisfaction, while showing that the institution cares about the wellbeing of its employees and values their input.

Sibson believes that a greater emphasis on consumerism and greater focus on communications, education, institutional health and wellness program integration, and incorporating behavioral economics principles to enhance the effectiveness of wellness programs will lead to a healthier employee population and, ultimately, lower plan costs. These need to be a focus for all institutions.

All decisions about changes to benefits and/or the introduction of new benefits should be made as part of an overall strategy that takes into account the institutions' needs of current and prospective employees and the benefits other institutions are offering, within higher education and other industries.

[11] See the 2019 *Segal Health Plan Cost Trend Survey*.

Questions? Contact Us.

This CUBS report does not cover all of the information in Sibson Consulting's extensive database of benefits offered by higher education institutions. Sibson can be retained to provide custom data reports, including comparisons among benefit designs, geographic regions, institution type, institution size, number of full-time faculty, number of undergraduate or graduate students, operating budget and/or endowment.

For more information about Sibson's college and university database and the CUBS data discussed in this report, or to find out how to participate in the next CUBS, contact one of the following consultants who conducted the study:

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Mr. Jacobson is a Senior Vice President, Actuary and Senior Consultant with more than 35 years of experience advising clients on the design and financial management of their benefit plans covering both active employees and retirees. He is the Benefits Team Leader of Sibson's higher education consulting practice and consults to many of Sibson's higher education clients on health and wellness program strategy, design, pricing and cost-sharing structure. He also serves as liaison between clients and their vendors, managing carrier negotiations, conducting competitive biddings and analyzing renewals and settlements.

Leonard J. Spangher,
CEBS, MHP
212.251.5228
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Mr. Spangher is a Vice President and Senior Health Consultant with more than 20 years of experience in benefits consulting. He is responsible for administration and maintenance of Sibson's CUBS and database. Mr. Spangher advises corporate and public sector clients in health and welfare benefit design for active employees and retirees, performs competitive bidding, advises clients on matters related to the Affordable Care Act, develops contribution strategies, and conducts claims analyses and underwriting for health & welfare plans, renewals and settlement negotiations, and FAS valuations. He is an expert in wellness program design, determining health plan insurance reserves, and health and welfare nondiscrimination testing.

Maria Rutkowski,
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Ms. Rutkowski is a Senior Consultant who has nearly 20 years of experience in employee benefit plans, with a primary focus on post-retirement health and welfare valuations. Ms. Rutkowski has worked on has worked on FASB ASC 715-60 (formerly FAS 106), FASB ASC 712 (formerly FAS 112), GASB 43/45, SOP 92-6, SSAP 92 (formerly SSAP 14) and IAS 19 actuarial valuations, competitive bidding, renewal negotiations, reserve calculations and valuations, budget projections and claims analysis and underwriting.

To learn about Sibson's strategic consulting services for colleges and universities and/or to see a list of our experts in higher education human resources and benefits, refer to the last page of this report.

To receive *Data* and other Sibson publications as soon as they are available online, join our email list.

Sibson Consulting is a member of The Segal Group.

Methodology and Institutions Studied

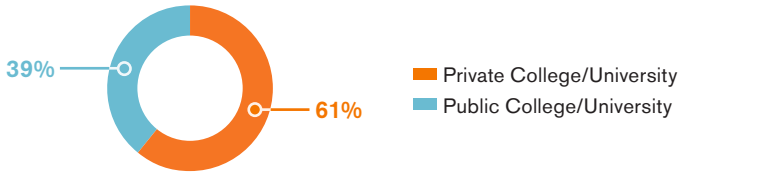
Sibson conducted the latest *College & University Benefits Study* in 2017. The study reflects data from more than 450 institutions.

Sibson collected 2017 benefits data from institutions' websites and from work with numerous college and university clients. In addition, through direct institutional outreach, Sibson obtained data that was not publicly available. To the extent that benefits differed by employment groups — faculty, administrative and professional staff, and clerical staff — Sibson compiled data on those differences. Sibson also invited human resources professionals at colleges and universities to participate in an online survey about their institution's strategies to manage health care costs for faculty and staff.

To calculate medical/prescription drug and dental rate increases, Sibson looked at only those plans for which premium and contribution information was gathered for both 2016 and 2017. Additionally, Sibson chose only those plans that appeared to be structurally similar to the previous year. Moreover, institutions that offered a different number of plans within each plan type in 2017 than in 2016 (*e.g.*, where two PPOs were offered in 2016 and three were offered in 2017), those that changed the tier election structure (*i.e.*, single, employee plus one, family changes to just single and family), and those that replaced a plan with a significantly different plan were excluded.

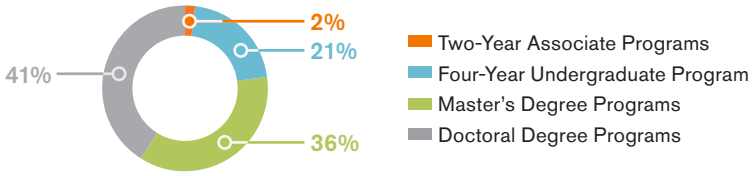
Type of Institution

A majority of the institutions in the study are private.



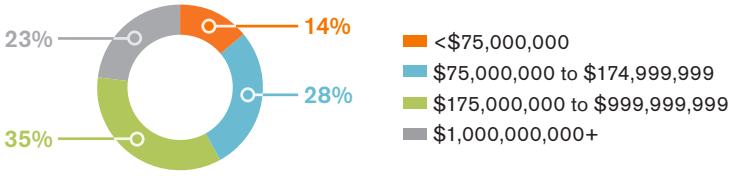
Type of Program

Over three-fourths of institutions in the study confer graduate degrees.



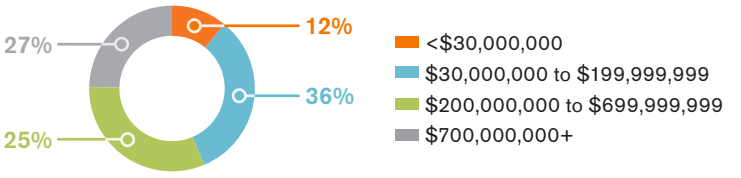
Annual Operating Budget

The institutions in the study vary significantly by annual operating budget. We have seen budgets continue to rise (significantly) on average.



Endowment

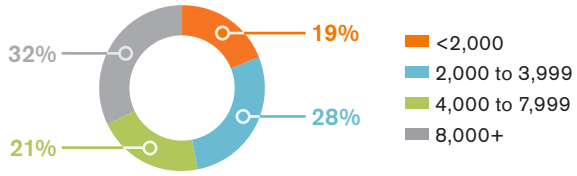
Endowment size of institutions in the study also varies. There have been increases in endowment, on average, as illustrated, however, these increases are not as significant as the increases in operating budgets.



Source: Sibson Consulting, 2018

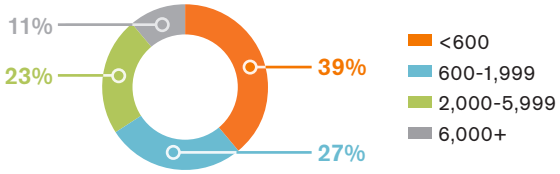
Undergraduate Enrollment

Little change, on average, since 2015.



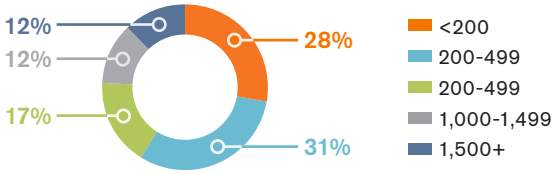
Graduate Enrollment

Little change, on average, since 2015.



Number of Full-Time Faculty

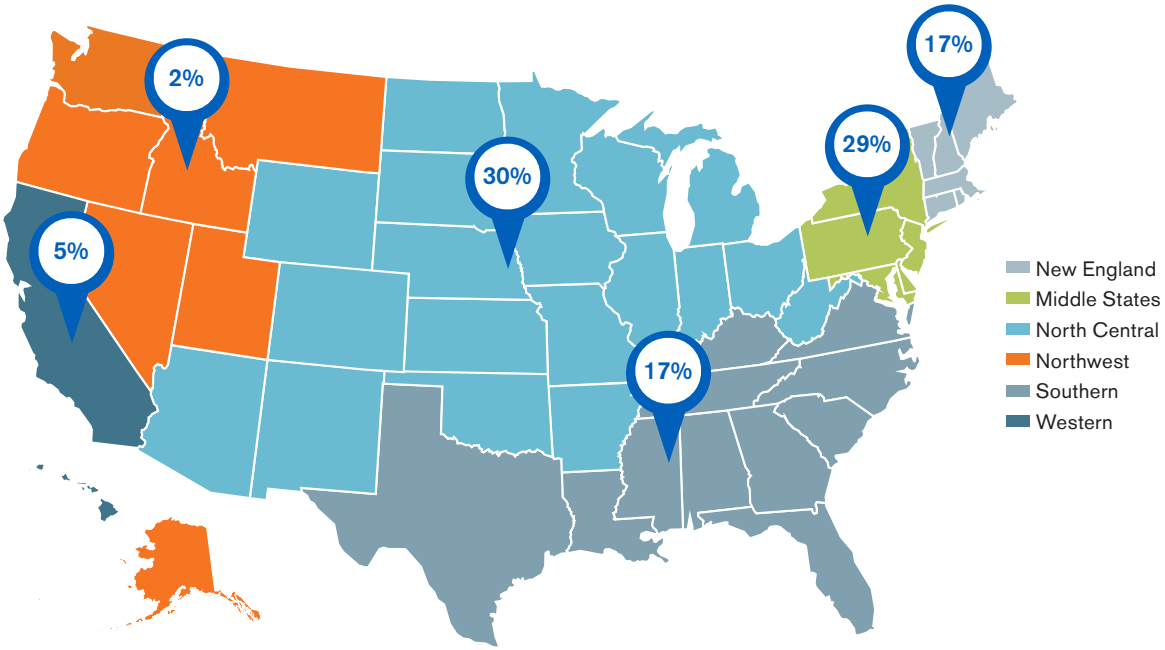
Most institutions in this study have under 500 full-time faculty.



Source: Sibson Consulting, 2018

A majority of the CUBS institutions are in the Middle States and North Central accreditation regions, as shown in the graph below.

Region of Accreditation as Defined by Accrediting Agencies*



* Regional Accrediting Organizations 2016-2017, Council for Higher Education Accreditation, accessed November 30, 2017. Regionally Accredited Colleges/Universities, State of Washington Office of Superintendent of Public Instruction, accessed January 5, 2016.

Source: Sibson Consulting, 2018

Sibson Consulting

Sibson Consulting Understands Higher Education

Strategic Consulting Services for Higher Education

Sibson's strategic consulting services for colleges and universities include the following:

- Total rewards benchmarking and design,
- Compensation studies,
- Health and welfare benefits studies and design,
- Retirement-income benefits studies and design,
- Employee communications, and
- Compliance.

For information about these services and how Sibson can help your institution, contact your Sibson consultant or one of these consultants listed.

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