

# Resuscitating Retirement Medical Insurance at Columbia

## A Public Report with Recommendations

Eli Noam

January 2023, updated version June 21, 2023

### I. Introduction

#### Summary

This report aims to contribute to a discussion of the new medical insurance system for retired Columbia Officers. An understanding of that arrangement is generally limited. Its financial workings are non-transparent. Its multi-dimensionality inhibits a holistic perspective. And there is a general unfamiliarity with the series of gradual decisions over the years which have, perhaps unintentionally, affected current and prospective retirees in a serious manner.

The report

- aims to shed light into the black box of the retirement insurance system;
- quantifies the enormous financial cliff of medical insurance facing new retirees;
- tracks the support level by the university over time, from full coverage to a merely nominal support;
- discusses the implications of disincentives to retirement for the self-renewal of the university and for junior faculty;
- analyzes structural problems in the new system instituted in 2022, in particular the exclusivity granted to one company as the only way to receive the remaining support;
- observes the inequity in support to future retirees over that extended to most current ones;
- looks at the impact, in particular, on those retirees who depend on expensive drugs;
- compares the support level extended by Columbia to the much higher ones at peer institutions;
- identifies an existing funding source, the Columbia University Retiree Medical and Life Insurance Trust, which currently holds about \$260 million;
- examines how this Trust Fund has under-supported the 82% of Columbia employees who are Officers, and who receive only 3% of Trust disbursements;

- reviews the financial management of the Trust Fund;
  - provides three alternative plans as options for improvements;
  - invites a mutually respectful and cooperative effort to develop a system that serves the Columbia community.
1. Since 1994, when mandatory retirement at universities was abolished by legislation, the average retirement age at Columbia has risen considerably, partly due to financial disincentives, including those of medical coverage. A decade ago, a Provost's Working Group on Retirement found that at Columbia, retirement was frequently characterized as a "cliff rather than as a normal life course transition."<sup>1</sup> And a national survey of HR officers found that "The second most cited barrier to retirement is employee anxiety about post-retirement health care..."<sup>2</sup>

To counteract the graying of its researchers and teachers, Columbia instituted several incentives for voluntary retirement, such as buy-out plans. But when it comes to medical benefits the opposite was done. This has created a disincentive to take emeritus status, with active officers postponing retirement to maintain their benefits. The consequence has been slower turnover, fewer vacancies, less opportunity for younger people to move up, and fewer young mentors for doctoral students. It impairs the University's essential need for self-renewal.

2. Active Officers at Columbia (82% of all employees) pay about \$3K per year in medical insurance. For typical Columbia retirees, the cost of comparable plans (including Medicare payments) is now a much higher \$8.6K - \$13.5K (including income taxes.) For a couple, these numbers approximately double. And this happens just as they stop earning salaries.
3. Over the years, Columbia's retiree medical coverage has changed significantly, something that is not well understood. The changes, taken together, have greatly reduced University support from an earlier full coverage of medical insurance to one covering only a trivial share of a ballooning expense. Columbia's contribution to a retiree's overall expense towards medical plans (Medicare plus Columbia Plan cost) in 1993 was 78.1%. Under the new system, it is 1.2 percent. In inflation-adjusted dollars, the University reduced during that period its overall support level by 95%. It spends 100 times more on the medical insurance of active Officers than on retired ones. Taken together, it has created major disincentives to retire.
4. In an abrupt communication to retirees in 2022, the University ended medical plans for all Officers – a system that has existed for decades. New retirees will receive a tiny contribution, while for current retirees, such residual support goes only to the small and

---

<sup>1</sup> Columbia University, Provost's Working Group on Faculty Retirement, Final Report, December 2012.

<sup>2</sup> Green, Kenneth with Jaschik, Scott and Lederman, Doug; The 2012 Inside Higher Ed Survey of College and University Human Resources Officers; September 2012

shrinking number of grandfathered participants (22%) whose current support was cut by a further 75%, having already been cut by 50% a decade earlier.

By way of comparison, Support Staff employees, represented by their unions in an effective manner, are receiving in retirement a full medical coverage, for their entire household.

Also by way of comparison, the support levels provided by many peer institutions to their retirees are higher, and often substantially so. For a retired Office with 20 years of service and a spouse, Columbia contributes **\$330**, while Harvard provides **\$9,744**, and NYU, going forward, **\$3,391**, (Also, Harvard and NYU provide their support to almost all of their eligible retired Officers, while Columbia extends it to only about 22% of current retired Officers, namely those who were still on the Columbia plans in 2022<sup>3</sup>.)

5. As a replacement for its own plans, the University directed retirees to establish a commercial relationship with Via Benefits, a Medicare Exchange company, which would provide advice and assistance in signing up with a private insurer.

The overall transition to a private Medicare exchange system is, by itself, a positive step that ratifies reality, given that almost 80% of Columbia retired Officers already subscribe to private outside plans due to the high cost of the Columbia-sponsored plans.<sup>4</sup>

Via is not an insurance company and does not process claims. Its role is to sign up customers for the insurance companies. In doing so, Via's main contribution – and a welcome one – is a personal consultation of choices and options that goes beyond the information already widely available on public and private websites. That contribution is useful if done with sufficient resources, with advisors familiar with the Columbia transition, and without company incentives toward high-priced plans.

6. However, there are several major structural problems with the arrangement. In particular, there are no alternative Medicare exchanges available to retirees if they wish to remain within the residual Columbia subsidy system. But having such alternatives in picking a service provider could :
  - protect against the potential negatives of the vertical integration of Columbia's service vendor company, Via, which in turn is owned by Columbia's HR advisor WTW. At least potentially, vertical integrations of this kind are problematic, and competitive alternatives would reduce the problem;
  - eliminate for retirees the conditionality of receiving the Columbia subsidy and the catastrophic drug support, in a highly objectionable tie-in based on a retiree's signing up with one commercial company, Via;
  - give retirees options and provide competition in service quality;

---

<sup>3</sup> Future Columbia retirees are included, and this will gradually, over two decades and more, raise the percentage of retirees who are supported.

<sup>4</sup> Transition problems affect several individuals disproportionately, a problem that can be resolved, as discussed.

- encourage more diversity in plans offered and explore ways to create group discounts;
  - provide yardsticks for Columbia in overseeing Via's performance.
7. With more options, prices offered by the Via exchange could become more subject to competition.
- Contrary to the impression being fostered, the insurance plans offered through Via have no price advantage over those already available to any consumer individually in the market. There are no cost savings whatsoever.
  - Similarly, there are no additional insurance choices for retirees over what they could already have gotten on their own for years. Indeed, Via reduces the choice menu somewhat, by not offering all plans available in the NY region, several of which are cheaper.
  - Via's business model is based on commission payments received from the insurance companies for signing up retirees and renewing them annually. Via does not share these payments with the retirees whose business has generated them.
  - These commissions are substantial. The most popular plan is a standardized product known as Medigap Type G. For the UHC-AARP version of that plan, commissions to exchanges and other agents for the first signup would be about \$672, and for each subsequent year's renewal \$336. For the pricier and more extensive Humana Plan, these numbers would be \$1,076 and \$538, respectively. These numbers double for a couple.
  - To put these numbers in perspective: A retiree with spouse would receive a \$330 subsidy per year from Columbia. But this would be conditional on both spouses picking their insurance company through the Via exchange. Via would then benefit in commissions, depending on the plan, in the first year about \$1,300 and subsequently about \$700 each year, plus potential payments by the insurance companies for administrative expenses on top of that. For those 78% of current retirees and their spouses who were not previously on Columbia plans, the discrepancy is still higher. They do not receive any subsidy, but in order to qualify for the catastrophic drug coverage (a small but non-zero contingency for most) they must go through Via, which then collects the full commission of about \$1,300 initially and \$700 subsequently.
  - Technically, these commissions come out of the pockets of the insurance companies. But practically, they will be reflected in prices to the insured retirees that are higher than they would be otherwise, and quite possibly higher than the Columbia subsidy provided to them.
8. Another disturbing key element of the new system is that there is no subsidy support (known as HRA, Health Reimbursement Arrangement) at all for the 78% of retired Officers who had left the Columbia insurance plans because they had the foresight to seek the same private plans that have now become, per Columbia's changed policy, the only option. An equitable system would enable them to join the Columbia-supported exchange system and receive the same subsidy as new retirees.

Just as fundamental as the structure of the retiree medical insurance, discussed above, is its funding mechanism, a system that is even less well understood.

9. Currently, the Columbia insurance system, beyond the premiums paid by the insured retirees, is backed in its liabilities by a little-known independent financial entity called the Columbia Retiree Medical and Life Insurance Benefits Trust (“CURML Trust Fund”.) That Trust is directed, by its legal charter, to fund Columbia’s support of retirees’ medical and life insurance. The Trust pays for the subsidies that reduce the private cost of insurance.
10. In 2021, the Trust Fund held about \$260 million in assets.<sup>5</sup> From this considerable money the University now intends to spend, by our calculation, only about \$0.3 million annually for Officer retirement medical plans. Officers account for 82% of Columbia employees but will receive only an estimated 3% of retiree medical support payments. Yet the stated purpose and obligation of the Trust is to support all eligible retirees, not just a particular arrangement with a particular intermediary company or a particular labor contract.
11. Under the new system instituted in 2022, the contribution to retired Officers, from the entire Trust Fund, is only 1.4% of its total annual *gain*. Of the entire Trust Fund *assets*, it is only a minuscule 0.12%, one eighth of one percent, while the Trust Fund averaged an annual gain of 8.34% over the past 12 years.
12. This is a continuation of a stepwise elimination of Officer retiree medical benefits, from full coverage of retirees in 1993 to now zero for most of current retirees. It is not an inevitable trend. As mentioned, Support Staff retirees have been able to negotiate for their household’s medical insurance to be fully covered, plus life insurance. Given the size of the existing Trust Fund, the elimination of Officer support is not based on a financial emergency but on a unilateral policy decision.
13. The Trust Fund pays, depending on which measure one uses, between 6.8% and 10.3% of its annual financial gains to its investment advisor, State Street Global Advisors, for what appears to be mostly a custodial function with occasional minor tweaks of a conventional portfolio of conventional index funds of the State Street fund family.
14. The overall direct and indirect payments to State Street for managing the assets for Officer contingencies are an estimated \$1.155 million for 2021. As Wall Street fees go, this is a reasonable figure. But it should also be viewed in context, which is that the entire contribution from the Trust Fund to the Officers in the same year was an estimated \$1.1 million, about the same amount that was received by the investment management company.
15. The average annual performance achieved by State Street for the period 2009-2021, for the Trust Fund, was a respectable 8.34%. But in comparison, a simple S&P 500 index fund would have done better, averaging 11.02% over the same period, and with a significantly lower fee. (That index is one of domestic stocks only, whereas the Trust Fund also holds bonds,

---

<sup>5</sup> Figures for 2022 were not available yet at the time of the writing of this report. We estimate that they will be about 15% lower due to the downturn in the financial asset markets.

international stocks, and REITs, adding diversification. Even so, the beta measure of volatility for the Trust Fund portfolio is somewhat higher than for the S&P.)

16. The improvements proposed for the CURML Trust Fund are:

- A portion of the existing CURML Trust assets would be segmented specifically to support Officers. The proposal is to split the Trust Fund into two equal portions of about \$130 million, or a conceptually similar arrangement permissible within the law on retirement health benefits. In principle, the Officers' segment would aim to function like an endowment, with its overall annual income based on the University's payout rate on endowment accounts.
- That amount would be used for Officer support, including for catastrophic drug support and similar calamities. The available money would determine the value of points in the above-mentioned point system.
- Once the University has allocated and segmented these assets, its contingent obligations to Officer retirees end. All future payments are made by income from the assets.
- With this system and asset allocation, the support level for Officers would return toward the level that existed in 2011, extended to all retirees, while maintaining Support Staff retiree funding.

Given that the funds have accumulated in the Trust Fund for the purpose of supporting retirees and are available, this is a reasonable and affordable proposal.

17. For the contributions, three alternative plans are discussed, with specifics further below

*Plan A: Restoration of support to 2011 level, for all, with a point system that takes account of lower incomes and medical hardships.* Approximate support level for retiree: \$150/mo. Total net cost: \$3 million.

*Plan B: Restoration of support to 2022 level, for all.* Support level for retiree: \$72/mo. Total net cost: a cost saving of \$0.8 million.

*Plan C: Matching the NYU Plan.* Support level for individual: \$280/mo. Total net cost: \$7.7 mil

## Moving Forward

The report is based on the belief that in a university setting based on knowledge and learning, facts and analysis would be a way to resolve problems cooperatively rather than through lawyers<sup>6</sup>, strikes, and strife.

---

<sup>6</sup> It is only a matter of time before class action lawyers will swoop in, claiming breach of employment and retirement contracts, abrogation of fiduciary obligations by the Retiree Medical Insurance Trust Fund, etc.

The purpose of this report is not to cast stones but to seek a constructive improvement for a new system. This is not just to assist current and upcoming retirees, worthy of decent treatment though they are. It is also an economically sensible way for the University to go.

If one achieves an acceleration in retirements by just *one* year, and assuming an older Officer's compensation, including fringes, is \$100K higher than that of a junior Officer, the University would be ahead financially by about \$15 million per year. Plus, it could hire younger (and fresher and cheaper) new professors, researchers, and administrators, and improve the institution at a much lower cost than creating new positions. It is counter-productive to give people buyout incentives to retire while simultaneously inducing them stay longer to avoid falling off the benefits cliff. For a long time, Columbia's strategy (and that of peer institutions) has relied on innovation through incremental *addition*. This has raised size and fixed cost and is unsustainable in the future. The future strategy must be an even greater emphasis on innovation through *substitution*. And one element for such a strategy is to facilitate retirements.

A constructive conversation is needed that engages the University and its consultants, the retiree community, the University Senate, and the faculties of the various Schools, in a productive collaboration to make the system better and fairer. We all seek to balance retiree equity, budgetary affordability, and institutional rejuvenation. We recognize that the University, even with its relatively high endowment, trails other institutions in its financial capacity. And we recognize that some of the issues that need to be addressed are not the result of a plan to negatively affect retirees but are the unanticipated result of smaller decisions over the years.

Since an earlier version of this report was provided to the Administration in late January, it did, to its credit, engage in such a mutually respectful dialogue. The constructive role of Gerald Rosberg, Senior Executive VP of the University, has been particularly helpful in substance and tone. Similarly, the earlier report triggered discussions in Senate committees, by the retiree association EPIC, and by the Arts & Sciences Faculty's Policy and Planning Committee. I received many comments. Where factual disagreements were identified, they were either incorporated as corrections or discussed in the updated version of this report.

The Administration now seeks a wide set of consultations, with fact finding, possibly a Town Hall, and an internal decision process. A thorough examination is a laudable goal, though one must note that no such thoroughness and inclusiveness were deployed when the unilateral decision was made last year to *reduce* the benefits to retirees.

The net result of this process is to delay the decision time and move it to the administration of a new University President and to a potentially different set of decision makers who are likely to have a wide set of very different issues on their agenda of priorities. Even if a decision will be made in early 2024, given that elections to medical coverage plans are mostly done on an annual basis, this is likely to push any actual change for retirees into 2025. To Improve the situation for retirees for the year 2024, they must pick plans in November of 2023, and such

plans must be in place and communicated in October. Thus, any delay beyond September 2023 means that no improvement will occur until 2025. (It is therefore gratifying to hear that the University plans to reach a revised plan by the late summer of 2023.)

In the meantime, Columbia's retirees will continue to operate under the existing flawed system. For these reasons, the responsibility for a decision lies with the outgoing Administration since it is the one that changed the system in the first place, precipitating this discussion. It should not be left to a new team to contend with. At a minimum, a new system should be decided upon and available to retirees by the time of the Open Enrollment period of November 2023.

This contrasts with the letter from the Administration to the Arts & Science Faculty in late March which states that "The new benefit will further evolve over time as we learn from experience with it and how it works for our retirees and learn more about its actual cost." Of course, one hopes that any plan will be subject to regular review. But after a new plan was sprung on 80-year-olds last year, the promise of a multi-year careful and deliberate process for its improvement is not an alluring prospect.

Also not encouraging is that within the Administration, after several months of conversations, there is still the belief, as communicated in a letter to the A & S faculty, that "Nearly 100% of retirees will be better off through the new exchange program than continuing to enroll in Columbia retiree medical plans." Implicit is the belief that retirees should actually be grateful for the change. This does not match the perspective of well-informed retirees. They might lack the energy of their prime, but those who follow this subject are resentful at the treatment by an institution to which they have given decades of service, and which builds its reputation on their shoulders, too. For most of them, the outside plans offered are the same as they could have picked already, not a penny of difference, but now with less choice. Most of these retirees will get no Columbia contribution at all even though that is promised to future retirees. The drug backstop is a minor contribution and unneeded starting next year due to the recent Federal legislation. And for the other 22% of Columbia Officer-retirees, well-educated and thoughtful as they are, who had deliberately preferred the Columbia plans over the outside offerings, and whose contribution from Columbia has now been cut by 75%, in what possible way can they be said to be better off by a denial of an important option without a single new one being created?

In addition, "cost savings" to a retiree is a meaningless concept without reference to benefits and service quality. A plan might be cheaper in price, but if it is less favorable in covering out-of-pocket expenses, limits access to doctors, requires co-insurance for drugs, and is more restrictive in approving or covering treatments, it is not necessarily a better value.<sup>7</sup>

---

<sup>7</sup> A former Columbia Officer of Administration provides a good example. By his description, he very carefully reviewed the retirement medical plans in the past, and it was part of his original signing up for employment with Columbia in mid-career. Having had this plan for several years in retirement, he believes that it is a benefit that vested yet was now being unilaterally terminated. By his account, none of the new coverage options adequately covers the doctors he has been using. That coverage was the reason he had chosen the Columbia plan, being fully aware that it was costlier. He did his homework in the past and rationally concluded that given his needs, risks, and



Adhering to its own narrative, the Administration, in a communication to the A & S Faculty, believes that “The Noam report advocates that we should do even more”. To judge the assertion contained in “even more,” it is helpful to consider the following data points:

- Columbia’s contribution to a retiree’s overall expense towards medical plans (Medicare plus Columbia Plan cost) in 1993 was 78.1%. Under the new plan, it is 1.2 percent.
- The aggregate of the contribution, adjusted for inflation has declined by 83% from 1993 to 2021, and by more than 95% by 2023.
- In 2023, Columbia’s contributions would be 72% below even the 2022 levels that already were much smaller than in previous years.
- Columbia spends 100 times more on the medical insurance of active Officers than on retired ones.
- a retired couple will receive in 2023 \$4,170 less of what they would have received 28 years ago, in today’s money.
- By way of comparison, Support Staff employees, represented by their unions in an effective manner, are receiving in retirement full household medical coverage.
- Also by way of comparison, as mentioned above, Harvard supports the medical insurance of a retiree with spouse at \$9,744 per year, while Columbia contributes \$330. In fact, it does so only for those 22% of current retirees who in the past had picked the high-cost Columbia plans. Harvard spouses get the full coverage, i.e., \$406 per month, whereas Columbia spouses get a token of about \$9. Assuming a similar-sized retiree population, if one combines the two measures -- support level and participation rate-- then Harvard provides about 134 times as much medical insurance support to its current retiree pool than Columbia does.
- NYU’s annual contribution for a retiree, going forward, is \$3,391. Columbia’s is \$220. NYU covers spouses/domestic partners fully, whereas Columbia provides only one-half coverage. Thus, for a retired couple, NYU will provide \$6,782<sup>8</sup>, vs Columbia’s \$330. That is over 20 times as high. In addition, and importantly, NYU does not tie its contribution to the use of a particular exchange. While it uses the same Via exchange as Columbia does, the retiree is free to pick other medical insurance coverage outside of Via, and still get their university’s contribution. One should also note that NYU gives its officers the same support as for its unionized support staff, whereas Columbia does not.

---

the respective costs, the Columbia plans were his best option. He does not agree that he is now somehow better off.

<sup>8</sup> That amount, higher than NYU’s past contribution, applies to officers hired after 2011 who gain retirement eligibility.

## Why This is Important

This analysis recognizes the Administration's lead role in managing benefits through its responsible senior executives who must consider the overall good of the University. Nor is this report wedded to a status quo.

That said, the steady reduction of a long-standing benefit that affects most Columbia employees – active and retired—as well as the turnover of faculty, researchers, and administrators of the institution is not merely an administrative matter but should be subject to a broader discussion. Furthermore, the University has also legal and fiduciary obligations to its retirees, including those created by the Trust Fund, and to those approaching retirement status. These obligations were created at the beginning of employment not at its end. (This report, however, is not a legal brief but a discussion of policy and structure.)

For retirees, adequate medical coverage is literally about life and death, and about peace of mind and financial solvency. Retirement issues might seem to many something only old fogies should worry about, but it is important for everyone in the Columbia community. If older faculty and researchers do not retire, then there are fewer positions for younger and fresher people. Older faculty are also more expensive.

Although retirement plans benefit most immediately those who have already retired, the majority of the CU active Officer community will reach that stage themselves, sooner or later. It becomes more relevant to people as they grow older. But by the same token, childcare, dependent medical plans, and tuition coverage are more relevant to younger Officers. The benefits basket is an intergenerational compact. And “honor thy father and mother” has been an ethical principle since time immemorial for all cultures.<sup>9</sup>

Retirees are perhaps the most vulnerable members of the Columbia community. They are aged, often ailing, worried, with limited alternative income options beyond their savings and 403(b) plans<sup>10</sup>, with no bargaining power once they have given their productive years to Columbia, cautious of change, and with only a muted voice in Columbia affairs.

Retiree medical support is good social policy and is practiced in the social safety nets and tax code of most countries, including in the U.S., where the system is a complex mix of public and private support. Most medical benefits are progressive with age. But at Columbia, as in most American organizations, they are regressive with age. That is due to a strong reliance on

---

<sup>9</sup> For a popular overview, <https://www.marieclaire.co.uk/life/how-different-countries-treat-the-elderly-20839>

<sup>10</sup> 403(b) plans are the non-profit and governmental cousins of the better-known 401(k) plans of the private sector. Both are ways for active employees to set aside a certain amount of their salaries and invest it in accounts administered by companies such as – in the case of Columbia—TIAA/CREF and Vanguard. The employees need not pay income taxes on that income and on its investment gains until they withdraw the money at retirement age. Employers often pay a certain percentage of salary into those retirement accounts as a lump sum on top of nominal salaries or match a certain percentage of employees' contributions.

employer contributions to health insurance plans during active employment. At retirement age governmental Medicare kicks in, but it still requires monthly in-payments, and, for most people, a supplemental or substitutional private coverage to deal with the gaps in Medicare coverage. Adding up the numbers, in terms of medical costs it is expensive to retire from Columbia.

Even beyond the dimension of social responsibility, on a pragmatic institutional level, the retirement system has an impact on the entire University:

1. As mentioned, a retirement system that creates a strong disincentive to take emeritus status means fewer opportunities for younger faculty and less young mentors for doctoral students. It impairs the University's essential self-renewal.
2. Most current Columbia Officers will retire at some point. Therefore, a change in future benefits for a period that may well cover about 20 years of a person's life adds up to a substantial amount in terms of current net present value.
3. The changes in medical insurance of retirees might well become the model for future similar changes in the medical plans of all active Officers. Protecting retirees today helps protecting active faculty in the future.

## About this Report

In the past, Columbia's system of retirement medical insurance was little understood, and it was under the radar.

This report aims to add to understanding and analysis. It was entirely prepared using publicly available information. It was not the preferred choice. Requests for data were rejected. Going forward, a cooperative information-sharing practice is necessary to develop a better system.

In the spirit of confidentiality, I have avoided using any information gained in meetings of the two University Senate committees which I chaired or co-chaired until the summer of 2022 (the Budget Committee and the Joint Subcommittee on Benefits)<sup>11</sup>, or utilized any materials from that process, other than my own independent writing, and excluded information received from others.

The main sources of Columbia-specific data are IRS Forms 5500 and 990 filed by the University annually and available on the IRS website, plus some data from the Columbia general website. Other members of the retiree community, organized in EPIC (Emeritus Professors in Columbia), have been helpful in the final shaping of this report and deserve many thanks<sup>12</sup>.

---

<sup>11</sup> In any event, the main confidential information that was shared by the Administration was that the system would be changed a few months hence, along the lines that are now public.

<sup>12</sup> From EPIC, helpful feedback was received from Roger Bagnall, Peter Messeri, Francoise Simon, Jeanne Stellman, Peter Strauss, and Frank Wolf. Outside of EPIC, many helpful comments were received. Rosalind Morris, Chair of the Policy and Planning Committee of the Arts and Science Faculty, contributed especially valuable feedback. Responsibility for this report is mine, however.

Caveats:

- The subject is far removed from my professional expertise.
- It proved difficult at times to interpret the various categories of financial accounting since their definitions are sometimes unclear and changing.
- In the absence of access to data, some of the calculations are back-of-the-envelope, reverse-engineering estimations, with the methodology explained in the text or in footnotes. There is room for improvements, and feedback as well as non-confidential data from the University are welcomed. Where I received corrections, I incorporated them in an updated version. But better data – unless they are radically different – are not likely to alter the big picture issues that are identified. In this matter, the devil is not in the details.

## II. The Existing System—Columbia, Government, and Private Insurance

A brief overview of the complex system of American old-age medical insurance is provided in Appendix A.

### The Medical Insurance System for Columbia Retirees

It is rarely recognized just how expensive the step from active to retiree status is in terms of health care costs. This absence of knowledge is partly based on the extraordinary complexity of the system in comparison to that of active employees, and partly due to a psychology of avoidance by most people when it comes to looking ahead to old age.<sup>13</sup>

**For active Officers**, monthly individual medical plans have been administered by Aetna and UHC, at a cost of about \$196 for Choice 90, the most popular plan<sup>14</sup>. When these premiums got

---

<sup>13</sup> An earlier report about retirements quotes one faculty member in a focus group: “I am not very informed. I never thought about health benefits. I have heard about Medicare but I don’t even know what Medicare means for me. For an educated person, I am very uninformed.” Columbia University, Working Group on Faculty Retirement, Final Report, December 2012. That same report notes, more generally “Research shows that, while faculty spend their lives seeking knowledge, most remain woefully uneducated about retirement. They are trained to probe deeply in their areas of expertise but may ask only limited questions about the performance of their retirement savings accounts; indeed, some never inquire. While faculty are always planning for the next project, book, or experiment, they may devote little or no energy to planning for their long-term future. They can talk with knowledge about the life cycle of a faculty member – post-doc, junior, probationary period, tenure, senior – but lack vocabulary for the post-retirement period. These gaps are unfortunate but are due not just to actions (or inactions) on the part of faculty but also to failures on the part of the institution.”

<sup>14</sup> Assuming a non-minimum salary in the range of \$135K-\$175. There is also a cost of about \$30 in dental coverage. Vision is included in the main plan. Choice Plus 80 costs \$136.

raised there were loud complaints to the Administration, as was the case in 2021 when the University Senate took up this matter. These plans are significantly subsidized by Columbia. A comparable plan by UHC in NYC (UHC Platinum) cost in 2022 \$1,618 per month after taxes for participants.<sup>15 16</sup> This implies a contribution by the University of \$1,822 per month, achieved through a variety of ways, such as negotiating group rates, assumption of risk, and a direct subsidy.

(By way of comparison, in the new system of retiree medical insurance, the support level is \$18.33 per month, almost exactly 1/100 of what existed on the day before retirement.)

For active officers, the Columbia plan premium payment for Choice 90, plus dental coverage, add up to about **\$2,712 annually**. It is deducted from the paycheck pre-tax, i.e., it does not come out of taxed income, a feature which can be worth easily 35%<sup>17</sup> in comparison to an officer paying for insurance with after-tax dollars.

**For active Support Staff**, the arrangement is indirect. Union members pay no premiums for their healthcare insurance but make contributions through their union dues, equal to 2% of their gross salary. We can compare a Support Staff employee with an Officer employee, both at the minimum salary of their respective grades. (All figures in this discussion are for 2022.)

Administrative Coordinators at Grade 9B – the highest Staff grade -- are paid \$56.8K per year and would be paying union dues of \$94.67 per month. They would receive the Choice Plus 90 plan, which also covers their spouse and children.<sup>18</sup>

Officers begin one notch higher in the grade scale. A Grade 10 Officer who is compensated at that grade's minimum (\$58.5K per year) would be paying a comparable \$119 per month for themselves, but a much higher \$466 a month for a family.

**For retired Officers**, the system (up to 2022 when it was abolished) was one in which Columbia offered four plans, three of which were administered by UHC and one by Aetna. These companies were not the insurers, however. Columbia functioned as a self-insurer, pooling the risks of those who signed up for the plans, and keeping a contingency reserve to deal with unforeseen risks. The two companies were managing the system, for a fee, and were not at risk.

In parallel to the four Columbia sponsored plans, there are and have been many separate private plans offered by many private companies (including by UHC and Aetna themselves). These plans offer a variety of combinations of benefits, some as a substitute for federal

---

<sup>15</sup> Assuming that they are not old enough for Medicare or poor enough for Medicaid.

<sup>16</sup> Group rates differ from individual rates, affecting the Columbia subsidy.

<https://www.peoplekeep.com/blog/group-coverage-vs-individual-health-insurance-cost>

<sup>17</sup> Federal, State, and NYC local.

<sup>18</sup> The union dues also entitle employees to legal representation in work-related issues, and other benefits.

“Original Medicare” benefits with both extensions and restrictions (“Medicare Advantage”), and some as an addition to such benefits (Medigap). The system is described in Appendix A.<sup>19</sup>

After retirement, there were three basic options, each with several sub-options.<sup>20</sup>

**Option 1: Columbia Plans (not available after 2022)<sup>21</sup> with Medicare<sup>22</sup>**

Total: \$972/month, or **\$11,664/year<sup>23</sup>**

This plan had excellent prescription drug coverage with limited out-of-pocket expense participation.

**Option 2: Original Medicare with Medigap<sup>24</sup>**

**Total: \$836/mo., \$10,032/year**

This option has a relatively limited out-of-pocket expense coverage.

**Option 3: Medicare Advantage<sup>25</sup>**

**Total: \$531 per month or \$6,372 per year.**

This option has larger out-of-pocket expenses and more restrictions on access to doctors.

The cost to retired Officers for all three options is after-tax. Payments are made from income after paying a tax on it unless one has significant medical expenses relative to income (over 7.5%) and one itemizes deductions. To compare to active employees, one must therefore add

---

<sup>19</sup> It is therefore not easy to compare prices.

<sup>20</sup> Prices are given on a per month basis, using national averages or the most popular plans. Retirement income including Social Security and distribution from retirement plans assumed \$160/year. Individual only, without spousal coverage. Not included: out-of-pocket expenses; long term care insurance (about \$220/mo if started at age 55, and \$300/mo when started at age 65.)

<sup>21</sup> Prices of the four Columbia plans, on top of Medicare:

UHC Choice Plus 100: 548; spouse 584.

UHC Indemnity: 473; spouse 509.

Aetna Medicare Advantage Plan (PPO): \$394.44; spouse: \$430.44

UHC Group (HMO): \$261.63; spouse: \$297.63.

The most popular plan is UHC Choice Plus 100 which costs annually  $\$548 \times 12 = \$6,574/\text{yr}$ , and for a couple: \$13,584.

<sup>22</sup> Assuming a retirement income of \$160K, including Social Security and distribution from retirement plans.

Monthly payments are income dependent, for incomes under \$91K it is \$170.10; for 91-114K, \$238.01; for \$114-142K, \$340.20; for \$142-170K, \$442.30; above \$170K, \$544.30.

<sup>23</sup> *Option 1*--Medicare Part B (doctors' office) - \$442/month.

-Supplemental group coverage offered through two Columbia PPO plans that are administered by UHC, at about \$500/month.

-Dental: \$30

<sup>24</sup> *Option 2*--Original Medicare - \$442

-Medigap - \$280

-Part D prescription drugs- \$44

-Dental & Vision - \$70

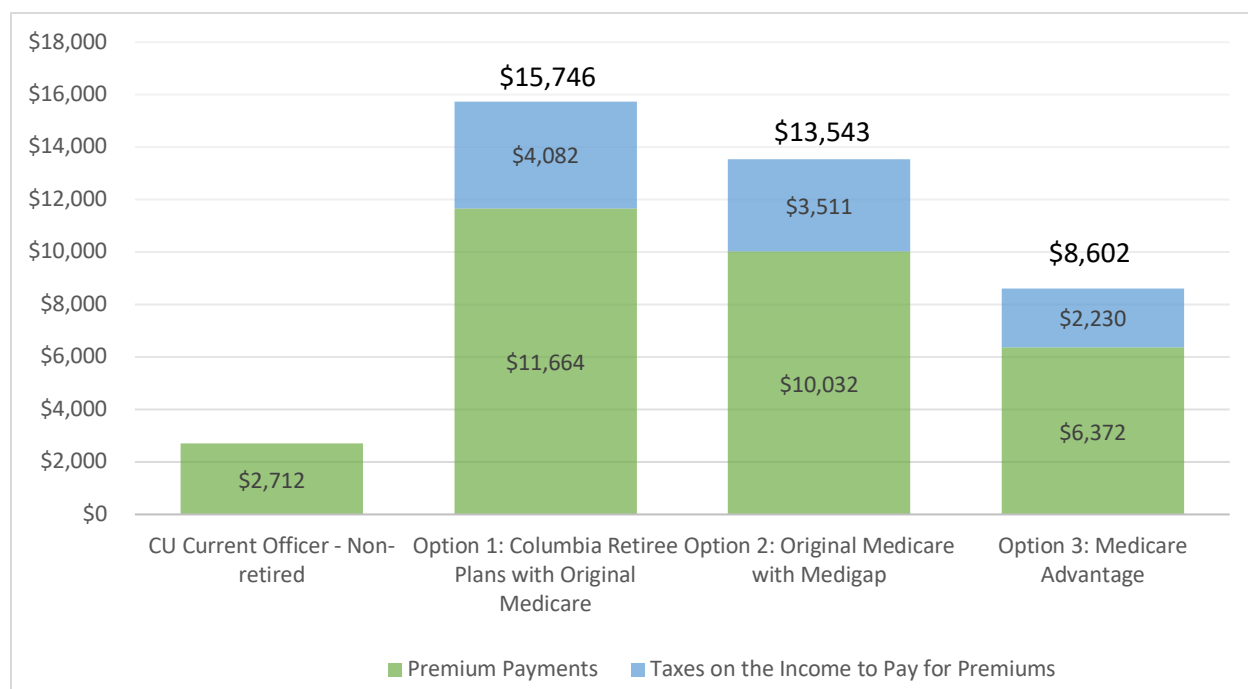
<sup>25</sup> *Option 3*-- Medicare payments- \$442

Medicare Advantage extra- \$19

Dental and Vision - \$70

an estimated 35% in marginal US, NYS, and NYC tax rates, which accounts for the taxes paid on withdrawal from retirement plans<sup>26</sup> or taxes paid earlier on income that was saved or put into a Roth retirement fund to generate the funds required to pay for the insurance premiums. This adds, e.g., for Option 1, another \$4,082 to cost, for a total of \$15,746 pre-tax income per year.

**Graph 1: Overall Medical Cost to Officer Retirees vs. Active Officers**



*Adding spousal coverage approximately **doubles** these numbers.*

Not included in this comparison are the higher out-of-pocket outlays, and in particular, the long term care insurance for assistance at home, assisted living facilities, or nursing homes. Many retirees consider it essential protection against the cost of chronic disorders such as Alzheimer's or physical incapacities requiring regular help. It costs about \$2,600 per year for basic coverage if started at age 55, and about \$3,600 when started at age 65.<sup>27</sup> Better coverage costs much more. This considerable expense item is on top of the medical insurance costs that are detailed here.

The numbers identify two major discrepancies.

<sup>26</sup> If the withdrawal is from savings outside of 403b plans, taxes would have been paid during the active employment period.

<sup>27</sup> It is rarely available after 75. The cost to women is higher than for men, given life expectancies..

### **1. The cost discrepancy between active and retired Officers.<sup>28</sup>**

For an individual Officer retiring at 65, and who chose the Columbia plans, the annual difference was \$8,952. With the taxes considered, the cost is \$13,034. With a life expectancy of 20 years,<sup>29</sup> the cumulative cost would add up over those years to \$260,680.<sup>30</sup> Adding spousal coverage doubled overall cost to \$521,360, over half a million dollars.

In comparison, during that same 20-year period an active Officer's pre-tax cost would be \$54,240 individually, or about \$136,800 for a couple.<sup>31</sup> Thus, the retired Officer paid about 4-5 times as much for the Columbia plan as the active Officer.

And this financial hit comes just as that person's earned (W-2) income drops to zero.

An offset is that the retiree does not contribute anymore to Medicare by way of FICA payroll taxes.<sup>32</sup> But this is a function of not being on a payroll anymore. And substantial Medicare premium payments are due each month, subtracted from Social Security.

Several factors contribute to this enormous discrepancy:

- The relative generosity of the Columbia plan for active officers
- The national practice by most organizations, including universities, to focus on existing employees, and to leave retirees to fend for themselves, partly supported by Medicare and Social Security as the safety nets.
- The rising cost of medical services, with Medicare being able to cover only a percentage, and a declining net percentage at that, given the increased contribution by retirees towards it.<sup>33</sup>

### **2. The cost discrepancy between Columbia retiree insurance plans and non-Columbia plans.**

The cost of the pre-2023 Columbia plan was more expensive than non-Columbia plans. The difference was \$1,632 in comparison to the Original Medicare plus Medigap (14% cost savings), and \$5,292 in comparison to the Medicare Advantage plan (55% cost saving). (If we add the tax aspect, these dollar gaps would increase by a proportional 35%.)

---

<sup>28</sup> All numbers are for 2022 where available; when they are not available, earlier recent numbers are used and typically indicated.

<sup>29</sup> According to the CDC, as of 2019, a 65-year-old woman would live an average of an additional 20.8 years, and a 65-year-old man would live an average of an additional 18.2 years. Columbia Officers' life expectancies are likely to be higher.

<sup>30</sup> Not counting general inflation, medical cost inflation, and the time value of money.

<sup>31</sup> Not counting general inflation, medical cost inflation, and the time value of money

<sup>32</sup> 1.45% of taxable income, plus 0.9% for incomes above \$200K.

<sup>33</sup> These contributions to Medicare coverage are based on income and are thus skewed against high-income, high-cost regions such as New York.



Given the significant cost difference, most retirees left the Columbia plans. The majority seems to have gone to Original Medicare plus Medigap option.<sup>34</sup> Indeed, why did anyone at all stay with the Columbia plans? There are several explanations:

- Some retirees did not know or care about alternative options. There was comfort in staying with Alma Mater Columbia.
- Columbia's HR people would be at times advocates for retirees when the insurance companies balked at approving payments. By personal testimonies received, the HR staff did a good job.
- Most importantly, the Columbia plans included a strong drug coverage, which for some retirees was essential, both as a reality and as a protection for an uncertain future.

The abolished Columbia plans' prescription drug coverage was one of a group plan with a *co-payment* of \$45 per month. In contrast, the new plans require a sign-up with individual drug coverage plans based on a *co-insurance*, which means a certain percentage of the drug's cost must be borne by the retiree. Such co-insurance percentage, for Class 4 drugs, can easily be 30% or more. Thus, the out-of-pocket for a \$6,000/month prescription drug<sup>35</sup> would cost, under the Columbia plan, \$45 per month, but on the outside plan, \$2,000 per month.

Partly in consequence of the drug coverage, the Columbia plans attracted a higher-risk, higher-cost pool, which contributed to a price that was significantly higher than that available in the outside market for those retirees with a lower risk or cost profile. The result was a classic case of adverse selection, in which those with lower risk left the pool for perfectly adequate and much cheaper plans outside, thereby increasing the riskiness of the remaining pool and thus its subsequent insurance premiums.

The extent to which the pool of retired Officers that stayed in the Columbia plans was a high-cost population can be quantified. Columbia's annual IRS filings (discussed further below) include statements by its auditor PricewaterhouseCoopers (PwC) about annual claims submitted per capita. For Officers, they were, in 2021, \$6,291. In contrast, the Support Staff pool, which included almost all non-Officer employees, had average annual claims per capita of less than \$2,318. In other words, Officers' claims were 2.7 times higher per capita than those of

---

<sup>34</sup> According to a survey taken by the Columbia retiree organization EPIC, 36 respondents enrolled for 2023 in Traditional Medicare (Part B), plus a Medigap policy and a Part D prescription drug policy. 5 respondents enrolled in a Medicare Advantage Program (Part C).

<sup>35</sup> For context: The median annual price of the new drugs which the U.S. Food and Drug Administration (FDA) approved in 2022 is was \$222,003. Reuters, Jan 5, 2023. Among existing drugs, according to the AARP, the annual wholesale cost of the drugs Tecartus for leukemia treatment was \$424,000. The same cost applied to the lymphoma drug Yescarta. The Hepatitis-C drug Harvoni cost \$33,600 for 28 pills. Drug costs for diabetes with no insurance can cost about \$15.6K per year. For Leukemia it was \$16.5K.

Support Staff. It is unlikely that this is due to Officers being less healthy, but rather can be explained by the Officers who picked the Columbia plans being an atypical high-cost subset of the entire Officer retiree pool, whereas the Support Staff includes virtually everyone in that employee category.

Another reason for outside plans having been cheaper than Columbia's is because they were more restrictive in various dimensions, such as geographic coverage, choices of doctors, need for referrals to specialists, and co-payments.

## The Officers Covered

This section quantifies the number of retired Officers who took the pre-2023 Columbia plans and who are most affected by the 2022 change in the system.

A word of explanation is first needed. The term "officers" is popularly associated with top leadership, such as commanders of military battalions or C-suite executives running a company. In contrast, at Columbia almost every employee is an officer: an Officer either of Instruction, Research, Administration, or Libraries. In 2021, Columbia's total employee count was 18,148, of whom 15,255 were Officers (84%). The remainder of employees (3313)<sup>36</sup> is categorized as "Support Staff". These employees are typically compensated at a lower rate, and most are represented by one of several labor unions.<sup>37</sup> (Of overall employees, Officers of Instruction account for 24%, with their number having grown by 23% in a decade; Officers of Administration, of Libraries, and of Research (no separate breakdown is published) account for 60% of the total, with an absolute growth a hefty 41% over the decade. Support Staff accounts for about 17%,<sup>38</sup> with a growth of less than 3% over the decade.

### Table 1: Take Rates of Medical Insurance Plan

---

<sup>36</sup> Column 5 from Columbia-filed Form 5500, while Columns 1,2,3 & 4 came from Columbia Yearly fact sheets. The difference in the numbers may be due to the 5500 form reporting the FY from 7/1-6/30, while Columbia's OPIR numbers are for a calendar year.

<sup>37</sup> UAW/AFL-CIO Local 2110 Union for Technical, Office & Professional Workers; TWU/AFL-CIO Local Union No. 241 Security Officers, Maintenance, and Custodial; 1199 SEIU Healthcare, Medical Assistants, Cafeteria, and Clerical; 32BJ SEIU Apartment Building Services; and several small unions.

<sup>38</sup> The University's reported employee count does not add up exactly.

	<b>All Officers (Instruction, Administration, Library, Research) (1)</b>	<b>Officers of Administration, Library, &amp; Research (2)</b>	<b>Officers of Instruction (Full Time Faculty) (3)</b>	<b>Support Staff (4)</b>	<b>Total Active Employees (5)</b>	<b>Retirees or Separated Receiving benefits (6)</b>	<b>Support Staff Retirees [Persons Receiving Life Insurance] (7)</b>	<b>Officer Retirees on Columbia Plans [All Retirees minus Support Staff Retirees] (8)</b>
<b>2010</b>					15199	2208		
<b>2011</b>	11364	7734	3630	3402	14710	1944		
<b>2012</b>	11283	7714	3569	3222	15060	1945	1188	757
<b>2013</b>	11679	8013	3666	3195	16992	1935	1158	777
<b>2014</b>	12094	8331	3763	3238	15815	1903	1168	735
<b>2015</b>	12388	8582	3806	3205	15448	1842	1141	701
<b>2016</b>	12872	8996	3876	3073	15708	1803	1115	688
<b>2017</b>	13394	9395	3999	3219	16394	1800	1096	704
<b>2018</b>	13878	9764	4114	3318	16810	1722	1052	670
<b>2019</b>	14397	10192	4205	3378	17518	1711	1029	682
<b>2020</b>	15035	10665	4370	3395	18338	1682	1017	665
<b>2021</b>	15255	10874	4381	3313	18148	1652	997	655

	<b>Overall Officer- Retirees (est.) (9)</b>	<b>Take Rate of Officer-Retirees on Columbia Plans/ Officer Retirees] (10)</b>	<b>Officer-Retirees on Columbia Plans/Total Active Officers (11)</b>	<b>Support Staff- Retirees on Columbia Plans/ Total Active Support Staff (12)</b>
<b>2010</b>				
<b>2011</b>				
<b>2012</b>	2500	30.28%	6.71%	36.87%
<b>2013</b>	2556	30.40%	6.65%	36.24%
<b>2014</b>	2611	28.15%	6.08%	36.07%
<b>2015</b>	2666	26.29%	5.66%	35.60%
<b>2016</b>	2722	25.28%	5.34%	36.28%

<b>2017</b>	2778	25.34%	5.26%	34.05%
<b>2018</b>	2833	23.65%	4.83%	31.71%
<b>2019</b>	2889	23.61%	4.74%	30.46%
<b>2020</b>	2944	22.59%	4.42%	29.96%
<b>2021</b>	3000	21.83%	4.29%	30.09%

Overall retirees, from Columbia's filings, number 1,652. (Table 1, Column 6). These figures have trended downwards since at least 2010, with a decline of 25% over a decade. Of these plan retirees, a large percentage are not Officers, for reasons that will be discussed below. The number of Officer retirees choosing the Columbia plans is not being disclosed. However, it is possible to reverse-engineer such numbers.<sup>39</sup> For 2021, there were about 655 Officers on the Columbia plans.

This number is down from 757 a decade earlier, 13.5% lower, despite an increase of 41% in the number of Officers during the same period (from 11,283 to 15,255).<sup>40</sup>

With 655, the current number of officers estimated to be in the Columbia plan, the average number of retirees per cohort taking the plan each year, assuming an average life expectancy of 20 years in retirement, would be 32.7. About 267 Officers retire each year<sup>41</sup> of which we estimate 150 are eligible for retirement benefits.<sup>42</sup>

Of these, it seems that 22% overall are taking the Columbia plans. (32.7/150). *This means that 78% of Columbia retirees were already choosing private plans outside of Columbia.*<sup>43</sup>

In fairness, it was not the University that caused this out-migration from its plans but the dynamics of adverse selection. If anything, the generosity of its drug coverage and its cost to healthy retirees accelerated the out-migration to cheaper outside plans. And the University also

---

<sup>39</sup> The CURML Trust Fund pays for the life insurance of all Support Staff retirees but specifically not that of Officers. This provides the number of Support Staff retirees (997 in 2021), and by subtraction, one can estimate the number of Officer retirees for that year at 655. Similar calculations can be done for the other years.

<sup>40</sup> During that period, the retirement age (as provided by the University as part of the public calculation of contingencies by its auditor PwC) did not change much.

<sup>41</sup> There were 15,255 Officers in 2021. There are about 40 age cohorts (from 25 to 65 year olds, 65 being the average retirement age for officers. (Average retirement ages: Officers of Instruction/librarians: 67; Officers of administration: 62.) Each cohort would then be about 381 people. However, since the number of Officers has risen by about 26%, and assuming the additional hires are younger than the average age, the older cohorts are estimated to be below that average by 30%, i.e., 267.

<sup>42</sup> Assuming that 40% of retirees are not eligible for retirement benefits, which reduces the number of eligible retirees to 150 per year. If a lower percentage of retirees are in fact ineligible, this would raise the share of retirees who do not take the Columbia plans. For example, if only 25% are ineligible, this would raise the share of eligible Officer-retirees opting for non-Columbia plans to 84%.

<sup>43</sup> The number for recent retirees who pick outside plans is probably even higher, given that the overall number of plan enrollees has been steadily dropping while the number of officers (and hence of retirements) has been steadily rising.

tried to slightly mitigate the gap from being even larger by providing a modest subsidy to those staying within the Columbia plans.

### III. The New Plan

In August 2022, a letter sent by Columbia University Human Resources informed retired Officers that it had changed the retiree medical insurance arrangement. (Apparently, no similar notice was given to currently active officers, whose retirement financial calculus was affected, too.)

- The four Columbia-sponsored plans were to be abolished by the end of 2022.
- Instead, an *exchange* run by a company called Via Benefits would list a set of privately offered insurance plans by third-party insurance companies and be available to advise retirees through benefit consultants and online tools about plans that would make most sense to them. Via would then forward the application to the company that the retiree picked.
- The subsidy by Columbia would be reduced from \$72 + \$36 per month to a smaller number, \$18.33 + \$9.17 per month (an annual \$220 + \$110), available to those current users of the Columbia plans who chose to go through the Via Exchange. (For retirees grandfathered under plans before 2011, these numbers are doubled. Those who retired before 1994 under a still different plan, and who are still with us, are unaffected.)
- Future eligible retirees would receive the subsidy \$18.33 (+ \$9.17 for a spouse) if they selected their plans through Via.
- There would be some support for cases of catastrophic prescription drug cost, for those retirees selecting their plans through Via.
- The Columbia-sponsored dental plan remains.
- The new plan was based on the recommendations of Columbia's HR consultancy WTW (Willis Towers Watson). The operator of the exchange, Via Benefits, is a WTW subsidiary.

#### Analysis Of the New Plan

Positives of the new plan are:

1. The exchange provides an organized platform with trained consultants to assist retired Columbia officers in exploring health plan options.
2. The catastrophic support alleviates a prescription drug cost spike for those using the Via exchange.
3. For the University, it helps contain future cash requirements, reduces administrative burden, and makes costs predictable.

Problems include:

1. Though obscured by details, the bottom line of the plan is the downscaling of what used to be the University's fairly significant medical insurance support to its retirees, a system that has existed for many decades, in favor of a nominal contribution. It will

now contribute, for a typical future retired couple, a mere 1.2% of the pre-tax cost of its overall insurance coverage.

2. Grandfathered support to existing participants of the Columbia plans would be greatly reduced, from currently \$72 to \$18.33 per month.
3. No support is forthcoming for those 78% of existing retirees who have not chosen Columbia plans in the past, having been deterred by its high cost and having had the foresight to pick the outside plans whose selection is now becoming the only option available.
4. The value of the catastrophic drug support has only short-term value, given the provisions of the recent (August 2022) Inflation Reduction Act that will soon cap an individual's out-of-pocket drug costs at \$2,000 per year, much lower than Columbia's trigger of support of \$10,048.<sup>444546</sup>
5. The requirement to go exclusively through the Via Exchange and its offerings, both for the subsidy and the catastrophic prescription drug backup, reduces user options, especially outside the NY metro area, and has potential negative ramifications for price reductions and service quality.
6. The existing funding mechanism for retiree medical insurance would channel an available significant pool of Trust Fund money away from intended beneficiary Officers.

These issues will be discussed in the following.

## The Overall Magnitude of the Contribution to Retirees

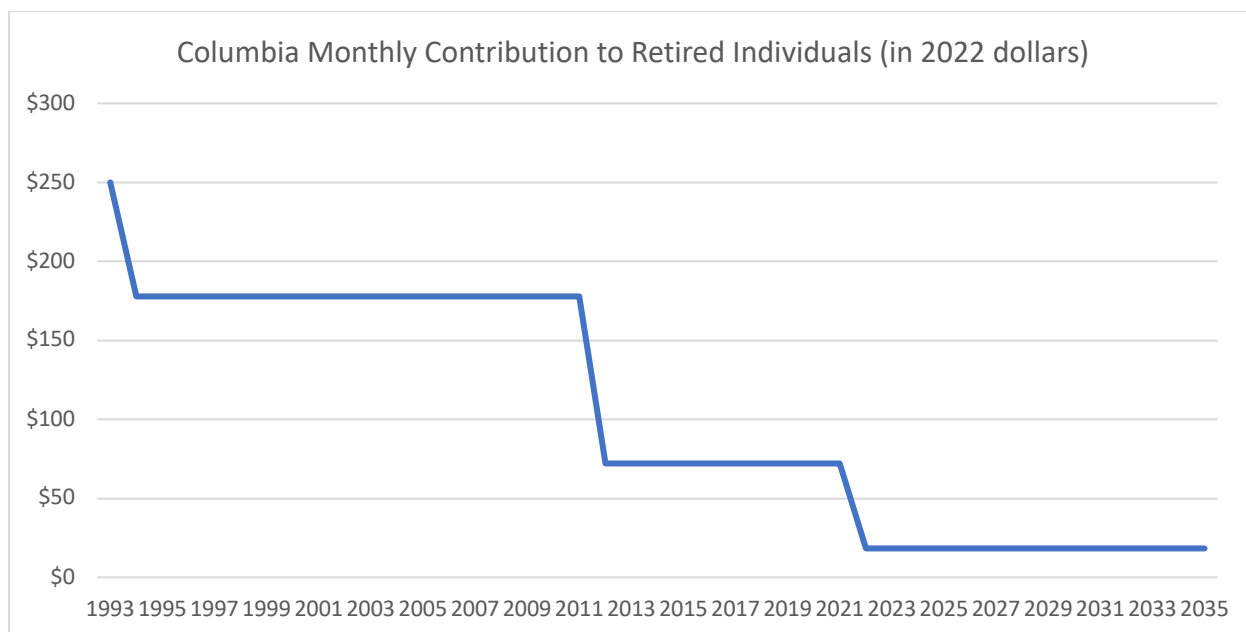
### Graph 2: Columbia Monthly Contribution to Retired Individuals

---

<sup>44</sup> Columbia's support would hence apply only in highly unusual situations such as a retired eligible employee not eligible for such Federal support, as might be the case for non-citizen on a Green Card who has lived in the U.S. for less than 5 years and is hence not eligible yet for Medicare but who has worked for Columbia for more than 10 years, for example abroad. The Columbia benefit would then be, e.g., for high drug costs of, say, \$50K a year, about \$0.8K/year. (Covering the 5% out-of-pocket contribution for drug costs over about \$34K, assuming a co-insurance of 30% below \$34K which would reach the catastrophic threshold of about \$10K out-of-pocket.) The Via brochure incorrectly describes Medicare eligibility to be for 'Americans,' which would exclude the Green Card holders who have lived in the US for more than five years.

<sup>45</sup> Kaiser Family Foundation: "The Inflation Reduction Act amends the design of the Part D benefit. For 2024, the law eliminates the 5% beneficiary coinsurance requirement above the catastrophic coverage threshold, effectively capping out-of-pocket costs at approximately \$3,250 that year. Beginning in 2025, the legislation adds a hard cap on out-of-pocket spending of \$2,000, indexed in future years to the rate of increase in per capita Part D costs."

<sup>46</sup> This cap provision has wide bipartisan Congressional support, and a change is a possibility but not a probability.



It is important to understand the history of Columbia’s contribution to the medical expenses of retirees. That contribution – which is a central benefit to retirees and a promise to active employees—has quietly shrunk to a nominal amount.

- a. Until 1994, Columbia covered the **entire medical plan of every retiree**. (We call this “Plan #1”). Its value can be estimated as a monthly \$160 (or **\$250 + \$125 for a spouse** in today’s money<sup>47</sup>. )
- b. After 1994 and until 2011, Columbia support shrunk to a subsidy for the medical plans (only to those choosing Columbia plans) of \$144 per retiree plus \$72 for a spouse.<sup>48</sup> In today’s money, this would be **\$178 + \$89**. (“Plan #2.”)
- c. After 2012 and until 2022, these benefits were cut in half to **\$72 + \$36** (and only to Columbia plan users). <sup>49</sup> (“Plan #3”)
- d. After 2022, the new plan provides an “HRA” (Health Reimbursement Arrangement”) **\$18.33 + \$9.17** (\$220 + \$110 / year). (“Plan #4”).<sup>50</sup>

By these numbers, a retired couple will receive in 2023 \$4,170 less than what they would have received 28 years ago, in today’s money.

And that is a still much smaller share of that retiree’s overall medical expenses. In 1994, Medicare itself charged, for all retiree incomes, only \$35/month (in today’s money about \$70 per month or \$825 per year.) In other words, it was almost free for those who had paid their

<sup>47</sup> We assume that medical inflation is 2.5% above general inflation.

<sup>48</sup> Benefits were grandfathered for those who already received them.

<sup>49</sup> Benefits were grandfathered for those who already received them.

<sup>50</sup> This money, small as it is, is not paid for by the University but by the accumulated retiree medical fund. On the other hand, it is likely to cover more people. These issues will be discussed further below.

Social Security/Medicare payroll taxes in their active years.<sup>51</sup> Columbia's contribution to a retiree's overall expense towards medical plans (Medicare plus Columbia Plan cost) in 1993 was 78.1%. Under the new plan, it is 1.2 percent.

Those who joined Columbia 28 years ago or earlier—today about 53 years or older—did so under an employment arrangement which provided the expectancy of a much higher retirement medical coverage than is now being offered.<sup>52</sup> Those Officers who recently entered into retirement agreements did so with a similar expectation. And those who are already retired and signed up for the Columbia plans have now lost their drug plans for whose option value as a safety net against unforeseen medical calamities they had paid high premiums for years.

Presumably, a large share of current retired Officers<sup>53</sup> were hired well before 1994, under agreements that provided, in some way, retirement arrangements. When it comes to retirement *savings* benefits such as the 403(b) plans with TIAA or Vanguard, the relevant date is the *hiring date*. But when it comes to retirement *medical* benefits, the University treats the moment of *retirement* as the source of its obligation, without consideration to any understanding that it previously gave to its Officers regarding those future benefits. Arguably, not-yet-retired Officers in 1994 were entitled to the medical benefits then prevailing, and the changes subsequently were more in the nature of unilateral amendments of employment contracts. The same holds true for subsequent step-downs in support of medical insurance.

## Contributions by the University

### Graph 3: Columbia Aggregate Contribution (in Million 2022 Dollars)

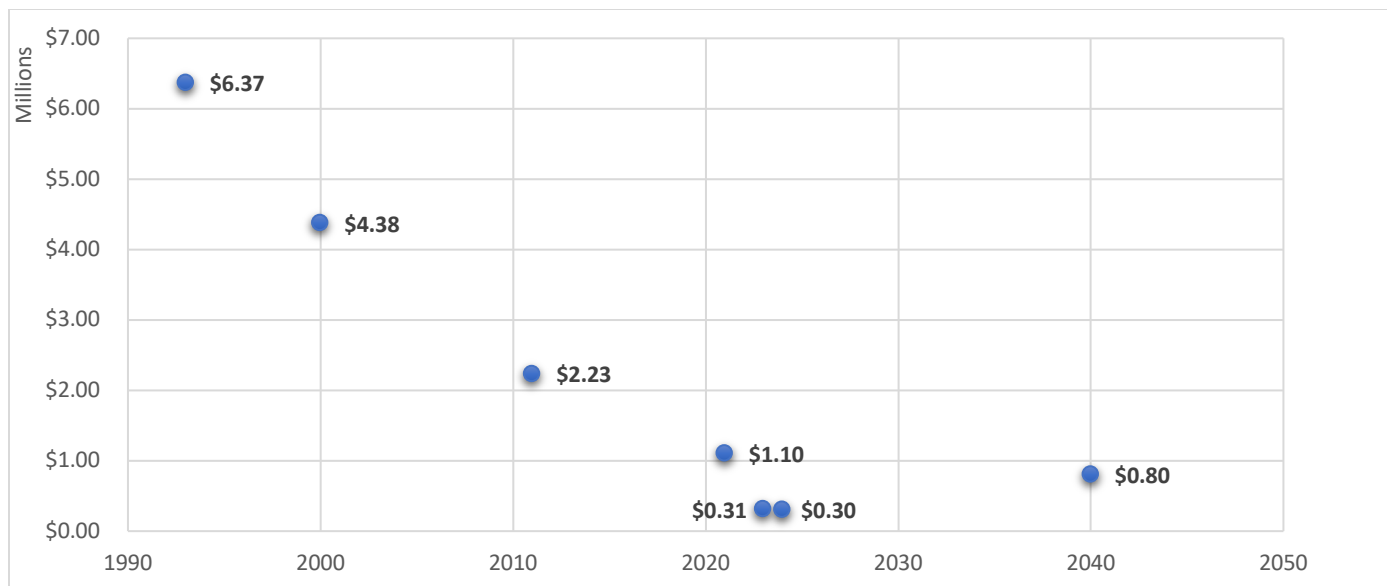
---

<sup>51</sup> Payments were raised over time, including for higher retiree incomes in 2006, and by the ACA ("Obamacare") in 2010.

<sup>52</sup> All of the age numbers are illustrative generalizations.

<sup>53</sup> Other Officers were hired as senior faculty members already.





When it comes to the aggregate cost of the subsidy to the University, here are some estimates.

- a. In 1993, there were an estimated 1,700 Officer retirees.<sup>54</sup> Presumably, virtually all of them picked the Columbia-offered plans, given that they were free to them. The cost of such a plan was, at the time, an estimated \$250 per month in today's money,<sup>55</sup> and with spousal coverage, \$312.<sup>56</sup> Total Columbia annual contribution to Plan #1 was therefore an estimated **\$6.37** million in 2022 dollars.
- b. By 2000, there were about 1825 retirees<sup>57</sup> and each of them received a monthly \$144 contribution. In addition, a spouse would receive a \$72 contribution. In today's money, this would be \$300 per retiree. We assume that 2/3 of retirees picked the Columbia plans. We also add 20% for coverage of retirees grandfathered to Plan #1. Columbia's total annual contribution at Plan #2 would then have been **\$4.375** million in 2022 dollars.
- c. In 2011, before the transition to plan #3, there were an estimated 2,444 Officer retirees.<sup>58</sup> An estimated 772 of them chose the Columbia plans.<sup>59</sup> Each of them received a subsidy, in 2022 dollars, of \$178, plus \$89 for a spouse, where one half of retirees had a spouse on the plan. We assume 20% of retirees were

<sup>54</sup> This is based on a downward extrapolation from the 2021 number of Officer retirees, with the assumption that Columbia's Officer count has risen by 1% each year for the past 30 years.

<sup>55</sup> We assume medical inflation to be 2.5% above general inflation.

<sup>56</sup> We assume that spouses cost an additional \$125, and that half of retirees had spousal coverage. Together this would be \$312 per retiree. (According to a survey taken by the Columbia retiree organization EPIC, 35 of 60 respondents are insuring themselves as well as their spouses, which is close to the 50% we are assuming in this report.)

<sup>57</sup> This is based on a downward extrapolation from the 2021 number of officers, with the assumption that Columbia's Officer count has risen by 1% each year for the past 30 years. (In the past decade, the Officer count rose by 3% per year.

<sup>58</sup> Extrapolating from the 2012 number in Table1

<sup>59</sup> Extrapolating from the 2012 number in Table1

grandfathered into Plan #1 and included this increment. Columbia's total annual contribution in 2011 would then have been **\$2.232** million in 2022 dollars.

- d. In 2021, there were about 3,000 Officer retirees.<sup>60</sup> 655 of them picked the Columbia plans. Each of them was supported by \$72/month, plus \$36 for a spouse, for an estimated \$90. We add an estimated overall 25% for retirees whose benefits are grandfathered, assumed to be one half of the non-grandfathered retirees. This would mean that Columbia's contribution to Plan #3 was about **\$1.1** million. This is only 49% of what it was in 2011, 25% of what it was in 2000, and 17% of what it was in 1993.
- e. Though it has been suggested that the aggregate level of subsidy in the new Plan (#4) would not decline post-2022 (which would then be **\$1.1** million), this is not the case. Going forward, the cost components for the subsidy would be:
  - i. If *all* current participants in the 4 Columbia plans participate – a highly optimistic number, considering the lower numbers found in a small-sample survey by the Emeritus Professors in Columbia association (EPIC)—and taking into account the higher support levels for pre-2011 retirees, then the overall HRA subsidy would add up to **\$240K**<sup>61</sup>, and only in the first year. That number would shrink with the number of such grandfathered retirees and reach near zero in 20 years if one assumes such an average life expectancy.
  - ii. At the same time, new retirees would be added to receive the subsidy. Earlier, we estimated 150 annual retirements of eligible Officers and a life expectancy of 20 years. Thus, in steady state, the number of covered retirees would reach 3,000 in 2043, for an overall expense, including spouses<sup>62</sup>, of \$825,000.

---

<sup>60</sup> The number of Officer retirees is not reported by Columbia. Indeed, Columbia may not have an accurate count of its retirees since many would have moved away or died. Our estimate is based on the following: There were, in 2021 15,255 active officers. In 2011, 11,364. That number keeps declining as one goes back. We assume, over the past 40 years, an average of 12,000 Officers. We also assume that these Officers are evenly distributed over 40 age cohorts, from 25-65. Many of them leave the University before retirement eligibility (55 or older, with 10 years or more of service after the age of 45, and no other full-time job.) We assume that these conditions cut out one half of those ending Columbia employment at some point in their career. Together, this would translate to 150 Officer retirements per year. Assuming an average of 20 years in retirement, given life expectancies, this would result in an aggregate Officer retiree pool of 3,000).

While imprecise, these numbers provide an order of magnitude in the absence of reported data.

<sup>61</sup> We earlier calculated the number of plan participants at 655, of whom we assume one half take spousal coverage, and 33% being pre-2011 plan participants who receive the more generous contribution for these retirees. Thus, total contribution toward the overall pool of retirees is  $\$220 \times 655 \times (1 + (0.5 \times 0.5)) \times (1 + 0.33) = \$239,566$

<sup>62</sup> Here as elsewhere in this report, we estimate that half of retirees add a spouse's insurance.

- iii. To that must be added the cost of the catastrophic drug coverage, which we calculate, for the next year or two, as \$69K<sup>63</sup> and soon near-zero.<sup>64</sup>
- f. **The total contribution toward retiree medical insurance is thus about \$309K in the short term. In 2023, it would be 72% below even the 2022 levels that already were much smaller than in previous years. The contribution would then start to rise gently over twenty years to a steady state of \$825K.**<sup>6566</sup>
- g. Even that subsidy, if not regularly adjusted, would decline in actual value since it is not indexed to the general CPI rate of inflation (8% in 2022 and about 4% in mid-2023), let alone medical inflation (about 2.5% faster than general inflation in most years).
- h. The aggregate of the contribution has hence declined by 83% from 1993 to 2021, and by more than 95% by 2023, and then to 87% in 2043.
- i. Even that comparison is an understatement. Before the 1994 change in the age-discrimination law, Columbia had a mandatory retirement age. But after 1994, Officers could stay on the job much longer, and they did, as discussed below. Assuming that life expectancy has grown only modestly for these cohorts, this means that the length of retirement years has been shrinking and with it the average support per retiree, even before changes in their level.

---

<sup>63</sup> According to Kaiser Family Foundation's 2018 nationwide figure, for 4.4% of Medicare users, out-of-pocket drug expenses exceed the Federal threshold (CCL, currently \$10,048.) There are about 3,000 Columbia retirees. We assume that 1,832 will use the Via exchange. (All 655 plan participants plus one-half of the rest of retirees.) This would mean 81 such cases per year. To reach the CCL, given a 30% co-insurance, a patient's Rx bills would have to be about \$33K. For expenses above the CCL, co-insurance drops to 5%. If we assume that the average Rx bills for the group in question is \$50K per year, Columbia's average contribution would be 5% of \$50K- \$33K= \$850. The aggregate contribution to catastrophic prescription drugs would therefore be about \$69K per year. But even that is an overestimate.

<sup>64</sup> As mentioned earlier: Given the impending change in Federal coverage of catastrophic drug issues, the only remaining Columbia contribution would be for the unlikely cases of catastrophic out-of-pocket drug costs that are not covered by the Federal ceiling. Columbia's support would apply only in highly unusual situations such as a retired eligible employee not eligible for such Federal support, as might be the case for non-citizen on a Green Card who has lived in the U.S. for less than 5 years and is hence not eligible yet for Medicare but who has worked for Columbia for more than 10 years, for example abroad. The Columbia benefit would then be, e.g., for high drug costs of, say, \$50K a year, about \$0.8K/year. (Covering the 5% out-of-pocket contribution for drug costs over about \$34K, assuming a co-insurance of 30% below \$34K which would reach the catastrophic threshold of about \$10K out-of-pocket costs.) Once can assume that the number of such cases will be so tiny as to make Columbia contributions a rounding error.

<sup>65</sup> With current eligible retirees leaving the scene in accordance with the assumed life expectancy, and new ones retiring, the overall number of HRA recipients rises each year by 117.5, for a dollar total of \$32K/yr each year until 2043. In the first two years this is offset by the reduction in catastrophic coverage requirements, but the overall then rises after 2025.

<sup>66</sup> To that one must add to allow for an expanded number of Officers and a rising life expectancy, but also subtract to allow for the rising age when Officers retire.

The conclusion is that a benefit that had been part of the Columbia package for decades is being eliminated beyond a nominal residue. This has happened gradually, in an accumulation of smaller decisions over time whose impact was not understood or foreseen.<sup>67</sup>

The result was counter to the expressed sentiment of the Columbia community, as reflected in this University Senate resolution in 2011:

THEREFORE BE IT RESOLVED that the University Senate affirm the following principles to guide the Provost's advisory group in its search for changes in Columbia's fringe benefits program:

--that major recommendations for changes should honor expectations that have been established over the course of the careers of current officers, and should assure grandfathering of essential health, tuition, and retirement benefits to the maximum extent possible;

And yet, in 2022, as Laurie Mark (retired chief of division of ophthalmic anesthesia) was quoted in the *Columbia Spectator*: "We all feel like we're just being thrown to the wolves...with no recognition and no appreciation for the years that we put into Columbia."<sup>6869</sup>

## Benefits From the Via Medicare Exchange

The concept of moving away from company-sponsored medical insurance plans to private plans offered in the market, and to provide options through a "Medicare Exchange", is a system that has spread in recent years.<sup>70</sup> In principle, it is positive.

For the retirees, it may mean availability of a consultation mechanism as they make their choices.

As exchanges go, a Medicare exchange is a simple process, in comparison with a travel site such as Travelocity or Orbitz, which aggregate tens of thousands of sites operated around the world

---

<sup>67</sup> Many retirees take a harsher view and believe that the reductions were a deliberate plan to eliminate support altogether.

<sup>68</sup> Emily Forgash and Ayaan Ali, "University ends Columbia health care plans for retirees, shifting them to private company," *Columbia Spectator*, December 5, 2022, <https://www.columbiaspectator.com/news/2022/12/05/university-ends-columbia-health-care-plans-for-retirees-shifting-them-to-private-company/>.

<sup>69</sup> An important problem is that of retirees who have been on a Columbia retiree medical plan for years and now contend that they are vested, and who adamantly want to stay on such a plan. One might consider, if possible under existing regulations, to let such people join a Columbia plan for *active* officers, though at a different price point with a much lower subsidy.

<sup>70</sup> For an early and extensive analysis of the system, see Christine Buttorff, Sarah A. Novak, James Syme, and Christine Eibner, "Private Health Insurance Exchanges", RAND Corporation, 2016.

by airlines, hotels, rental car companies, etc., each of which has numerous offerings, and whose prices change constantly. In contrast, Via provides an aggregate of 43 medical options and 13 drug options from 6 companies, many of them offering a product that is standardized by regulation, and whose prices change only once a year, with most of transactions being repeat business.

Via's information base is hardly unique. The data is also available from free informational websites that show, for each zip code, the available Medicare Advantage and Medigap plans. For Medicare Advantage plans, the federal website *Medicare.gov* provides pretty much the same plan details, comparisons, and enrollment.<sup>71</sup> New York and other states list prices and providers, sometimes also by sub-region.<sup>72</sup> Nonprofit organizations are other sources of information, as are HR departments and the websites of rival exchanges, brokers, and of the insurance companies themselves.

Other advantages described by WTW in its website promotion to employers as potential clients of Via are<sup>73</sup>:

- A phone system that facilitates the routing of retirees' calls (i.e., a voice-response system, though this is not necessarily something considered positive by elderly retirees).
- A self-service website to keep track of the use of the HRA subsidy for insurance premiums or deductibles.
- Detailed Explanation of Benefits (EOBs) with instructions to fix claims issues. (Such instructions are useful, but this also seems to imply that no direct assistance is given to a patient in a dispute with an insurer or with a medical service provider).
- Customer support representatives.

But the main promise of Via is to be the exclusive channel for the Columbia subsidy and catastrophic drug support. The HRA subsidy applies only to the small percentage of current retirees who in 2022 took the Columbia plans, and to future retirees. For the numerous Officer retirees who have been outside the Columbia plans (78% of current Officer retirees) the plans available over the Via Exchange are identical to those already available to them in the open market, and they cost exactly the same, as is shown in Appendix B.

Columbia states in the brochure sent to retirees that "We expect more than 99% of our participants to see cost savings." This needs to be substantiated, beyond a reference to actuarial models – black boxes whose assumptions are unstated. But one should not suspend common sense:

---

<sup>71</sup> For Medigap plans, Medicare.gov provides details, lists of available plans with the price, but customers then click to the website of providers.

<sup>72</sup> Each state has a State Health Insurance Assistance Program (SHIP). The NYS site is less user-friendly and redirects the user to the Federal Medicare.gov for more information.

<sup>73</sup> From the publicly accessible website which nevertheless claims confidentiality "© 2022 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only."

- a. If “participants” include only those 655 retirees still using the four Columbia plans, this 99% percentage would imply that less than 7 retirees in total do benefit from the current drug coverage of the Columbia plans *over what is already available* in the market if they switched.<sup>74</sup> This would imply an economic irrationality by 99% of those choosing the Columbia plans, which makes the projection highly unlikely.

Also, according to the Kaiser Family Foundation, 4.4% of Medicare beneficiaries are in the situation of catastrophic drug expenses. Applied to the Columbia plan participants this would mean 29 people, not 7. And, as discussed, the Columbia pool is almost certainly above-average in prescription drug needs since that is its main attraction, so even that larger number is likely to be a significant understatement.

- b. If, on the other hand, the term “participants” applies to all retirees, or to those who will choose to go through the Via exchange, not only those who have chosen the Columbia plans, then the 99% number becomes mathematically impossible, given that 78% of retirees already use the outside plans and do not have any cost savings from the shift to Via.<sup>75 76</sup>

In addition, “cost savings” is a meaningless concept, as mentioned before, without reference to benefits and service quality. A plan might be cheaper, but if it is less favorable in covering out-of-pocket expenses, if it limits access to doctors, and if it is more restrictive in approving or covering treatments, it is not necessarily a better deal.

For example, one retiree reports from personal experience that “Common drug categories such as acid reducers, antiviral topical creams, influenza medications and blood thinners, that had copays generally capped at \$45 monthly in the 2022 Columbia Group Plan, now have copays that can be 4 to 8 and up to 25 times higher than the 2022 Group Plan copay rates.”<sup>77</sup>

Clearly, some of the current users of the Columbia plans were overpaying relative to the risk probability. But they seemed to feel safer with that extra cushion. Without that alternative they will now pay less, by having to take outside plans that had been already available to them before. Taking away several options (the Columbia plans) without adding a single new option that was not already available at the same price should not be described as an improvement to risk-averse beneficiaries.

---

<sup>74</sup> The small HRA subsidy might affect a small number of plan participants on the margin.

<sup>75</sup> The only exception would be if almost all of those already on non-Columbia plans have chosen, for some reason, a wrong (and more expensive) plan, and that Via advice will now correct these misjudgments made by over 2,000 highly educated people who have a major stake in the fit of their health coverage.

<sup>76</sup> A survey taken by the Columbia retiree organization EPIC, shows that 30 respondents reported costs in 2022 of over 8,000/year, and 15 said that their expenses expected them to be lower in 2023. That would be a reduction for 50%, not 99%. But, as mentioned, the lower-priced options were already available before and had not been chosen.

<sup>77</sup> Given that the new arrangement has been in place only for a few weeks at this writing, the author is unable to gauge the prevalence and persistence of such negative experiences. Over time there will be a more extensive data base.

According to Via, another of its advantages is that it provides “Seamless delivery model for Health Reimbursement Account (HRA)”. This presumably means that Via receives Columbia’s subsidy to those retirees who have been bumped off the Columbia plans and can apply it to whatever health plans are picked by retiree, according to their wishes. Such management of the subsidy might be helpful if the subsidy were larger in size. But the feature that enables a flexible allocation of a subsidy totaling a mere \$220-330 per year across a retiree’s 1-3 plans seems to be an unimportant facet. If the subsidy were larger this could be more useful.

It must also be understood that whatever the aggregate subsidy is (estimated as about \$309K) it does not come out of Columbia’s budget but out of the accumulated Columbia University Retiree Medical and Life Insurance Benefits Trust Fund. It can only be spent on retirees’ medical plans. This will be discussed further below.

## Potential Conflicts of Interest

It is not good practice to intermingle the roles of an ongoing consultant— who is a fiduciary to Columbia—with that of a service provider who sells its product to Columbia in the same subject area. Conflicts of interest are built into such arrangements. It is for that reason that public accountancies, for example, have been forced to separate from their consultancy business. Even with good faith by all and with corporate decentralization, potential problems loom. This is the situation of WTW advising Columbia, while its subsidiary Via Benefits runs services for Columbia as well as for its retirees. Suppose that Via becomes less effective than a competitor? How would Columbia be advised? How would one reduce the problem?<sup>78</sup> Options for Columbia include:

1. *A full separation of its relationship from one of the two entities.* This would be effective but disruptive
2. *A firm firewall between the two functions.* Judging from such efforts in other industries, this is often window-dressing, absent monitoring.
3. *User choice.* Perhaps most effective and easiest to operate: give Columbia retirees access to additional exchanges and to direct engagement with insurers. This would provide retirees with choice and Columbia with a yardstick to judge performance and act on that information.

## Via’s Business Model

It is important to understand Via’s business model. Via declares that using it will cost the retiree nothing. If so, how does it maintain profitability? As it is said for the digital economy in general,

---

<sup>78</sup>WTW itself intermingles. Its website promotion to employers as potential clients of Via (which can be found on the public Internet) includes, as an advantage of Via, that it is “*Guided by WTW experience (e.g., best practices, exceptions, unique situations)*”. It also touts other Via advantages, discussed earlier. From WTW’s publicly accessible website, though it asserts confidentiality © 2022 Willis Towers Watson. All rights reserved. Proprietary and Confidential. For Willis Towers Watson and Willis Towers Watson client use only.

if you are not paying for a product, you *are* the product being sold. An insurance exchange makes its money largely by commissions from the insurance companies for which the retirees sign up, with the exchange being the conduit. An exchange does not actually bill people or service their claims. It provides retirees with information about the options and signs them up for the selected insurance company.

For that connection, the insurance companies pay a commission to the exchange. Via does not disclose this information in its brochure to Columbia retirees, but its general corporate website provides it if one looks closely enough.

The proverbial fine print, at the very end of the “welcome to Via Benefits” page, states:

“Via Benefits receives compensation in the form of commissions from insurance companies from the sale of insurance products and services we offer. Some of the compensation that Via Benefits receives may be contingent and may vary depending on a number of factors, including the insurance contract and insurer you select. In some case[s], other factors such as the volume of business Via Benefits provides to the insurer or the profitability of the insurance policies that Via Benefits provides to the insurer also may affect our compensation... Via Benefits also may receive other compensation from third parties, such as for selling or referring to the sale of other products or services.”

According to that language, Via can receive higher compensation from some insurers and from some types of contracts than from others. If so, it and its customer consultants would have a financial incentive to favor some insurers and plans over others. For example, there is no commission on a retiree taking the straight governmental Medicare –known as “Original Medicare”, in contrast to choosing the private Medicare Advantage plans, known as Part C.

Via addresses this issue by stating:

“Via Benefits may accept this compensation in locations where it is legally permissible and meets standards and controls to address conflicts of interest. Whether or how much insurers may pay in such compensation does not play any role in the Via Benefits' insurance recommendations.”

Via argues that its representatives have no incentives to recommend high-priced insurance plans. That might indeed be the case for the individual employees, though that would depend on the company's compensation and bonus system, about which we have no information. But an absence of economic incentives cannot exist for the company itself, given that the revenue model for its Medicare exchange is based on commission payments.

All this would not make much difference if the commission received by the exchange would be minor. Which raises the question of how high it is. That number for Via is undisclosed, as it seems to be for other Medicare exchanges. But there are indicators and analyses for the size. The maximum size of the commission by Medical Plan brokers and agents is regulated by the Federal Government, which suggests that problems have existed.



A report explains<sup>79</sup>:

“Maximum commissions for MA [Medicare Advantage] and Part D are set annually by the [U.S. Government’s] Centers for Medicare and Medicaid Services (CMS) and are commensurate with fair market value (FMV). Within the maximums set by CMS, insurers determine the exact compensation level they will pay agents, which can vary by product or contract.<sup>80</sup> CMS maximums are set nationally, although they may be higher in certain states because of cost of living and other conditions. For example, for 2022, CMS has set the maximum national commission for first-time enrollment in MA at \$573 per beneficiary for most parts of the country. In California, however, the maximum first-time commission is \$715. For standalone Part D plans, the 2022 maximum national commission for first-time enrollment is \$87 and does not vary by region. These commissions are paid when the beneficiary first enrolls in an MA or Part D plan.”

“CMS maximum commission rates are set lower for “switchers” and “renewals” — 50 percent of the first-time commission. For 2022, the maximum national commission for renewals and switches is \$287 for MA, with variations in certain markets. For example, in California, the renewal commission is \$358. For Part D, the national maximum renewal commission is \$44.”

On top of these enrollments and renewal commissions whose ceilings are regulated, there are also entirely unregulated “administrative expenses” paid by the insurance companies. Similarly, for the Medigap plans that sit on top of Original Medicare there is no regulation of commissions.

“ A recent report indicates that first-year commissions for enrollments in Medigap are approximately 20 percent of annual premiums.....The commission for subsequent years (i.e., the renewal commission) is set at 10 percent of the premium. Based on our analysis, the average premium in 2020 for Medigap was \$1,660, meaning an agent would be paid \$322 for the first year and \$166 as a renewal commission.”

“First, the difference in MA and Medigap compensation creates a potential conflict — the agent may be motivated to recommend one type of coverage over another based on the compensation rather than the beneficiary’s need. CMS could consider setting

---

<sup>79</sup> Ali, Riaz and Lesley Hellow. “Agent Commissions in Medicare and the Impact on Beneficiary Choice.” The Commonwealth Fund. October 12, 2021. <https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice>

<sup>80</sup> Is a medical exchange like Via a Medicare Broker or Agent? This is a non-transparent area. An exchange wants to avoid being classified and therefore regulated as such. Via thus states that “The Company does not issue insurance contracts or bind coverage directly.” But it later also states that business is conducted indirectly: “All insurance quotes and products are offered through Extend Insurance Services, LLC, a Utah resident insurance agency (Utah License No. 104741) which is licensed as a non-resident agency or otherwise authorized to transact business as an insurance agency in all fifty states and the District of Columbia.” <https://app.viabenefits.com/about/licensing-legal>.

commissions to ensure that agents are not motivated financially to favor a particular type of coverage, and therefore, can provide beneficiaries unconflicted advice.”

According to the Federal CMS and New York State, the maximum agent level Medicare Advantage commissions in 2022 in NY are as follows:

- New to Medicare commission: \$573 (For CT, \$626)
- Replacement commission (Switching): \$287
- Renewal: \$287

For Medigap, for the Humana Type F plan, the first signup would result in a commission of \$1,076, and each subsequent year \$538. For the UHC AARP Type G plan, these numbers would be \$672 and \$336. (The most typical plan is Medigap Type G.) For a couple, these numbers would double.

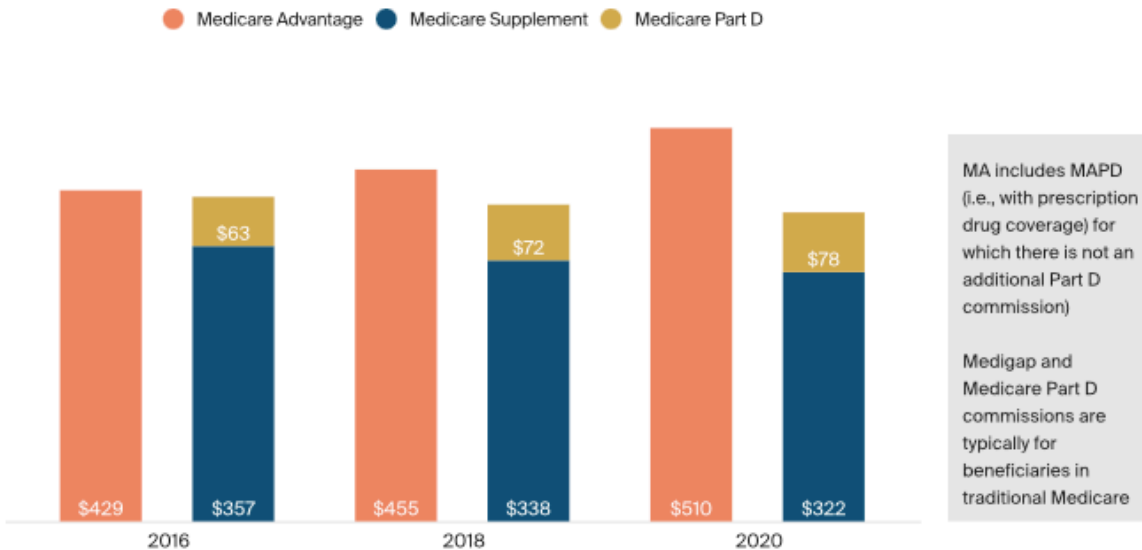
Thus, pricier plans would yield higher commissions. And where renewal commissions are the same as for switching, there is little incentive for agents to spend time each year to find a different plan for the retiree that might be a better fit to new circumstances.<sup>81</sup>

---

<sup>81</sup> The flip side is that with higher commissions for switching than for renewing, the incentive is to push for frequent switches.

## Graph 4: Commission Payments by Insurance Companies

### Nationally, An Increase in Medicare Advantage Commissions, Drop in Medigap Commissions, 2016–2020



Data: 1) Medicare Advantage and Medicare Part D data from Centers for Medicare and Medicaid Services, "Agent Broker Compensation," CMS, 2020. 2) Jeff Snyder, "2022 Maximum Broker Commissions for Medicare Advantage & Medicare Part D," Ritter Insurance Marketing, May 28, 2021. 3) Author calculation of 2016, 2018, and 2020 National Association of Insurance Commissioners (NAIC) Medicare Supplement data on average premium and enrollment. NAIC data included three-year cumulative data for premiums, so 2016 data included data from 2014–2016; 2018 data included cumulative data from 2016–2018; and 2020 data included cumulative data from 2018–2020. Based on these three files, the average Medicare Supplement premium in 2016 was \$1,784, the average Medicare Supplement premium in 2018 was \$1,691, and the average Medicare Supplement premium in 2020 was \$1,660. Not all companies are required to file for every schedule/exhibit. The states determine the schedule/exhibit for which each company needs to file. Some carriers in the health plan demo files are not included in the Medicare Supplement file. To calculate the average 2016 and 2020 Medicare Supplement premium and commission, we excluded all data that were not reported, including the \$0.00 premium and enrollment data along with plans that had an approval withdrawn and a plan closed date as of that year. We excluded plan type designations O and P from the Standardized Medicare Supplement to only show plan types A, B, C, D, F, G, K, L, M, and N. Plan type designation P identified policies issued prior to the effective date of this state's revisions to its Medicare Supplement regulatory program pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1990, and no longer offered in a state. Policies not meeting either of these definitions should be designated with O. This includes states that qualified for and received a waiver under federal law from the A–N requirements (Massachusetts, Minnesota, and Wisconsin). A policy issued in these three states that did not require changes as the result of modifications to the state regulatory program should be reported as O.

Source: Riaz Ali, "Agent Commissions in Medicare and the Impact on Beneficiary Choice," *To the Point* (blog), Commonwealth Fund, Oct. 12, 2021. <https://doi.org/10.26099/kwgc-8k34>

To put these numbers in perspective: A retiree with spouse would receive a \$330 subsidy per year from Columbia. But this would be conditional on both going to an insurance company through the Via exchange. Via would then benefit in commissions, depending on the plan, in the first year about \$1,400 and subsequently about \$700 each year, plus potential payments for administrative expenses. For those 78% of current retirees and their spouses who were not previously on Columbia plans, the discrepancy of benefits received by them vs those received by Via is even higher. They will not receive any subsidy, but to qualify for the catastrophic drug coverage (a small but non-zero contingency for most) they must go through Via, which then collects the full commission of about \$1,400 initially and \$700 subsequently.

This leads to the question: why don't the Columbia retirees and their spouses share in the benefit from the insurance company's commission payment to Via? Sharing commissions in ways that reduces cost to beneficiaries happens for retirement savings accounts. For medical plans, the insurance companies aggressively seek the retirees' business and are willing to pay to sign up customers— but to Via, not to the retirees. Via adds little in added value other than delivering the retirees to the insurance company<sup>82</sup>. Since it delivers thousands of retirees to the insurance companies, one would expect this to result in a lower group rate for the retiree. But no, the price for the retiree is the same as it would be for any individual off the street. There is no discount or pass-through to the retiree. Via claims that group rates are impermissible. Columbia's lawyers should be instructed to seek a lawful organizational arrangement that would result in price reductions.<sup>83</sup>

## Examples for the Impact of Commission Incentives

1. Via offers plans from several companies. But if the retiree already has an ongoing relationship with one of these insurance companies, they cannot remain with that company. Why? Because that insurance company, not unreasonably, will not pay Via a commission for signing up a retiree who is already a customer. For example, retirees who are already taking the UHC-AARP Type F plan cannot take that plan through Via, even though Via is offering it to everybody else. Instead, to remain with a Type F plan, they must leave a company they are perfectly happy with and where their relevant medical history is already stored, and instead pick a different company, at a higher monthly cost. Via helpfully suggests that after a year the retiree can return to UHC – because in that case Via will get the full sign-up commission from that company, too. There is a simple solution – for Via, as part of getting the Columbia business, to forgo the sign-up commission for those Columbia retirees who merely transfer their existing service to go through Via.
2. One retiree reports that Via does not offer three Medigap N plans available in his state that are cheaper than that of UHC/AARP. According to Via, these companies do not allow outside agents to sell their plans. Presumably, this is because they do not wish to have to pay the commissions to intermediaries such as Via, which enables them to pass on the savings to their customers. Columbia retirees must forgo such lower-priced insurance if they want to have the Columbia catastrophic drug coverage which is tied to Via.

## Exclusivity

What enables this system is the Columbia-granted exclusivity to Via, whose effectiveness is enforced by two tools:

---

<sup>82</sup> As mentioned, Via provides consultations, but so do free websites and non-profits; and it manages the Columbia subsidy, which is a benefit to the University but arguably not to the retirees who, because of Via's exclusive arrangement, become captive customers.

<sup>83</sup> One idea might be to create special academic insurance plans through AAUP, in the same way that AARP collaborates with UHC. This might not be possible, but the point is that Columbia should actively explore alternative plans (beyond self-insurance), since it is not in the interest of the industry to do so.

1. The subsidy is available only if one uses the Via exchange;
2. The catastrophic drug coverage is available only if one uses the Via exchange.

These two levers make retiree officers captive customers of Via if they want to keep the Columbia subsidy and/or the catastrophic drug coverage. Via need not compete for the Columbia officer by offering more favorable deals, such as by sharing the commission it received, or by negotiating a better deal for the retiree with the insurance company.<sup>84</sup>

For Columbia to provide Via with exclusivity over retirees' access to the HRA subsidy is a judgment call one should disagree with. *But to give Via an exclusivity over the catastrophic drug support goes far beyond that and is a highly troubling policy.* Intentionally or not, this conditionality, together with the fear of the unknown health future by an elderly population, pushes these people to channel their medical insurance business through one particular commercial vendor, Via.<sup>85</sup>

This incentive affects the choices not only of the retirees now leaving the Columbia plans as they are being abolished, but even of the other 78% of retirees who cannot get the subsidy anymore because they have been on non-Columbia plans, and the future retirees. If they don't want to miss out on the catastrophic drug coverage, they must switch to Via from exchanges or insurance companies they have been perfectly happy with.

None of this should be read as an indictment of a profit-making company. But it raises the question about an arrangement of exclusivity whereby the Columbia Officers are being tied to one particular vendor of a Medicare exchange. There are numerous other vendors competing for the insurance or intermediary business, as evidenced by the offers that fill everyone's mailbox once they reach a certain age. Columbia and its retirees could still have a relationship with Via without making it exclusive through the subsidy being tied only to this particular company. This could be accomplished by making the subsidy portable to any insurance arrangement the retiree chooses. The subsidy and its administration would be separated from the choice of exchange or insurance plan. This is done by NYU, using the same company, Via. Alternatively, there should be one or two alternative exchanges that could be picked by a retiree.

---

<sup>84</sup> A positive argument for Via's exclusivity over the Columbia retirees is that it might provide Via with greater leverage – though the larger user base--towards insurance companies when it comes to quality control of its plans. There is no evidence, at this admittedly early stage, that this is taking place.

<sup>85</sup> This lever will drop in importance as the Federal rules on maximum drug out-of-pocket kick in in 2024. But having a belt-and-suspenders protection against an unknown future will remain an incentive since it is free, as long as it is channeled through Via.

Many important HR arrangements at Columbia provide more than one vendor. For example, for the 403(b) retirement savings plans there are TIAA and Vanguard.<sup>86</sup> Providing the option of one or two alternative exchanges would

- Create competitive pressures for service quality.
- Create competitive pressure on exchanges to share some of the commissions they receive from insurance companies with the retirees.
- Facilitate Columbia's ability to supervise and enforce service quality.
- Provide retirees with alternatives when they are unhappy with an existing arrangement.
- Provide retirees with options of other insurance providers, especially when they live in other states with a different mix of providers.
- Columbia's Administration, as well as WTW's consultant (WTW is the parent company of Via) argue that it would be administratively burdensome to have more than one vendor as the conduit for insurance and subsidy. But at NYU, which uses the same exchange as Columbia does, this seems to be no problem. At NYU, the HRA contribution is separated from a plan purchased through Via, but it is *administered through Via*. Indeed, the HRA need not be spent only on medical insurance but can be used also for copays, medical procedures that are not covered by insurance, or other health-related expenses, in the way that FSAs (Flexible Spending Accounts) operate. Here's what NYU says:

**— Am I required to purchase a retiree health plan through Via Benefits in order to receive the NYU contribution to my HRA?**

No. You are not required to obtain retiree health coverage through Via Benefits to obtain access to the HRA and the NYU annual contribution.

A similar system could be instituted by Columbia, with Via administering the HRA contribution extended by the University to its Officer retirees, and with the retirees able to choose to pick their insurance coverage either through Via itself, or outside Via with other providers without losing their HRA support. Or Columbia retirees could use the HRA to fund other medical expenses. This is an arrangement that Via offers. NYU chose it, but Columbia did not. It seems that Via is charging extra for such a flexible arrangement, and that Columbia did not want to incur that cost. But the cost cannot be high. Indeed, to an economist, if a competitive bidding for running the exchange existed, it would be Via that pays Columbia and not the other way around. After all, Columbia is delivering thousands of potential customers, most of whom will be a source for Via's commission income. A flexible arrangement might reduce that percentage

---

<sup>86</sup> 403(b) plans defer taxes for a portion of a person's income if it is put into a restricted savings plan. It is the non-profit equivalents of private-sector 401(k) plans. For the related 457(b) plans, on the other hand, Vanguard has exclusivity for Columbia's Officers. The result is a service quality that is lower than for the competitive 403b plans.

somewhat, but it would still be a profitable arrangement for the company. A company normally expects to invest in customer acquisition. Here, it seems that it is getting paid by Columbia.

The claim then is made that Via is not really selling consumers a product as much as it is advising them. And in doing so it incurs a cost. Let us review this, back-of-the-envelope. Assume generously that an advisor's compensation costs Via \$100K per year, including benefits, which covers 48 weeks of 40 hours. This means a per-hour cost of \$52. Assume a doubling to cover company overhead and technology. Assume a consultation time of 45 minutes and of 30 minutes for the sign-up. This would mean that a retiree consultation and sign-up cost the company about \$130. (And it might be argued that the time spent on the actual sign-up isn't a benefit to the retiree – who would get that from the insurance company for free and with a warm thank-you – but to Via itself. But even if we use the generous cost of \$130, it contrasts with the commission benefit to Via which we estimated earlier as \$672 for the popular UHC Type G plan in the first year. The profit is hence \$542, a high margin of 416%.

In subsequent years, Via's consultation time and sign-up would shrink considerably, given that only a tiny percentage of retirees change their plans once picked. If we assume quite generously that costs per returning retirees is one third of what it is for new signups, this will reduce the cost to \$43. The commission is reduced, too, to \$336, which translates into a profit of \$293, a margin of 681%. All this is virtually free of risk, since Via's money comes from the insurance companies which, by their basic business model, are as low a risk as they come. On top of that, Via is also being compensated by the University.

Even if all of these numbers could be shown to be on the high side, it is hard to see how the calculation could come down to a normal profit. This therefore suggests that there are significant market imperfections.

## Service Quality

A question touched by the bullets above is the impact of the exchange system on the quality of the service. Retirees on the current Columbia plans can be excused for being apprehensive about having to deal with a subsidiary —Via— of a giant company headquartered in the UK— WTW—whose name most of them have never heard before.

It is necessary to assure that there will be no lower service quality. Comments by dissatisfied retirees of other institutions suggest problems. On one website —*Trustpilot*—88% of the 42 comments gave Via Benefits a rating of 1 out of 1-5. The average was 1.5. The *complete* set of headings of their comments, listed in the footnote below, convey the sentiments.<sup>87</sup>

---

<sup>87</sup> **Via Reviews from *Trustpilot*—A complete set of the headings of customer postings, in the order listed**

This is the worst company in the world

We are Ford Retirees

I really wish I could give them a zero!

Only because GE makes me...

This was the worst customer experience...

On the *Better Business Bureau* website, 195 comments, on a scale of 1-5, averaged 1.06.<sup>88</sup>

It is likely that most of these complaints were made by active employees on an employer's defined benefits plan rather than by retirees. But atypical as they might be in general and for the specific Columbia arrangement in particular, one needs to be assured that such stories will not be experienced by our own retirees.

Based on the author's personal impressions in the November enrollment process and in the weeks that preceded it, Via seems to have performed well, with appointments available and competent and responsive staffing.<sup>89</sup> But other retirees had complaints. The *Columbia Spectator* reported about several retirees who expressed difficulties interfacing with Via in the

---

This company is by far the worst i have...  
This is the worst company I've ever had...  
Worst Company I've ever dealt with  
Can't get MedSup premiums paid monthly.  
Nothing but a hassle  
the worst service ever  
Negative 20  
HORRIBLE COMPANY  
No satisfaction - No resolution  
Set up appointment to sit in general queue.  
The worst kind of company that takes advantage of older people  
Feeling abandoned by the company I gave 33+ years to.  
Via Benefits takes forever to sign you up.  
For the past 4 hours as of right now  
Wish I could give a zero  
Via Benefits is the worst thing that...CHEVRON did to retirees  
Worked 38 years and retired at 61 from...  
3M did a disservice to their retirees...  
Promises, lies and inefficiency  
Via Benefits - Lousy Retirement Reimbursement!  
Actually NEGATIVE 1.  
This company is BAD!  
I have had two great experiences with...  
For those of you that are having a...  
VIA Benefits Service Company Agents Carson and Courtney Positive Feedback !  
No one is accountable if there is a mistake made.  
Horrible Experiences  
Unresponsive and incompetent  
Worse customer service  
Scam company that beats you out of your money to keep for themselves  
Via Benefits does fraudulent advertising of health care plans  
I am a retired Allstate employee and...  
Via Benefits? Oxymoron, it benefits only itself.  
<https://www.trustpilot.com/review/viabenefits.com#:~:text=VIA%20Benefits%20Is%20Way%20Too%20Costly%20With%20Less,better%20prices%20for%20the%20same%20benefits%20and%20more.>  
<sup>88</sup> <https://www.bbb.org/us/ut/south-jordan/profile/insurance-consultant/via-benefits-one-exchange-1166-22242628/customer-reviews.>

<sup>89</sup> A negative observation was that as the deadline approached there were no appointments left for the final days, but that is to be expected for a last-minute rush.



early stages of the rollout.<sup>90</sup>) One retiree was on the phone for five hours, possibly with a ‘very inexperienced person.’ He then received a letter from the insurance company anticipating a late enrollment fee due to a gap in his drug coverage, which was erroneous information based on the Via representative’s instructions.

“[Frank Wolf, VP of the retiree organization EPIC] said some retirees are unable to switch to a new plan without outside assistance, and he had received calls from retirees asking him for help. He helped three different people ‘just get on the website’ and create their profiles and sent a number of emails in an effort to help them troubleshoot.”

Another retiree wrote: “We did everything that we were told we should do, but the results have been altogether burdensome and confusing. The service provided by Via Benefits was shabby and cumbersome in the extreme. One day - among many additional phone calls to VB - we both spent 3.5 hours on the phone with one of their representatives making very little progress, if any. (Yes, that's 7.0 hours for just one of many phone calls.)”

Via’s contract with Columbia is likely to include performance guarantees such as Service Level Agreements (SLAs) with quality metrics and financial penalties for unsatisfactory quality levels.<sup>91</sup> The question is who will collect and interpret the data: Columbia, or the vendor Via itself, or Columbia’s HR consultancy WTW that happens to own Via, or an independent monitor? And what would be the direct complaints channel of retirees to Columbia HR?

An approach that might be better than constant monitoring of service quality would be to move away from single-sourcing and allow for 1-2 alternative exchanges so that frustrated Columbia customers could transfer to an alternative.

## Choices Of Insurance Plans

Via states: “*The marketplace can offer expanded choices at affordable prices by leveraging the buying power of millions of retirees who enroll for coverage.*” However, the plans offered through Via are identically priced to those available to any individuals on their own. There is no evidence of any ‘leveraging of buying power’ in the retirees’ favor. Most retirees have already moved to such plans. They gain no different or better deals. Nor do new retirees or those leaving the discontinued Columbia plans.

The cost figures available online for plans show Via-offered prices that are identical to the penny to the ones available to anybody in the marketplace. See Appendix B, Table 2. The table lists all insurance plans offered by the Via exchange and compares their prices to the price they offer on their websites to anybody. In every single case the price offered by the insurance

---

<sup>90</sup> Emily Forgash and Ayaan Ali, “University ends Columbia health care plans for retirees, shifting them to private company”, *Columbia Spectator*, December 5, 2022, <https://www.columbiaspectator.com/news/2022/12/05/university-ends-columbia-health-care-plans-for-retirees-shifting-them-to-private-company/>

<sup>91</sup> Performance metrics would include user satisfaction, resolution time, response speed, etc.

companies directly is identical to that offered to individuals by way of Via. In fact, UHC gives direct customers a small discount if they agree to automatic electronic payment, making getting the same plan through Via even slightly more expensive.

Does Via offer different options? The Via exchange offers 6 companies for Medicare Advantage coverage, offering 22 plans<sup>92</sup>. The Medigap offerings are 19 plans by three companies.<sup>93</sup> This covers major insurance providers for the area. All of these Via-offered options already exist for retirees in the open market. In that sense, Via does not add choices as it claims. To the contrary, it does not offer all options that exist in the NY market. There are 12 companies offering service overall in downstate NY, of which several are not offered, such as Mutual and Transamerica.

Several plans are available in New York that are cheaper than the Via-offered options. (One explanation might be that their quality is inferior.) There are also several types of plans that are not offered.

**Table 3: Cheaper Options not offered by Via**

	Market Price
<b>Plan C</b>	
EmblemHealth Plan	\$300.87
<i>Cheapest Via Plan C</i>	\$332.25
<b>Plan F High Deductible</b>	
Bankers Conesco	\$75.69
EmblemHealth Plan	\$74.00
Globe Life Insurance	\$72.00
<i>Cheapest Via Plan F High Deductible</i>	\$93.09
<b>Plan G High Deductible</b>	
Bankers Conesco	\$75.69
EmblemHealth Plan	\$67.69
Globe Life Insurance	\$72.00
Humana	\$101.93
<i>(Plan not offered by Via)</i>	
<b>Plan M Deductible</b>	
Bankers Conesco	\$446.65
Mutual of Omaha	\$526.10
Transamerica Financial	\$256.00
<i>(Plan not offered by Via)</i>	

<sup>92</sup> Aetna, Empire Blue Cross (Anthem/Elevance), UHC/AARP, Cigna, Humana, and Wellcare.

<sup>93</sup> Humana, Empire, and UHC AARP.

Thus, Via is engaged in a selection/curation process, which might well be based on quality criteria. But, as mentioned, Via – as do all exchanges — has also a built-in incentive against being all-inclusive, not just as a matter of consumer protection (the outside plans are already regulated and supervised) but because it may be able to use its selectivity as a bargaining tool to obtain high payments from the selected insurance companies. It is this dynamic that must have been one of the reasons for such payments being capped by regulation, as discussed earlier.

Another issue is that many medical insurance companies are regional, and that a retiree who moves to, say, Florida or California, would not have the choice of the respective largest medical insurers in those states, Florida Blue and Kaiser Permanente, if they want to stay with the Via exchange in order to have access to the Columbia subsidy and the catastrophic drug coverage.

What value does the exchange then add?

1. As mentioned, the advisory function. This is, indeed, a positive contribution, assuming it is well-staffed. While there is no shortage of website-based comparative information, Via offers a personal consultation for those retirees who need to ask questions, or who are uncomfortable with conducting transactions of such significance by screen.
2. The other benefit of the exchange is that it manages the “HRA” (Health Reimbursement Arrangement), i.e., the subsidy by Columbia to the medical plans. Via touts its function as administrator of that HRA. This sounds good but one must realize that the service seems to be mostly a phone-based or web-based system for basic account information, and that the amounts that are being managed are minor, mostly at \$200-300 a year.

## **Choice Of Doctors**

This report does not investigate the question how the termination of the Columbia plans affects the availability of doctors. According to one retiree, ColumbiaDoctors Psychiatry already does not accept Medicare, and its acceptance of insurance is limited to the Columbia University Employee Plan, the New York Presbyterian Employee Plan, Aetna, or self-pay, and it specifies that "we do not accept other commercial insurance plans." Presumably, retirees must then get reimbursed by their insurance at the lower out-of-network basis. This affects coverage, for example, of assessment and treatment of cognitive abilities. It is observed that the same issue applies to other specialty areas, too, as many physicians at ColumbiaDoctors have dropped out of Medicare in recent years. This is a related subject deserving further study.

## **Catastrophic Drug Coverage**

Retirees who currently participate in the four Columbia plans are affected, in particular, by the change in the drug plan. The new arrangement is less favorable in its high-cost drug coverage options. For some, it creates a sudden change in circumstances by a change in a benefit

coverage upon which they had relied, with legitimate expectations, in retirement, and possibly in their decisions to work at Columbia or to retire.

This observation needs to be balanced by noting the lower rates on the other aspects of medical coverage that moving off the Columbia plan entails. Thus, one component of medical cost will come down, while another will rise. How does all this add up? It is difficult to disentangle the various cost components. Those with drug costs that are low or somewhat above average will be better off. The problem exists for those with heavy needs, and it is often not possible to predict these needs in advance. Drug costs for diabetes with no insurance can cost about \$15.6K per year. For Leukemia it is \$16.5K.

Retirees with such needs are not likely to find similar coverage in the Medicare Part D or Medicare Advantage plans offered on the Via exchange and will therefore end up paying substantially more out-of-pocket. Columbia, aware of the problem, created a partial offset in the form of CPDC (Catastrophic Prescription Drug Coverage). The way it works is that for drug use that is above a Federal Catastrophic Coverage Limit (CCL), some support would be available from a catastrophic support fund. A catastrophic event is defined as over \$10,048 per year in unreimbursed drug cost. Columbia would then pay out the out-of-pocket above that amount that is not covered by the insurance company (which covers 95% above the CCL), up to \$10,000 per year.

The overall problem is being limited through the recent Inflation Reduction Act which permits the Federal government to negotiate Maximum Fair Prices (MFPs) with drug manufacturers.<sup>94</sup>

More importantly, that law eliminates, starting in 2024, the 5% beneficiary coinsurance requirement over the catastrophic coverage threshold. It caps the out-of-pocket costs at about \$3,250 for that year. Starting in 2025, there will be a hard cap on out-of-pocket spending of \$2,000. These numbers are indexed to increases in drug costs<sup>95</sup>

(Note that these improvements, helpful as they are, do not help retirees in 2023 and 2024.)

The system is not easy to understand.<sup>96</sup> In the existing coverage, the Columbia patient paid a *fixed dollar co-insurance* that depended on the tier a particular prescription drug was placed in.

---

<sup>94</sup> Suzanne M. Kirchhoff. "Selected Health Provisions of the Inflation Reduction Act" *Congressional Research Service* September 1, 2022. <https://crsreports.congress.gov/product/pdf/IF/IF12203>.

<sup>95</sup> <https://www.kff.org/medicare/issue-brief/how-will-the-prescription-drug-provisions-in-the-inflation-reduction-act-affect-medicare-beneficiaries/>3Chttps://nam02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.kff.org%2Fmedicare%2Fissue-brief%2Fhow-will-the-prescription-drug-provisions-in-the-inflation-reduction-act-affect-medicare-beneficiaries%2F&data=05%7C01%7Cfls4%40cumc.columbia.edu%7C8402dcb24374453a1e7908da9f53980a%7Cb0002a9b0017404d97dc3d3bab09be81%7C1%7C0%7C637997478638230632%7CUnknown%7CTWFpbGZsb3d8eyJWljoIMC4wLjAwMDAiLCJQIjoiV2luMzliLCJBTil6lk1haWwiLCJXVCi6Mn0%3D%7C3000%7C%7C%7C&sdata=agojv1brDos0BoHHaGCQubQtTCADcXMZTNIW2L7WSJA%3D&reserved=0%3E

<sup>96</sup> There are co-payments (the insured pays a certain fixed amount per prescription); co-insurance (the insured pays a certain percentage of the drug's cost); caps; catastrophic thresholds; drug tiers; and more. With standard Part D benefits, beneficiaries are responsible for: a deductible, then a 25 percent coinsurance up to an initial

It was not directly tied to its actual cost. However, under the outside insurance plans that must now be picked, patients incur a co-insurance cost that is based on the *percentage* of the cost of the prescription drug. For Part D plans such as Aetna's, Tier 4 and 5 drugs have co-insurance of 25% to 50%, whereas under a current Columbia plan<sup>97</sup> the patient only has co-pays of up to \$45 monthly.

A concrete example is a faculty member with a rare cancer, multiple myeloma (MM).<sup>98</sup> Under the plan that existed until 2022, the co-payments were about \$200 for a year's supply of the main medications, for a medication that retails in the order of \$120,000 a year. This is a generous benefit for the relatively few retirees living with MM or other chronic diseases that require high-cost medications. However, isn't the whole point of medical insurance to protect from unplanned catastrophic costs? Nobody chooses to be afflicted by MM.

Under the new policy, for this hypothetical scenario<sup>99</sup> the uninsured portion would be about \$14,300, of which the retiree would pay \$10,048 and Columbia would cover about \$4,300. Thus, the retiree would pay for the new plan 18.6 times as much as under the old plan. After 2025, with the Federal cap of \$2,000, this would drop to a ratio of 3.7 of new plan cost versus old plan cost.

To deal with this, we propose further below (in Section V) a revised system for high and unreimbursed Rx expenses.

## Equity among Retirees

Small as they are at \$18.33/month, and lower as they are by 75% over the previous level, the HRA subsidies also manage to be inequitable. Future retirees will receive them but not the 78% of current retirees who have opted in the past to take the very same outside insurance plans that are now being presented as improvements. These retirees are excluded forever. It is hard to conceive of explanations for such glaringly unequal treatment beyond the desire to save money.<sup>100101</sup>

---

coverage limit, which is followed by a coverage gap (the "donut hole") in which they paid 40 percent (for brand drugs) or 50 percent (for generic drugs) of the drug price until their total out-of-pocket spending reached a set limit (\$10,048 in 2022), and enter catastrophic coverage.  
<https://www.commonwealthfund.org/publications/issue-briefs/2020/sep/catastrophic-coverage-medicare-part-d-drug-benefit>.

<sup>97</sup> E.g., the Indemnity plan.

<sup>98</sup> It is possible to effectively manage MM for many years through a combination drug therapy. The current state of the art involves three drugs, two of which are exceedingly expensive, classed as Tier 5 drugs.

<sup>99</sup> Assuming a 30% co-insurance up to \$10,048 and a 5% co-insurance beyond that is covered by Columbia's CPCD up to a total of \$10,000.

<sup>100</sup> Recall that the purpose of ERISA is to protect retirees.

<sup>101</sup> Possibly, the University does not know their addresses, but that burden need not be on it but on those retirees to make themselves reachable.

## Consultation And Information

In March of 2022, the University Administration briefed the University Senate's Joint Subcommittee on Benefits of its plan to change the retiree medical insurance system. There was a discussion and a subsequent meeting.<sup>102</sup>

The retiree community itself was not informed or consulted by the University in advance, and it remained unaware of these anticipated changes until the letter to retirees went out in early December.

As reported in the *Columbia Spectator*: “Frank Wolf, dean emeritus of the School of Professional Studies and vice president of Emeritus Professors in Columbia [EPIC]—a group of retired professors, researchers, and administrators—said the affected retirees were sent the letter, but not consulted in advance. Wolf said the University ‘would have been smarter if they had come to us and said, ‘Look, this is what we’re doing. This is why we’re doing it. This is how it’s going to work. What are your concerns?’”<sup>103</sup> Another retiree, Laurie Mack, was quoted in the same article: “This came out of the blue. There was no prior warning.”

As to information reaching active employees, it is difficult to prove a negative. But it seems that no information of any change in benefits was conveyed directly – by email, letter, or otherwise—to such *prospective* retirees, that is, to currently active Officers, even though they are directly affected, in a delayed way. The alternative means of information would be the Columbia HR benefits website, which after September 2022 mentions an HRA subsidy available to eligible officer retirees. This would then require an unprompted and non-intuitive search by an Officer<sup>104</sup> looking for a brochure of a company they have never heard of, offering a service arrangement they are unaware of.

A subsequent briefing on retirement to the University Senate plenary, in May 2023, explained retirement steps but did not discuss the options that had been recently eliminated. It is doubtful than most Senators understood that context.

---

<sup>102</sup> The author of this report was co-Chair of that Subcommittee at that time, as well as Chair of the Budget Committee. He has since retired as a faculty member and hence as University Senator. He holds these meetings in confidence. Nothing in this report is information (confidential as well as non-confidential) that was obtained during the proceedings of that sub-committee.

<sup>103</sup> Emily Forgash and Ayaan Ali, “University ends Columbia health care plans for retirees, shifting them to private company”, *Columbia Spectator*, December 5, 2022, <https://www.columbiaspectator.com/news/2022/12/05/university-ends-columbia-health-care-plans-for-retirees-shifting-them-to-private-company/>

<sup>104</sup> Such a search would lead to a website segment “Retirement and Financial”, then “Retirees” (but not “Officers”) from there to another website “Retiree Benefits” to “Prospective Retiree Officers”, and to a tab “Related Documents.” which would list, among several documents, the “Via Benefits: Post 2012” brochure that was sent to actual retirees. One would need to know what that means.

There is also a 43-page ERISA-mandated formal Plan Document. That legal document is not something most people would seek, find, read, or understand. The document was filed almost three months before the retirees themselves were notified.<sup>105</sup> Via Benefits is mentioned only once, in Appendix A.<sup>106</sup>

The philosophy behind ERISA is one of protecting participants, including through the disclosure of information that affects their retirement benefits and decisions. Columbia might have met the letter of the law in that respect, but only very careful and informed reading would have been understood by current or future retirees that the retiree support program that had existed for many decades was being significantly cut for current beneficiaries. Instead, this termination was merely communicated as a transition from the Columbia plans to a more flexible private exchange. (Although not a single option was added that had not already been available to retirees.) The end of subsidies to any new retirees, and the cutback for existing ones, is then described in terms that appear positive: “As part of the transition, the University will provide a subsidy to eligible retirees through a tax-free Health Reimbursement Arrangement (HRA) ...”. Eligibility among existing retirees, however, is limited to those already enrolled in Columbia plans, as long as they go through Via. Excluded are the other 78% of current retirees.

And even for the small group of currently eligible retirees, that subsidy is being cut by 75%, without this being stated.

To conclude on the subject of communications and consultation:

- The retiree community was not consulted or informed in advance.
- It seems that active employees are not aware of the changes that affect them prospectively.
- The reduction and/or elimination of benefits are not meaningfully communicated to the Columbia community.

---

<sup>105</sup> Although identified as effective January 1, 2023, the Plan Document was not updated and states that the HRA subsidy is \$200, whereas it was raised, in fact, to \$220.

<sup>106</sup> The Plan Document is not on the Columbia HR webpage where employees would check benefits. To reach it one needs to first find the above mentioned Via brochure. The same difficulty of finding information holds for the existence of the Columbia University Medical and Life Insurance Trust Fund. The information is public and not being withheld—it can be located through Google searches—but this requires some advanced knowledge of what to look for.

## IV. The Self- Renewal of the Institution

### The National Context

Most universities in America used to have a mandatory retirement age, typically at 65. But in 1986, Congress passed amendments to ADEA (the Age Discrimination in Employment Act of 1967), moving the mandatory retirement age for higher education to a floor of 70. This was an exemption for higher education over the full uncapping of the mandatory age for other occupations, and it was not renewed in 1994. For universities, setting a mandatory retirement age became illegal. Several studies looked at the impact.<sup>107</sup> Empirical research by the noted labor economists David Card (Nobel Prize 2021) and Orley Ashenfelter<sup>108</sup> found that “In the mandatory era, only about 10 percent of faculty who were working at age 70 were employed three years later. After the lifting of mandatory retirement that rate has risen to about 50 percent.”

As older faculty postponed retirement the number of vacancies for young faculty declined. But it is important not to jump to the conclusion that this means fewer opportunities in the long run. Such an observation is not intuitive. The basic idea behind it is that people retire sooner or later, and once a new level of retirement age is reached, the annual number of retirements and hence vacancies would catch up again to what it had been before. The drop in vacancies would therefore be transient only. In such an analysis, the main impacts would be on a few young cohorts during the transition to a new steady state, as well as on the average age of the faculty which would rise.

Yet this conclusion, too, is incomplete. There is a direct relationship of length of employment and number of vacancies. Larson and Diaz (2012)<sup>109</sup> modeled the availability of hiring of assistant professor level at MIT between 1980 and 2010. Their OR model showed that the number of years that senior professors remained employed in the analyzed MIT departments increased from 17.64 to 21 years starting in 1994. More problematically, their model showed analytically that the number of new assistant professors hired would decline in steady state,

---

<sup>107</sup> The National Research Council (NRC) was commissioned by Congress to report on the potential impacts of its legislation Hammond, B.P., *Ending Mandatory Retirement for Tenured Faculty*. National Academy Press. DC, 1991. It concluded that reducing mandatory retirement would reduce faculty turnover and the faculty reinvigoration that helps these institutions maintain their leading-edge role. It would thus reduce the hiring and promotion of new faculty and raise cost due to the higher salaries for senior professors.

<sup>108</sup> Ashenfelter, Orley A. and David Card, “Did the elimination of mandatory retirement affect faculty retirement?” *Amer. Econom. Rev.* 2002;92(4):957–980. [[Google Scholar](#)]. They observe that after 1994, the fraction nationally of 60-year-old faculty who worked until 73 had risen to about 10%, and that it had grown to 30% and more at private research universities.

<sup>109</sup> Richard C. Larson and Mauricio Gomez Diaz, “Nonfixed Retirement Age for University Professors: Modeling Its Effects on New Faculty Hires” <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3737001/>. Published in final edited form as: *Serv Sci.* 2012 Mar; 4(1): 69–78.doi: [10.1287/serv.1120.0006](https://doi.org/10.1287/serv.1120.0006)



and they found a drop at MIT from 57 per year to around 46.<sup>110</sup> They conclude that an increase in faculty career length requires a compensating reduction in the rate of new faculty hires, and that this reduction is permanent in steady state, not just in the transition to it. Their model finds, for MIT and a 75-year retirement age, a reduction of junior faculty hiring by 19%. And this, one must recognize, is on top of the national trend of replacing professorial appointments by limited-term and non-renewable lectureships.

## **The Columbia Context**

The Columbia administration has argued that the reduction in retirement medical insurance was a faculty decision. According to that narrative, in 2011 a faculty committee recommended to favor the medical insurance of active faculty over that of retired faculty. Let us review the reports.

### **Committee #1. Provost's Working Group on Faculty Retirement, 2011**

Provost John Coatsworth tasked in 2011 a Working Group on Retirement<sup>111</sup> to look into these questions, and to identify incentives and disincentives associated with retirement. The Working Group found that

“during the decade of the 1990s and into the first half of the 2000s, faculty were retiring in their middle-to-late 60s. Starting in 2004, the average retirement age jumped to the early 70s.”

“By fall 2000, there were 67 active tenured faculty at Columbia over the age of 69; in fall 2010, the number was 115, or 12% of the total tenured faculty (see [Appendix C]), and the trend strongly suggests further growth in the future. In fall 2000, there were 12 active tenured faculty 75 years of age or older; in fall 2010, there were 49. While the absolute number of tenured faculty younger than 55 has grown, they represent a decreasing percentage of the total tenured faculty, having dropped from 52% in 2000 to 43% in 2010. Although the numbers are smaller, similar trends are seen in the non-tenure eligible ranks of the lecturer, clinical and practice faculty.”

The Working Group compared Columbia with peer Ivy-plus universities and found their retirement age to be rising, too, but “not as significantly as at Columbia.”

The report observed one explanatory factor:

---

<sup>110</sup> The intuition behind their analytical conclusion is the hypothetical of a university with a fixed term of only one year for its 1,000 professors. There would be 1,000 new hires each year. But now suppose that the fixed term is lengthened to two years. Then there would then be only 500 vacancies. The same logic applies to more realistic settings.

<sup>111</sup> This quotes and the subsequent ones in this section are from Columbia University, Provost's Working Group on Faculty Retirement, Final Report, December 2012. Note that its mandate was focused on tenured faculty.

“Those institutions not seeing these trends include ones that had developed what they call ‘strategic faculty refresh programs’ in response to the elimination of mandatory retirement in the early 1990s.”

A “strategic faculty refresh program” means creating vacancies for younger faculty by making the retirement decision more attractive to older ones. But at Columbia,

“The Working Group frequently heard retirement characterized as a cliff, rather than as a normal life course transition.”

The Working Group focused on three areas of attention--retirement savings plan, housing, and the retirement experience itself. It did not make specific recommendations about medical insurance and touched the subject only very lightly. But it observed a national finding that

“The second most cited barrier to retirement is employee anxiety about post-retirement health care, with 50% of the private university HR officers noting it as of great concern, perhaps with justification.”<sup>112</sup>

And it noted that

“Research has shown that faculty take the gap between how much the institution subsidizes the health care premiums of active faculty members and how much it provides to retirees into account when thinking about retirement; *too large of a gap has been found to function as a disincentive.*” [Emphasis added.]

The Working Group observed that:

“Most retired faculty and their spouses/partners rely on Columbia for access to health care coverage to supplement Medicare which serves as their primary insurance. If it is perceived as unaffordable by current retirees, their experiences will influence the decisions of current faculty about whether and, if so, when to retire.”

It also took note of the program at the University of Chicago, where:

“Tenured faculty...who sign an agreement to retire between the ages of 65 and 70 receive a bonus and have the retiree medical premiums for themselves and their spouse/same sex domestic partner paid by the University for the remainder of their lives.”

## **Committee #2: University Task Force on Fringe Benefits Programs, 2011**

To pin all blame on the administration for the retirees’ inadequate medical insurance system might be a good tactic for mobilization but it would be disingenuous. To see that, let us review

---

<sup>112</sup> Green, Kenneth with Jaschik, Scott and Lederman, Doug; The 2012 Inside Higher Ed Survey of College and University Human Resources Officers; September 2012

the second report that deals with benefits issues, written by a committee which included a substantial faculty representation. In 2010, the “University leadership decided to seek the input of the community” and instituted a Task Force on Fringe Benefits to stem the rise in the cost of such benefits.

The Task Force consisted of 27 people. The administration’s role must have very strong. The three co-chairs of the Task Force were the University’s top administrators below the President—Provost, Sr. EVP, and head of CUMC. These three selected the remaining members, in consultation with other administrators (“deans, senior administrative officers”) and the University Senate. 10 members, by their titles, served the University primarily as administrators, and many of them must have been quite knowledgeable about university budgets. The remaining 17 members can be identified as primarily faculty. They are distinguished in their fields and were presumably selected for their good judgement, fairness, and commitment to the university, but a brief review of their subject areas does not indicate expertise in benefits.<sup>113</sup> These factors might explain some of the puzzling white spots in the report that was produced, and which will be described below. It also puts in perspective the claim made today that the cuts of 2012 were a “faculty recommendation” when the process appears to have been, at best, an equilibrium of faculty and administration.

It should also be noted that while the Provost’s Task Force membership covered numerous constituencies to include their perspective, retirees were not among them. That, presumably, could be overcome by a process into which retirees could have had an input. But that, too, did not seem to have happened, at least judging from the Task Force’s own report.<sup>114</sup> (There is no Final Report, only a Preliminary one, and there is no recorded vote.) That document is subtitled “*Report to Full-Time Benefits-Eligible Officers of Columbia University*.” That designation excludes retirees. It also lists, as the very first of its nine Guiding Principles, the need to “Reflect input from Columbia faculty and other officers.” Again, no mention of retirees. The report identifies the range of outside opinions it solicited in consultation: “The Task Force established two critical channels for benefits-eligible officers to participate and share input. The first was the fringe-review@columbia inbox, which opened in August so officers could communicate with the Task Force from the very beginning of its deliberations. This online suggestion box continues to serve as an effective way for officers to express thoughts or concerns about the fringe benefits review. The second vehicle for input was November’s comprehensive [sic], anonymous online survey of all benefits-eligible officers.(See Appendix 1...” Just to make sure that there would be no outside access, the report itself was password-protected.

Thus, retirees, though being benefits-eligible, were formally excluded from participation, input, consultation, and even information-sharing.<sup>115</sup> They are also not directly involved with the

---

<sup>113</sup> Several of them were clinical medical professors with an institutional understanding of medical revenue streams. Closest to benefits issues was Prof John Rowe of the Mailman School, who has written about public policies in aging societies.

<sup>114</sup> Task Force on Fringe Benefits, Preliminary Report, April 5, 2011, 37 pages. The report is password protected.

<sup>115</sup> Conceivably, some informal conversations might have taken place among colleagues. We have no testimony to that effect.

University Senate or its Committees and thus lack an avenue of input into the process in that way.

The Task Force preliminary report covered a multiplicity of very disparate benefits issues in some depth. Regrettably, retiree medical coverage was not one of them. Even without arguing about the conclusion, the following must be noted:

- There is no analysis whatsoever provided about retiree medical insurance coverage, only a concluding bullet in the recommendations, which simply endorses cutting retiree medical support by 50%. (For retirees pre-65 years, by 71%.)
- There is, however, a mention, in the more general discussion of healthcare costs, that “the rising cost of retiree healthcare benefits is another contributor to the financial challenge for ...Columbia.” This statement displays a considerable lack of understanding of the Columbia system and its basic financial facts.
  - Columbia, since 1994, paid a *fixed* amount in contribution to retiree medical coverage (\$144/mo). That amount was entirely independent of whatever outside medical costs were, how they were rising, and even of general inflation. Thus, the cost to Columbia was not rising at all, for that reason alone.
  - Actually, the cost to Columbia had declined, first due to the changes in 1994 that removed the full coverage extended previously; second, due to the ongoing flight out of the pricey Columbia plans, which reduced the number of officers that were supported by Columbia; and third, due to the postponement of retirement of faculty once mandatory retirement was outlawed. In consequence, the estimated cost to Columbia had dropped (in terms of 2022 dollars), from \$6.37 mil in 1993, to \$4.38 mil in 2000, and to \$2.23 in 2011 when the report was written.
- There is no indication in the report that there was an awareness of these factors. Nor is there an indication of a recognition that those who remained tend to constitute a higher percentage of people with more serious medical conditions, who deserved, if anything, a higher contribution as the un-covered out-of-pocket medical expenses were rising.
- There is no indication in the report that there was an awareness, at least among the faculty members, of the existence of the Columbia University Medical and Life Insurance Trust Fund (CURML Trust Fund.) At the time of the report, that fund had \$132 million in assets. It is that fund that supports the retiree medical coverage, not the fringe pool. Indeed, one must ask, why was the retiree medical insurance coverage even under the purview of a Task Force on fringe benefits? The financial relation is tenuous. If in a given year the trust fund spends more than it takes in – which would indicate that it did not set the premium payments at the correct level-- and if it also does not want to dip into the asset base whose purpose, after all, is exactly to provide such a safety cushion, only then is an outside infusion needed. And even that infusion need not come from the fringe pool. The other potential call for outside infusion is if the actuarial assumptions

change, requiring a higher asset base against contingencies. But the Trust Fund is over-funded relative to its contingencies, even allowing for the super-cautious assumptions of actuaries, and given the declining number of retirees on the Columbia plans.<sup>116</sup>

- With assets of \$132 million in 2012, and a historic annual average return of 8.34%, the Trust Fund could be expected to return \$11 million per year. In comparison, in that year it paid out for Officer Retirees only about \$2.23. This does not even come close to requiring an outside infusion, whether from the fringe pool or the general budget, even after an allowance is made for the 16% of Columbia employees who are not categorized as Officers.
- It seems that there was a misconception that the medical insurance of retired and of active Officers were part of the same pool. And that such pool, in turn, included both Officers and unionized Support Staff. In other words, that it was all one big insurance pot. And by cutting the retiree benefits, it was incorrectly believed that it would reduce the pressures on the joint pool, by making retirees contribute more towards the contribution of Officers to contractual obligations to staff employees.

The Task Force's recommendations were to cut the coverage contribution by 50%, going forward (and by 71% for retirees under 65). As far as can be determined, no other benefit reviewed by the Task Force was cut as severely, and certainly not if one considers it in the context of the earlier severe cut of retiree medical coverage in 1993. In contrast, other benefits whose value was better understood were treated more favorably or were even raised. For example, same-sex couples were to receive \$1000 more relative to married and unmarried opposite-sex couples, in a sensitive recognition of the tax disadvantage they faced. (It should be noted that the same tax disadvantages existed for same-sex *retired* couples, too, without them being included in that benefit.)

Thus, the Task Force, in an effort to reduce pressure on the fringe pool, put a meat cleaver to the retiree medical benefit. Except that there was no meat. The University's contributions came out of a well-funded Trust Fund. Cutting them by one half or more did not relieve the fringe pool.

But even if the contributions would have come fully out of the fringe pool, they were a trivial part, a rounding error. The Report identifies the total annual benefit funding out of the pool as \$430.6 mil. The total medical plan support contributed to retirees, in 2012 before the cutback, was \$2.23 mil. This constituted 0.5 of one percent. Cutting it by half or more would have reduced the load of the fringe pool-- even under the flawed assumption that the fringe pool would have to cover everything--by one quarter of one percent, or one million. And, given grandfathering, it would not even reach that amount for several years.

---

<sup>116</sup> Since these assumptions have not been provided, we are unable to evaluate them.

On top of that, there is no indication whatsoever in the report that the long-term implications on retirement decisions, and their impact on the budget, had been considered. While the report lists, as one of its nine Guiding Principles, the laudable goal to “Emphasize recruiting and retaining outstanding faculty and other officers,” it did not stop to consider that to facilitate the recruitment of such outstanding faculty some vacancies would have to be created, i.e., retirements had to be incentivized. Such retirements would also reduce the actual expenses of salaries and fringe pool benefits, since high-cost senior professors would be replaced by younger and presumably cheaper ones.

The author discussed the Task Force’s deliberations with four of its members. Enough years have passed to dim memories, but one key participant recalls that the administration sought to pay the *difference between Columbia health benefits and Medicare*. Consider the impact if the Administration’s position were taken literally and was the policy today. It would mean paying the Medigap cost for the difference between Columbia health benefits and Medicare. This would be a monthly \$280-320, not the \$18.33 provided today. And that does not yet include the extra value of the Columbia drug coverage that apparently cannot be obtained in the market at affordable rates. Having Columbia cover a quality Medigap plan is an arrangement that most retirees would gladly accept. But this is not what happened. Despite the internal argument made that the change would cover the gap, the retirees outside the Columbia plans got exactly nothing, and those on the plans were left with substantial and rising expenses of their plans beyond Medicare, alleviated minimally by \$72 per month.

Also missing is a comparison of benefits. Although one of the nine Guiding Principles is to “Benchmark Columbia’s benefits to ensure competitiveness,” no such comparisons with peer institutions are provided in the report. Given the data above in Table 4, such comparisons would not have looked good for Columbia, unless things have changed drastically over the past dozen years.

Many of these factors could have been pointed out by the retiree community if they had been given a voice in the process.

A dozen years have passed since the 50% cuts were instituted in 2012. The earlier report, with all of its flaws, is now being cited as being somehow a justification for the 75% further cuts of 2022. If anything, the opposite is true. There is now a track record of the impact of those earlier cuts. We take heart from the Provost’s recent communication to the A & S faculty, that “The new benefit will further evolve over time as we learn from experience with it and how it works for our retirees and learn more about its actual cost.” Yes, but why start the evaluation with the year 2023, when we already have the data for the experience and how it works, starting in 2012, for such an assessment?

To conclude:

- After the outlawing of mandatory retirements, universities such as Columbia created incentive programs for faculty to retire voluntarily. But when it came to Columbia's retiree medical benefits there was a clear disconnect. While one Provost's Committee recommended *increasing* the money to be made available to pay for people to retire before age 74, a second Provost's Committee advocated at the same time to *lower* the support for retiree medical costs. And this was done just as medical insurance costs were rising rapidly, the gap in the cost of coverage between pre- and post-retirement was growing, and the higher age of faculty nearing retirement was leading to greater anxiety about medical needs. People postponed retirement in order to keep their benefits and they will continue to do so.
- Thus, in Columbia's effort to deal with a trivial cost item, the bigger picture of its interest in self-renewal was missed.

## V. A Comparison with Peer Universities

Contrasting medical insurance plans is difficult even for a professional, let alone for a consumer. One way to look at these plans as a bundle of features offered in variable amounts. Each feature's cost could be determined according to its magnitude and added up, making meaningful price comparisons possible.<sup>117</sup> For the purpose of this report we will focus not on the quality or quantity of the coverage but on the subsidies by universities. Table 4 provides a comparison.<sup>118</sup> For Columbia, both the new system and the one that existed in 2022 are listed.

For the first set of universities -- Columbia, Harvard, Michigan, MIT, and Stanford—identifying the subsidies is straightforward since they are stated by the universities.<sup>119</sup> The numbers in Column 3 show that for retirees with 20 years of service, Columbia's per months subsidy (now \$18.33) is far below those stated by Harvard (\$406), MIT (\$395.50), Stanford (\$281.72), and Michigan (\$277).

The previous Columbia subsidy, at \$72, was higher than it is now under the new system, but one should also note that the pre-subsidy price of Columbia's medical plans in 2022 was higher than that of other universities.<sup>120</sup> (Column 2). We list the top plan for each university.

---

<sup>117</sup> An econometric study could ascertain the market cost for each feature's magnitude. Plugging in a plan's actual feature numbers, one could determine whether the plan is a better deal than an alternative plan with different features and decide how much of a feature one would be willing to purchase.

<sup>118</sup> Often, that subsidy varies according to the years of service, and we assume 20 years. The calculations do not incorporate the difference in drug coverage. Most universities provide a co-payment system.

<sup>119</sup> These numbers do not include the potential benefit of a university negotiating a favorable group rate, and hence might *under-estimate* the overall benefit extended to a retiree.

<sup>120</sup> Conceivably this higher premium was based on a superior coverage, a question not analyzed here. It is a question independent from the magnitude of the subsidy discussed.

Columbia's plan cost \$548 before the subsidy of \$72. Thus, of these five universities, its subsidy was the lowest and its price for insurance coverage was the highest.<sup>121</sup>

For the other universities, the calculation becomes more complicated because their subsidies are not stated. One must therefore calculate the contributions by looking at comparable plans offered by the same insurer in the open market, and contrast that number with the price charged to the retiree through their university.<sup>122</sup> The difference is the contribution, plus potential advantages of a group rate. (Note that Columbia, under the new system, has no favorable group rates.) That calculation shows a subsidy of \$101.20 for the U of California system, plus \$30 for a free dental coverage, for an overall support level of \$131.20, also higher than Columbia's.

The same approach is used for the remaining four universities listed in the Table, namely Cornell, Penn, Princeton, and Yale. Here, the comparisons with market prices require a further step, because while the university plans are similar to market-offered plans by the same insurers, they differ insofar that they have a much lower ceiling on the maximum out-of-pocket (MOOP) payments, and in some cases also a lower deductible<sup>123</sup>, both of which are valuable features that must be considered in any price comparison of internal and external plans.

We identify these differences in Column 3 and impute their value in Column 4.<sup>124</sup> Given these steps, the final numbers for these four universities are therefore more in the nature of estimations. Another adjustment is to include the value of free dental coverage which two of the universities provide. This augments a further \$30 to the subsidies of Michigan and California.

Column 6 adds up these numbers. These numbers are all on a per-month basis. They show that Cornell (\$79.28), Princeton (\$96.50), Penn (\$29) and Yale (\$155.80) have much higher contributions (either through direct subsidies or by negotiating lower group rates) than Columbia, which comes out at the tail end of the universities surveyed.

Note that some universities, such as Harvard, provide the same subsidy to a spouse, while Columbia offers a one-half subsidy.<sup>125</sup>

---

<sup>121</sup> See the preceding footnote.

<sup>122</sup> These numbers do not include the potential benefit of a university negotiating a favorable group rate, and hence might *over-estimate* the actual subsidy by a university.

<sup>123</sup> Yale, Penn, Michigan, Cal, and NYU, have a zero (or near-zero) deductible – an important feature--whereas Columbia's deductible is \$200, similar or slightly lower than at Harvard, MIT, Stanford, and Princeton. Cornell is an outlier at \$550.

<sup>124</sup> By comparing the prices of insurance for different levels of maximum OOP and deductibles, we estimate that \$100 in lower maximum OOP costs per year costs about \$2 in monthly premium payments. For the deductible, the value of a lower deductible is estimated as a full discount for all retiree except those with miniscule medical expenses. A \$100 lower annual deductible is then worth \$8 per month. These are admittedly a back-of-the-envelope calculations.

<sup>125</sup> We did not conduct a comparative investigation on the extent of inclusion of spouses across the universities.



## Examples

The differences can be substantial. **At Columbia, for a retiree with 20 years of service and a spouse, the University's annual support contribution is \$330. At Harvard, it is \$9,744, almost 30 times as high.**

At Harvard, one can assume that virtually 100% of current retirees<sup>126</sup> receive its support. At Columbia, of current retirees, only about 22% are eligible for it.<sup>127</sup>

Assuming a similar-sized retiree population, if one combines the two measures -- support level and eligibility -- into an admittedly simplistic joint measure for 2023, then Harvard provides 134 times as much medical insurance support to its current retiree pool than Columbia does.

While it is possible to dismiss Harvard's much more generous plan as based on that university's greater resources, the same cannot be said for our neighbor institution NYU.

NYU's annual HRA (contribution towards an outside retirement insurance plan) for forthcoming retiree cohorts is \$3,391.<sup>128</sup> Columbia's is \$220. On top of that, NYU covers spouses/domestic partners fully, while Columbia provides only one-half coverage. **Thus, for a retired couple, NYU will provide \$6,782, vs Columbia's \$330. That is over 20 times as high.**

In addition, NYU's retirement medical benefits have been rising, while Columbia's have declined.

Importantly, NYU does not tie its contribution to the use of a particular exchange. While it uses the same Via exchange as Columbia does, the retiree is free to pick other medical insurance coverage outside of Via, and still get their university's contribution, in contrast to Columbia which requires the use of Via and its offerings.

---

<sup>126</sup> Eligibility at universities typically begins after 10 years of service.

<sup>127</sup> Of current retirees, Columbia's HRA subsidy applies only to those who were on Columbia's plans in 2022, about 22% of overall retirees.

<sup>128</sup> From NYU's retirement brochure:

- **Health Reimbursement Arrangement (HRA) – Available beginning January 1, 2022**

Medicare eligible (generally over age 65) retirees receive financial assistance from NYU towards the purchase of health care insurance through a Health Reimbursement Arrangement (HRA). NYU will make an annual contribution to an HRA established for the retiree and, if applicable, a joint HRA that includes their eligible spouse or domestic partner, to help pay for eligible medical expenses, including premiums, deductibles, copays, and coinsurance.

- The annual contribution per HRA-eligible individual in 2022 will be \$3,291 and is prorated based on when you retire. *For example, if you retire in June, your HRA will begin July 1st and NYU's contribution for 2022 will be \$1,645.50.*

One should also note that NYU gives its officers the same HRA subsidy as for its unionized support staff, whereas Columbia does not.

**Table 4: The Contribution by Peer Universities to Retiree Medical Insurance (per Month)**

	Price to Retiree with 20 years of Service (1)	Pre-Subsidy Price, or Market Price of Similar Plan by same Insurer (2)	Difference Between Market Rate and Price Retiree Pays ( <b>University Subsidy per Month</b> ) (3)	Est. Imputed value of university plan vs comparable outside plans in the features of Maximum Out-Of-Pocket and Deductible <sup>129</sup> (4)	Free Dental Coverage, est. (5)	Est. Total Value of University-supported Benefit (6)
Columbia Old Plan (2022)	\$548 <sup>130</sup>	\$620	\$72 <sup>131</sup>			\$72
Columbia New Plan (2023)	\$273.4 <sup>132</sup>	\$291.7 <sup>133</sup>	\$18.33			\$18.33
Harvard	\$102	\$508 <sup>134</sup>	\$406			\$406
Michigan	\$246	\$523 <sup>135</sup>	\$277		\$30	\$307
MIT	\$169.50	\$565 <sup>136</sup>	\$395.50			\$395.50

<sup>129</sup> See the footnote slightly above for the imputation

<sup>130</sup> UHC Choice Plus 100, minus Columbia subsidy

<sup>131</sup> \$144 for those retired before 2011

<sup>132</sup> Columbia's new plan relies on market-offered choices whose benefit coverage is not the same, such as for drugs.

<sup>133</sup> Empire BCBS Supplement Plan G, minus the Columbia HRA subsidy

<sup>134</sup> BCBS Medex Harvard Plan cost, as stated by Harvard, is \$508. Of this, for retirees with 20+years of service, Harvard contributes \$406, retiree pays \$102

<sup>135</sup> U of M states that the total cost of its plan is \$523. For retirees with 20+ years of service U of M pays \$277; the retiree pays \$246

<sup>136</sup> BCBS Medex Supplement total cost, as stated by MIT, \$565. For retirees with 20+ years of service, MIT pays \$395.50, the retiree pays \$169.50

Stanford	\$300.35	\$582.0 <sup>137</sup>	\$281.72			\$281.72
University of California	\$210.80	\$312 <sup>138</sup>	\$101.20		\$30	\$131.20
NYU			\$282.60 <sup>139</sup>			\$282.60
Cornell	\$38.72	\$23 <sup>140</sup>	-\$15.72 plus better max out-of-pocket (MOOP) (\$4750 lower) but higher deductible (by \$45)	\$95		\$79.28
Princeton	\$125	\$120 <sup>141</sup>	-\$5 plus better MOOP (\$4450 lower) and lower deductible (by \$150)	\$101.5		\$96.5
University of Pennsylvania	\$228	\$176 <sup>142</sup>	-\$52 plus better MOOP (\$4050 lower); zero deductible	\$81		\$29

<sup>137</sup> Stanford states its Blue Shield Retiree Medical Plan total cost: \$582.07. With 20 years of service Stanford pays \$281.72; retiree pays \$300.35. Stanford's subsidy formula raises annual contributions to a retiree by \$169.03 times the number of years of service.

<sup>138</sup> Individual Market: Similar plan to Anthem Supplement Plan F, \$312

<sup>139</sup> NYU provides a flat HRA contribution toward any insurance plan, whether offered through Via or otherwise. The HRA can also be used for any other medical expenses, such as copays, over-the-counter drugs, FSAs, etc. This plan is for new retirees, going forward. Older retirees are still on a plan where they pay \$31 monthly for a UHC Group Medical Advantage PPO, whose market price is \$82, i.e., a subsidy of \$51/month.

<sup>140</sup> 80-20 Plan. Individual Market: a comparable plan does not exist. Multiple Aetna plans are \$0-23, but they have \$7,500-8,300 Out of Pocket maximums vs. \$3,550 Cornell plan

<sup>141</sup> The closest comparable market plan is Aetna Medicare Premier (Regional PPO) \$120 month, but with a \$7,550 Out of Pocket maximum vs. \$3,100 for the Princeton plan

<sup>142</sup> Individual Market: a comparable plan does not exist. Closest is Aetna Gold PPO \$176 month, but there is a \$7,550 Out of Pocket maximum vs. 3,500 UPenn plan

Yale	\$56	\$87 <sup>143</sup>	\$31 plus better MOOP (\$6700 lower), and zero deductible (lower by \$250)	\$134		\$155.8
------	------	---------------------	--	-------	--	---------

These comparisons do not imply that Columbia must match the numbers offered by peers. Each university has its own basket of retirement benefits, including savings plans, housing, gym, etc. It is legitimate for the components to differ. The housing cost is more of an issue in Manhattan than in Ithaca. Columbia's housing policy towards retirees is more generous than NYU's.<sup>144</sup> But when the numbers for the essential element of retiree medical coverage show as high a discrepancy as Columbia's support levels do in comparison with most of its peers, with these peer institutions offering a meaningful support program vs Columbia's essentially token support, they raise important questions.

## VI. The Trust Fund

This section discusses the funding mechanism of the subsidy, which is even less well understood than the medical insurance issues. Any change in the insurance arrangements involves finances. When it comes to any benefits issue, a common and sensible argument to consider is that it costs budget money at a time when these budgets are tight. However, when it comes to Columbia's retirement medical coverage, the situation is very different. The reason is the existence of a Trust Fund outside of the University budget whose function is specifically dedicated to retiree medical insurance.

For many years, there has existed a monthly subsidy to eligible retirees to lower their insurance premium cost. Where does that money come from? Some believe that it comes from the University's fringe pool that funds most benefits, such as children's tuition assistance or commuting cost support. That is not so. Neither does it come from Columbia's general budget. Instead, it is paid from a little-known pot of accumulated money called the **Columbia University Retiree Medical and Life Insurance Benefits Trust ("CURML Trust Fund").** The CURML Trust Fund is a not-for-profit 501(c)3 organization, set up in 1994, that is run by

<sup>143</sup> Individual market: a similar plan is available in New Haven (Aetna Medicare Explorer Premier Plan (PPO)) for \$87; thought the plan offered by Yale is superior, with \$0 Out of Pocket, and \$0 emergency room vs. \$6,700 Out of Pocket and \$95 emergency room.

<sup>144</sup> Universities also differ in the way that they provide housing support through forgivable loans, mortgage subsidies, etc.

Trustees who are University officials. But it is legally separate from the University. It is an entity with its own revenues, assets, tax returns, trustees, auditors, etc. It is not part of the fringe pool, nor has been funded by it. Moneys in that trust fund are not the University's but are held separately, for the mission, as stated in its name to benefit the retirees. Several 'Whereas' clauses identify the Trust's rationale and mission:

WHEREAS, the University provides medical and life insurance benefits (the "Benefits") to its eligible retired employees either by self-funding retiree claims or by paying premiums to obtain insurance coverage for such claims under various plans and arrangements (collectively the "Plans");

WHEREAS, it is an essential function and integral part of the exempt educational activities of the University to provide for the payment of the Benefits;

WHEREAS, the University desires to establish a trust to assist the University in paying its obligations under the Plans by accumulating in the trust a segregated fund for the purpose of paying the University's obligations for the Benefits;

These clauses show (a) a recognition of an obligation to all retirees either to self-fund retiree claims or to pay the premiums for their coverage; (b) a recognition that retiree benefits are an integral part of the University's "educational" activities, -- and that integration is assuring a retirement package that invites a retirement that cannot be commanded, in order to promote its continuous and essential self-renewal; (c) and a recognition of "obligations" to provide medical benefits for all retired employees.

This is somewhat more elaborated in the body of the Trust instrument. All Trust activities must be for the benefit of the University. The terms of the Trust can be formally amended or terminated with certain conditions, but this does not appear to have happened.<sup>145</sup>

The Trust was established by Columbia in 1994, and the date is important. In January of that year, mandatory retirement of faculty had become illegal under a Congressional amendment of EDEA (Age Discrimination in Employment Act), a so-called 'uncapping' measure that had been resisted by universities partly on the ground that it would delay retirements.

In 2021, the Trust Fund, (the latest data publicly available when this report was written) accumulated assets, as reported by Columbia, of almost \$260 million dollars. Data for 2022 has not yet been made public. One might estimate, given the declines in securities prices of about 10-20%, a decline of about 15% in 2022.

---

<sup>145</sup> The Trust document provided to the author did not show any amendments.

What makes the CURML complicated to evaluate is that it supports two very different categories of employees:

- Officers (of Instruction, Administration, Research, and Libraries)
- Support Staff, most of which is unionized and operates under collective bargaining agreements.

A central question to consider is how the assets (and income) of the Trust Fund are to be allocated among these two employee categories, now that the retired Columbia Officers' medical plans have been eliminated.

Assets of the Fund have grown over time, even as (or perhaps because) the number of Officers supported by it has declined. For 1993-- when virtually all eligible retired Officers were fully supported-- that number is estimated as about 4,000. It is calculated today to be 655. As we also calculated earlier, the aggregate support for Officers during that period declined, in today's money, from \$6.8 million in 1993 to, most recently, \$1.1 million, and soon to much less, despite the substantial growth in the number of Officers. At the same time, the assets in the Trust Fund have grown.

The main contributors to that growth were direct University in-payments, the rise of the stock market, the decline in Officers participating in the Columbia plans, and the cuts in support per participating Officer.

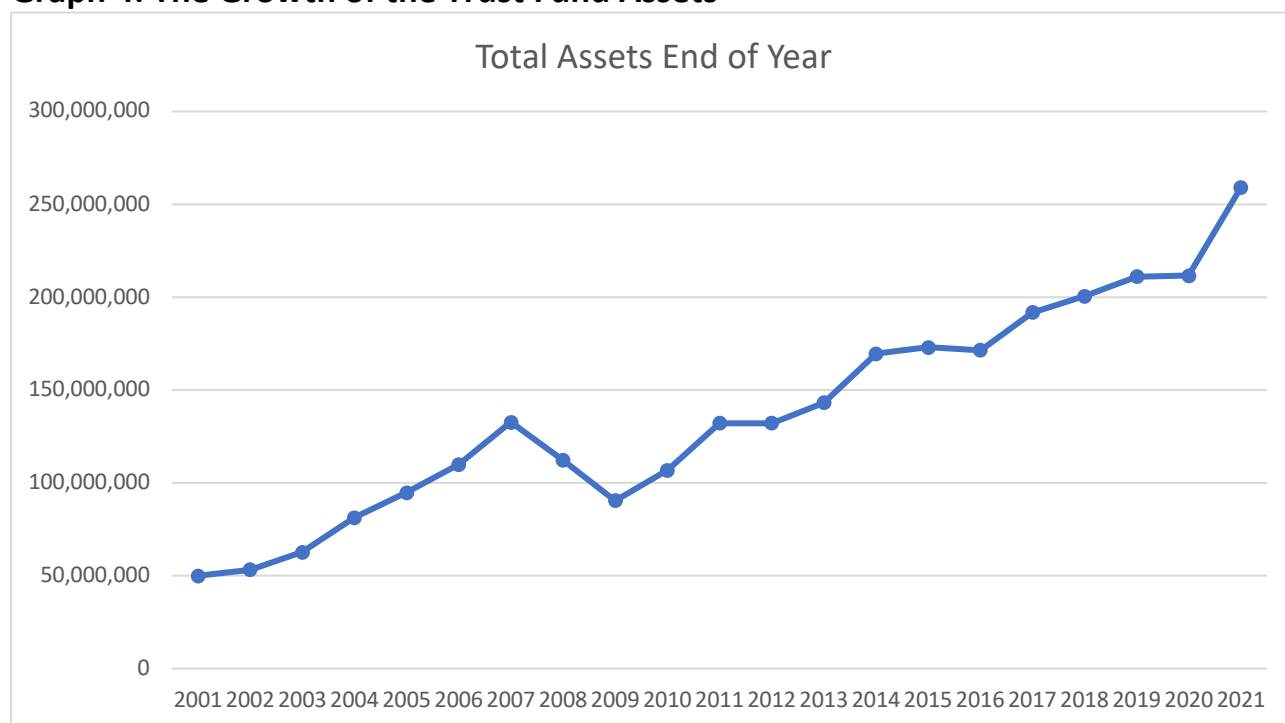
While much of the Fund was created by University contributions over time, some was contributed by officers collectively, as the Columbia filing language reflects.

In each of the filings between 2012 and 2008, and probably earlier, the auditors (PricewaterhouseCoopers) stated:

"The Plan's deficiency of net assets over benefits obligations at [June 30, 2009, and 2008] relates primarily to the post retirement benefit obligation, the funding of which is not covered by the current contribution rate provided by the University and retirees. It is expected that *the deficiency will be funded through future increases in contributions by the University and/or retirees.*" [Italics added]

There must have been a reason for this recurring phrase, which ended only once the fund's deficiency had been eliminated in 2013. That reality must have been that the Trust Fund's deficiency of assets was funded not only by the University but also by the retirees themselves, through premium payments that proved at times to be larger than they would have had to be otherwise, and thus raised the assets of the Trust Fund.

**Graph 4: The Growth of the Trust Fund Assets**



## Where Does the Trust Money Go?

How much does the Trust Fund spend annually on its contribution for retired Officers? That number is not disclosed in Columbia's filings, which lump together both categories of employees. But it can be estimated. The approximate number of Officer-retirees that are part of the Columbia plan is 655, as we calculated earlier. The average monthly subsidy is the amount for the Officer, plus a subsidy for the spouse at a rate one half of that of the Officer.<sup>146</sup> There are also retirees with grandfathered higher benefits.<sup>147</sup> We calculated earlier that the overall subsidy was about \$1.1 million per year.

The University's plan is now to use the Trust Fund to subsidize those who were on the Columbia plans. They would receive a \$220 + \$110 in an annual "RTA" contribution. Pre-2011 retirees on the Columbia plans would be grandfathered to twice that number (\$440+\$220). We calculated earlier that this would add up to \$240K.

<sup>146</sup> Many officers are single; or their spouse has a separate plan; or, the officer's plan is expensive, as noted earlier, because of its appeals to retirees with medical issues, and a healthier spouse can get a less expensive coverage separately elsewhere.

<sup>147</sup> It was \$140 for an individual, and, using the same assumptions about spousal participation, on average \$180 per month, i.e., \$90 higher than for subsequent retirees.

To this one must add the catastrophic prescription drug support. The aggregate contribution to catastrophic prescription drugs can be calculated as about \$69K per year.<sup>148</sup> Together with the \$240K towards the medical plan contribution, this comes to an overall contribution of \$309K.

A first observation is how small the contribution to retirees is.<sup>149</sup> If actual data would be provided it might modify this estimate. But even it was to triple, it would still be a minor sum in the context of a \$5.5 billion budget of Columbia University.

A second observation is that while a belief may exist that the University does not reduce its overall contribution under the new plan, only changing its nature (i.e., reduce the subsidy per participating Officer but increase its reach), the actual estimated new subsidy would be 72% smaller than that of 2022, with the per-beneficiary contribution cut by 75%.

A third observation is that this amount is a tiny percentage of the income of the Trust Fund that has been set up to support retirees. The investment gain on that Fund has averaged, as can be seen in Table 6 below, an annual 8.34% over the past thirteen years for which we have University IRS filings. Applying this return to the Fund's current assets then yields an annual \$21.86 mil in gain of assets. **Thus, the contribution to Officers' medical retirement and catastrophic drug coverage from the entire Trust Fund is only 1.4% of that Fund's annual total gain. Of the entire Trust Fund assets, it is only a minuscule 0.12%, a return of one eighth of one percent.**

If we exclude the unrealized appreciation of the assets and look only at investment income (interest, dividends, and realized capital gains) over 20 years, that annual return averages 4.14%, or \$10.76 mil., and the estimated 2023 allocation towards Officers (\$309K) would then be a minor 2.9% of this annual income.

Given these numbers, one must conclude that the University's not spending more from the Trust Fund on Officer benefits is not based on financial constraints – the Trust Fund is flush and

---

<sup>148</sup> According to Kaiser Family Foundation's 2018 nationwide figure)<sup>148</sup>, for 4.4% of Medicare users the out-of-pocket drug expense exceeds the Federal threshold (CCL, currently \$10,048.) There are about 3,000 Columbia retirees. We assume that 1,832 will use the Via exchange. The precise number should be available after December 1, 2022 when the enrollment period closes. Almost all estimated 655 Columbia plan participants are likely to use Via, due to the subsidy that is conditional on such usage. Of the other 2345 retirees who already use outside plans, we assume that one half will go through Via in order to be covered for catastrophic drug expenses. (This incentive will drastically decline after 2025, when the Federal cap on such costs comes into effect.). This adds up to 1,832 Columbia users of Via. This would mean 81 such cases per year. To reach the CCL, given a 30% co-insurance, a patient's Rx bills would have to be about \$33K. For expenses above the CCL, co-insurance drops to 5%. If we assume that the average Rx bills for the group in question is \$50K per year, Columbia's average contribution would be 5% of \$50K- \$33K= \$850. The aggregate contribution to catastrophic prescription drugs would therefore be about \$69K per year.

<sup>149</sup> Recall our earlier calculation that in 1993, Columbia's contribution was, in today's money, \$6.37 mil. In 2000, from the Trust Fund, it was \$4.37 million, in 2011, \$2.3 million, and in 2021, \$1.1 million.



can be used only on retirement medical and life insurance purposes -- but on a policy decision.<sup>150</sup>

That policy decision must be, absent another explanation, that the University, through the Trustees of the Trust Fund, plans to leave the Officers with a minimal token and use the Trust Fund overwhelmingly to meet its present and future labor contract obligations to the Support Staff. Given the Trust's stated purpose, there is nothing else the money could be used for without abolishing or amending the Trust.

The question is, what happens to those assets that were accumulated to benefit the Officers?

## **For Whose Benefit Have the Assets Been Created?**

The question is, who does this money belong to? Legally, to the Trust. The Trust Fund is not a 401(k) or 403(b) plan into which individuals pay and thus establish individual claims. However, the Trustees have fiduciary obligations to meet the purposes of the Trust and to all of its retirees (absent a compelling reason otherwise.)

As long as the University was managing the self-insurance system it needed the extensive Trust Fund to deal with potential liabilities. But now, the University is in the process of exiting from Officer retiree self-insurance altogether and leaving retirees to deal individually with market-offered plans.<sup>151</sup> The University is thus shedding its liability<sup>152</sup>, contingencies, and administrative load.<sup>153</sup> In consequence, is there a need for a Trust Fund to be held against liabilities that do not exist anymore?

The answer must be yes. The purpose of the Trust Fund is not to be a backstop for the four Columbia plans, but to support Columbia retirees. The Columbia plans were just a vehicle to do so. Since initially they were synonymous with retiree medical insurance, the issue did not arise at first. But for a variety of reasons this changed as most Officers moved out to more affordable plans. But this should not have implied that the support to such retirees should have ended. They have worked for Columbia and earned the retiree benefits, and there is no principled justification that their (usually reluctant) departure from the Columbia plans should have been

---

<sup>150</sup> There are, presumably, some regulatory rules on the allocation of retirement trust funds.

<sup>151</sup> The Via exchange does not offer any group rate advantages over what is available individually in the market. It is a channel to those plans, not a group plan.

<sup>152</sup> Liability is determined from pools of current retirees, those who can come back, and also all non-retirees who might join. All of these pools shrink to nothing. (Exceptions are pre-1994 retirees, and the catastrophic drug coverage contingency. Both of these are minor in magnitude.)

<sup>153</sup> The retirees off the Columbia plans, on the other hand, must now join new insurance pools that also have contingencies built in against liability, and their premium payments will have to contribute to *new* reserves against potential liability.

a cost saving to the Trust Fund.<sup>154</sup> It is called the Columbia University *Retiree* Medical and Life Insurance *Benefits* Trust, not the Columbia Insurance Plans Trust.

The purpose of the Trust Fund has not gone away just because the Columbia plans have. By basic fairness and law, the Trust's assets need to continue serving its stated purpose.

The question now is what the resources to support retired Officers are. Later, we will discuss how they should be allocated.

## **The Intermingling of the CURML Trust Funds**

The problem of determining the assets available to support retired Officers is that they are intermingled with assets for retired Support Staff. When retired, these employees have their medical payments fully covered by the University, per collective bargaining contracts. They do not pay premiums for medical coverage<sup>155</sup>. In consequence, almost all Support Staff employees remain with Columbia plans, whereas only a minority of Officers do, since they are deterred by the high premium costs.

The intermingling of the Trust Fund's several flows of in-payments and two major out-contributions, for two employee categories whose benefit plans are dramatically disparate, creates major problems in judging the administration of the Fund. This is still more complex when the Officer employees are directed to leave the Columbia-sponsored plan altogether while the Support Staff employees are not.<sup>156</sup>

The Trust Fund reported payments to all beneficiaries 2021 of \$10.2 mil. We estimated earlier that \$1.1 million went to Officers. By these numbers, only 11% of Trust out-payments went to a category of employees (Officers) that comprises 82% of all employees. Under the new system, they receive only 3%. These proportions should be explained to the intended beneficiaries.

The comparison of the Officers' plans with those of the Support Staff employees should not be misconstrued as begrudging or challenging. Quite to the contrary, their ability to obtain favorable plans should be admired and applauded. Officers should salute the ability of Staff unions to gain for their members a strong medical retirement plan. How good it is is evidenced

---

<sup>154</sup> The University might take the position that the total dollar amount spent on the contribution should be stable. But if so, then the subsidy per plan-retiree should have gone up in prior years as the number of subscribers to those plans declined. Instead, the University lowered its aggregate contribution by 75% from Plan #2 to today, in 2021. If, on the other hand, the principle is that the subsidy *per-subscriber* stays the same, then the same level as before (\$72) would have to be offered to all now. Instead, retirees on the plan get a significant reduction in their subsidy, while those with outside plans will get nothing. One cannot argue it both ways.

<sup>155</sup> They also pay Medicare premiums as everyone does.

<sup>156</sup> The staff plan is a Columbia group plan administered by Empire.

by the fact that it is 18 times higher than that now provided to Officers (an estimated \$330<sup>157</sup> for Support Staff vs \$18.33 for individuals per month for the 22% of Officers who are grandfathered, and \$0 for the rest of current retirees), plus a life insurance of \$90 per year<sup>158</sup> that is not being extended to Officers; and all adjusted to inflation. Officer-employees should wish for such terms.

As mentioned above, NYU gives its officer-retirees the same HRA support toward medical insurance as it does for its unionized support staff, whereas Columbia does not.

One must recognize, of course, the important fact that Staff employees are typically paid less than Officers and hence are likely to retire with fewer assets.<sup>159</sup> Contributions to their retirement savings plans such as TIAA or Vanguard are lower. Higher health benefits can therefore be justified as an offset to lower compensation, and then be paid for by the University in the same way that it pays for compensation and other labor costs, and not by cutting the benefits of another category of employees who are not represented by unions. By its labor contracts, the University owes Staff Employees certain benefits; they are not conditional on any particular internal account to fund them. This is not a situation of a zero-sum game, and Columbia employees should not be maneuvered into it. Payments of a labor contract are owed by the University and not by the Trust Fund which is merely a contributing tool.

## The Allocation of the Contingency Fund

The University does not report Trust data segmented by the two categories of beneficiaries. It undoubtedly has segmented information, if for no other reason than for use in labor negotiations, HR planning, costing of liability contingencies, pricing the medical insurance plans, etc. But in its filings, the Trust Fund aggregates these numbers, and this makes a comparison of the benefits extended to each of the two groups difficult.

---

<sup>157</sup> Columbia's Empire Blue Cross Blue Shield plan for retired staff incorporates the approximate equivalent of a Medigap coverage and Part D drug coverage. For Medigap, the average price of Via-offered plans is \$265. For Part D the average is \$65. Together, this amounts to an estimated \$330.

<sup>158</sup> Prior to 2018, with a different life insurance company as the underwriter, the per-person insurance was \$240-\$350.

<sup>159</sup> Salary scales for officers and non-union are available here: <https://humanresources.columbia.edu/content/salary-information>.

Grades 10 Officer) and 9b (Support Staff) are comparable, both consisting of Assistant and Coordinator positions. For FY 2023, for a grade 10 Officer (the lowest) at Morningside, the minimum salary is \$58,500.

For Grade 9B (the highest Union grade) at Morningside, the minimum salary is \$56,800. (\$73,030 with 9+ years of seniority.)

Professors are not on an official grade/pay scale. As a current example, an open track position at the Journalism School lists the following pay scale by rank: Assistant Professor: \$110–135K; Associate Professor: \$125-155K; Professor: \$140-200K. Salaries for top administrators are also not based on grade but on other factors, in particular for those in medical or financial services. Numbers are provided here: <https://projects.propublica.org/nonprofits/organizations/135598093>.

One way to look at this is to quantify for whose contingent liability the assets in the funds have been created. Appendix D looks at the two employee categories, and at the fund as a contingency against the liability of future claims.

This calculation then yields contingency assets of **\$221.3 million** for the officer pool. This is a considerable number. It is the result of the underlying officer population being much larger, and those who choose the Columbia plan to be much sicker. This more than offsets the staff's much higher sign-up rate and slightly longer life expectancy at retirement.

The alternative is the allocation on a per-capita basis, which imputed a share of \$213 million, which is almost the amount.

These calculations do not aim to be definitive, but to sketch orders of magnitude. A professional actuary might possibly come to lower numbers<sup>160</sup> but they would still be high.

We estimated the annual Columbia subsidy to be currently at about \$1.1 million, and the new plan would reduce this to \$0.309 million, rising slowly. To generate such an annual amount would require a certain asset base. Its size depends on the assumption of annual financial gain. That gain is listed in the Columbia filings with the IRS. Over the past 13 years these gains (which also included the down years of the 2008/9 Great Recession) averaged 8.34% per year. If we use this number into the future one would need assets of \$3.7million to generate these \$0.435 million. If we use instead an assumed a highly conservative return on assets of 3%, which is PwC's assumption, it would be \$10.3 million. And at the Columbia endowment's typical payout rate of 4.5%<sup>161</sup>, it would be \$6.87 million.

In contrast, the asset allocation based on liability towards the Officer retirees, as estimated above, is \$220.6 million, a hugely higher figure.

If we stay with the PwC's presumably conservative actuarial assumption for the expected return on investment— which is less than half of the actuality of the past 13 years—and assume a return on assets of only 3%, it would enable the CURML Trust Fund's assets held as contingency for officers, to spend annually \$7.8 million, 25 times as much as the estimated \$0.309 million, and to do so in perpetuity.<sup>162</sup> If we use the higher actual average return of 8.34%, the Trust Fund could spend on officers annually \$21.7 million, or 70 times as much as it will do in 2023, and 20 times as much as it did in 2021.

As it is, the \$0.309 million towards Officer retirees would be a payback from the Trust Fund of 0.0012, one eighth of one percent.

## The Financial Administration of the Trust Fund

---

<sup>160</sup> For example, a more sophisticated approach would recalculate life expectancy each year.

<sup>161</sup> The most recent rate is 4.5% for 2022

<sup>162</sup> As discussed earlier, the increase in retirees supported by the HRA raises the aggregate HRA each year by \$32K.

This discussion brings us to the management of the Trust Fund assets. This is not a central issue for this report, but with the data already collected from the Columbia IRS filings, we can take a look.

The assets in the Trust Fund are managed by State Street Global Advisors (SSGA), the world's 4<sup>th</sup> largest asset manager, with over \$4 trillion dollars under management. State Street invests the Trust Fund's money in index funds, which are all State Street funds.

The primary investment management contribution by SSGA is to pick index funds and their allocation within the overall portfolio. This sounds more complex than it is. Before 2018 just 5 index funds comprised the Trust Fund's portfolio, all of them State Street funds and all of them routine funds for a routine portfolio: one fund that followed index for huge domestic companies (S&P 100), one for a still larger set of large companies (S&P 500), one for international stocks (following the Morgan Stanley International Index), one for US bonds (a S&P Bond Index), and one for inflation-protected bonds (another S&P bond index). After 2018 the CURML holdings became a bit more diversified by an increase to 12 index funds, all of them again State Street funds, and virtually all standard choices like REITs, Emerging Markets, and more differentiated bond index funds. Once reorganized in 2018, the portfolio composition stayed fairly stable. According to CURML's disclosures, the mix of the assets gets changed by only about 2-3 trades per year (some conducted over several days in several transactions).

The CURML Trust Fund assets of over \$260 million are part of much larger pools that are collectively managed by State Street – known as CTFs (Collective Trust Funds) and of which CURML then has a share, like in a mutual fund. While this might reduce individual attention, being part of a large pool of many institutions helps keep fees lower than they would be otherwise.

The funds in the Trust Fund portfolio are:

**Table 5: 2021 CURML Trust Assets and Expense Ratios**

	Asset Value	Listed Net Expense Ratio	Percent of Asset
U.S. Aggregate Bond Index NL <sup>163</sup> QP CTF†	\$13,033,169	0.025%	5.01%
MSCI EAFE Index NL QP CTF†	\$28,331,920	0.3%*	10.9%
U.S. High Yield Bond Index NL CTF	\$12,992,177	0.1%	4.99%
U.S. REIT Index NL CTF	\$12,893,316	0.25%*	4.95%
U.S. TIPS Index NL QP CTF†	\$13,037,731	0.12%*	5.01%
Bloomberg Roll Select Commodity IND	\$13,207,785	0.29%	5.08%
Global Defensive Equity NL CTF	\$36,451,784	0.75%	14%

<sup>163</sup> NL (no-loan) indicates no securities are being lent by the fund for additional income, which slightly reduces risk as well as profitability. CTF (Collective Trust Funds) aggregate multiple investors.

Long U.S. Credit Index NL Fund	\$31,367,172	0.04%*	12.1%
Long U.S. Treasury Index NL Fund	\$13,088,865	0.06%*	5.03%
Daily MSCI Emerging Markets Index NL Fund	\$12,975,459	0.17%	4.99%
Russel 1000 Index NL CTF	\$62,504,112	0.2%*	24%
Russell 2000 Index NL CTF	\$10,359,374	0.3%	3.98%
<b>Total Assets</b>	<b>\$260,242,864</b>		
<b>Weighted Average Expense Ratio</b>		<b>0.25%</b>	

\*Gross Expense Ratio

† One of the five funds prior to 2018

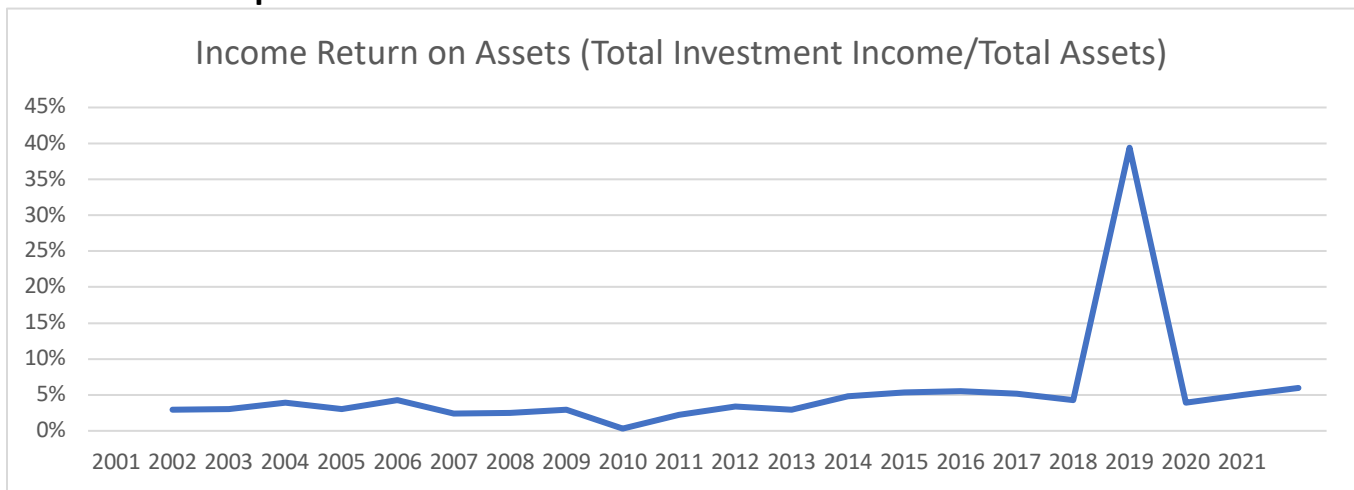
The management fee for the Russell 1000 Index Fund, at 0.2%, is almost three times as high as for the equivalent Russell 1000 fund index fund offered by Vanguard to regular investors (VONE, expense ratio 0.07%.) For an S&P 500 index fund that essentially covers the same territory (the largest US companies), an investor would have to pay Vanguard a much lower 0.03%. Similarly, State Street's Russell 2000 Index Fund costs 0.3% in annual fees, while Vanguard's charges 0.1%.

That said, these are business judgments well within the parameters of money managers. We should understand what they are and how much they cost.

Turning now to performance:

The graph below shows the income generated by the Trust Fund assets. "Income" is defined as dividends, interest, and net realized capital gains. Graph 5 shows this to be generally in the 3-5% range. One year, 2018, shows a dramatic spike, caused by State Street's one-time switch from 5 funds to 12, which necessitated sales of parts of those funds and generated capital gains. Excluding that year as exceptional, the average income generated per year was 3.7% or \$5.457 mil (The data is provided in Appendix E, Table 6.)

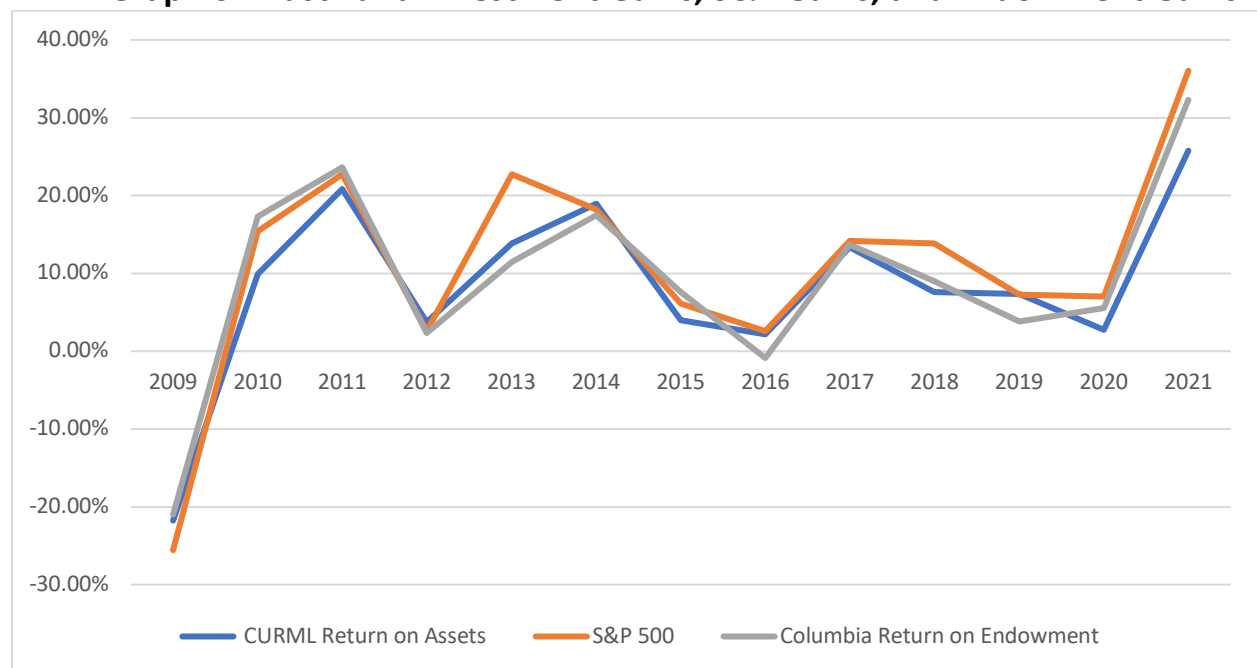
**Graph 5: Income Return on Assets**



One must understand that the actual income received in cash dividends and interest is a function of the asset types selected, such as high-dividends vs high-growth. In that sense, this measure is an imperfect indicator for performance. A better way to look at performance is to look at the gain in value of the assets, which include the appreciation in unsold securities.

Graph 6 provides the overview. The specific numbers are given in Appendix F, Table 7.

**Graph 6: Trust Fund Investment Gains, S&P Gains, and Endowment Gains**



The Graph compares the CURML portfolio performance (the blue line) relative to the S&P 500 index (the orange line), for 2009-2021. The average annual performance for this period, for the

CURML Trust Fund, was 8.34%. Meanwhile, the S&P 500 index did better, averaging 11.02%. That index is one of domestic stocks only, whereas the CURML Trust Fund holds bonds, international stocks, and REITs, adding diversification.

The measure for volatility of an asset relative to the overall market is known as the beta-coefficient. The S&P 500 Index is the typical benchmark, with -- by definition -- a beta of 1.0. Management costs of a fund holding that portfolio are 0.03% in fees (Vanguard). The beta of CURML is calculated as 1.19, at a cost of 0.25%.<sup>164</sup> The cost for the CURML funds, even before the additional overall management fee of about 0.23%, is thus over eight times as high as holding a straight S&P Index fund at a cost of 0.03%. The difference is 0.22%, over half a million dollars a year, with slightly greater volatility (risk), and with a lower return of 2.68%, which is about \$7 million.

The third (gray) line in Graph 6 is the return on the Columbia endowment. This is not a factor for this report, but it permits a performance comparison of a simple index fund tied to the main index of the stock market (S&P 500), with the basket of CURML index funds administered by State Street, and with an actively managed portfolio such as Columbia's endowment fund. Those endowment numbers are those reported annually by Columbia Investment Management Company.<sup>165</sup> The endowment's average annual return for the same period was 9.0%, higher than for the CURML (8.345%) but lower than the S&P (11.02%), and before the expenses of endowment management are subtracted. Its volatility relative to the S&P 500 is beta=1.1, i.e., somewhat higher than the benchmark S&P, and its liquidity, one assumes, is somewhat lower.

---

<sup>164</sup> From Table 5, the weighted average of the fees of the various funds.

<sup>165</sup> Jechinger, John. "Columbia Endowment Falls 21%." *Wall Street Journal*. September 12, 2009. <https://www.wsj.com/articles/SB125268835271803725>; Fabrikant, Geraldine. "Columbia's Endowment Posts 17% Return." *New York Times*. September 15, 2010. <https://www.nytimes.com/2010/09/16/business/16columbia.html>; Barth, Chris. "Columbia Endowment Performance Tops Ivey League for Second Straight Year." *Forbes*. October 18, 2011. <https://www.forbes.com/sites/chrisbarth/2011/10/19/columbia-endowment-performance-top-ivy-league-for-second-straight-year/>; Columbia News Staff. "Endowment Investments Earn 2.3 Percent Return in 2012, Capping Decade of Above Market Growth." *Columbia News*. October 14, 2012. <https://news.columbia.edu/news/endowment-investments-earn-23-percent-return-2012-capping-decade-above-market-growth>; Hornsby, Robert. "Columbia's Endowment Investments Generate 11.5 Percent Return in Fiscal 2013, Continue Leading 5- and 10-year Performance." *Columbia News*. October 10, 2013. <https://news.columbia.edu/news/columbias-endowment-investments-generate-115-percent-return-fiscal-2013-continue-leading-5-and>; Fabrikant, Geraldine. "Columbia University Reports 17.5% Return on Endowment." *New York Times*. October 1, 2014. <https://www.nytimes.com/2014/10/02/business/columbia-university-reports-17-5-return-on-endowment.html>; Lorin, Janet. "Columbia University's Endowment Posts 7.6% Investment Return." *Bloomberg*. October 14, 2015. <https://www.bloomberg.com/news/articles/2015-10-14/columbia-university-s-endowment-posts-7-6-investment-return>; Columbia News. "Columbia Endowment Investments Return a Negative .9 Percent in Fiscal 2016." October 5, 2016. <https://news.columbia.edu/news/columbia-endowment-investments-return-negative-9-percent-fiscal-2016>; Katz, Michael. "Columbia Endowment Reports 9.0% Return for 2018." *Chief Investment Officer*. October 12, 2018. <https://www.ai-cio.com/news/columbia-endowment-reports-9-0-return-2018/>; Steyer, Robert. "Columbia endowment returns 5.5% for fiscal year." *Pensions & Investments*. October 7, 2020. <https://www.pionline.com/endowments-and-foundations/columbia-endowment-returns-55-fiscal-year>; and Columbia Finance. "IMC CEO Statement on FY21 Endowment Returns." October 21, 2021. <https://www.finance.columbia.edu/content/imc-ceo-statement-fy21-endowment-returns>.



## The Cost of Investment Management

State Street charges the Trust Fund a management fee, (in recent years, of about \$500K which seems to be based on about 0.2%-0.25% of assets under management, with an average of 0.23%, which we assume is the set rate (Table 6, Column 1). This seems to be in the normal range of fund management fees.

One also needs to take into account another element of cost, namely the second tier of fees already discussed above. The funds selected by SSGA--all State Street funds themselves--also charge their own fees. They are listed in Table 5 above, and their average is 0.22%.<sup>166</sup> Together, this means an average overall State Street expense ratio of 0.48% of assets (Column 2 below). This still does not look large, but the more meaningful measure is to compare it not with assets but with investment income and investment gains.

Column 5 shows the share of investment income that goes to State Street. Its average annual is 10.32% of income.

Another and probably better comparison would be with the investment gain of the Trust Fund, as reported by Columbia. Those annual gain percentages are provided in column 6, and average 8.34%. State Street's overall fees, as a share of these investment returns, are listed in Column 7. They average 6.84%.

Thus, the Trust Fund pays, depending on which measure one uses, between 6.8% and 10.3% of its financial gains to its investment advisor, State Street, for what appears to be mostly a custodial function (maintaining an account) and occasional minor tweaks of a conventional portfolio of conventional index funds.

A related question is what the financial management costs are for the portion of the Trust Fund assets that backs the contingency liability for Officers. If we apply the overall management cost of 0.48% to the Officer part of the Trust Fund, which we calculated to be \$221.3 million, then the overall payments to State Street for managing the assets for Officer contingencies are about \$1.155 million in 2021. In comparison, the entire contribution from the Trust Fund to the Officers was estimated to be \$1.1 million for that year.

**Table 6: Cost of Investment Management**

	<b>State Street Management Fees (Tier 1) % of</b>	<b>State Street Management Fees (Tier 1) plus Average Expense Ratio of</b>	<b>Total State Street Management Cost (3)</b>	<b>Income Return on Assets (Total Investment Income /</b>	<b>State Street Fees as a Share of Total Investment Income (5)</b>	<b>Investment Gain on Total Assets (6)</b>	<b>State Street Share of Investment Gain (7)</b>
--	---	--	---	---	--	--	--

<sup>166</sup> The weighted average is 0.25, from Table 5, but we will use in the further calculation the unweighted average of 0.22, since the management fees might have changed over the years.

	<b>Total Assets (1)</b>	<b>Funds (Tier 2) (2)</b>		<b>Total Assets Year<sub>x-1</sub> (4)</b>			
<b>2001</b>							
<b>2002</b>				3.27%			
<b>2003</b>				4.59%			
<b>2004</b>				3.98%			
<b>2005</b>				4.98%			
<b>2006</b>				2.78%			
<b>2007</b>	0.22%	0.44%	\$580,799	2.99%	14.72%		
<b>2008</b>	0.26%	0.48%	\$542,238	2.47%	19.43%		
<b>2009</b>	0.23%	0.45%	\$404,406	0.25%	180.00%	-21.77%	-2.07%
<b>2010</b>	0.20%	0.42%	\$449,994	2.67%	15.73%	9.90%	4.24%
<b>2011</b>	0.21%	0.43%	\$572,198	4.23%	10.17%	20.83%	2.06%
<b>2012</b>	0.22%	0.44%	\$582,031	2.97%	14.81%	3.70%	11.89%
<b>2013</b>	0.23%	0.45%	\$644,562	5.22%	8.62%	13.84%	3.25%
<b>2014</b>	0.22%	0.44%	\$742,722	6.29%	7.00%	18.97%	2.32%
<b>2015</b>	0.24%	0.46%	\$799,268	5.68%	8.10%	3.95%	11.65%
<b>2016</b>	0.25%	0.47%	\$801,726	5.14%	9.14%	2.17%	21.66%
<b>2017</b>	0.22%	0.44%	\$853,605	4.79%	9.19%	13.38%	3.29%
<b>2018</b>	0.22%	0.44%	\$883,706	41.20%	1.07%	7.61%	5.78%
<b>2019</b>	0.23%	0.45%	\$956,746	4.08%	11.03%	7.33%	6.14%
<b>2020</b>	0.24%	0.46%	\$980,627	4.97%	9.26%	2.72%	16.91%
<b>2021</b>	0.23%	0.45%	\$1,154,923	7.29%	6.17%	25.77%	1.75%
<b>Averages</b>	0.23%	0.45%	\$729,970	4.14% (excluding g 2018)	10.32% (excluding 2009)	8.34%	7.58%, (excluding 2009)

There is nothing unusual about these numbers. These cost and performance numbers seem to basically track the practices of the financial industry for this kind of service. And State Street provides the imprimatur of a respected financial institution. But the question for the Columbia Fund's Trustees is to consider whether there are alternative ways to raise the value-added of the not insubstantial investment management cost.

## VII. Proposed Improvements and Outlook

Having considered these issues, this report offers three alternative plans that constructively deal with the shortcomings of the new plan and its funding. Common to them is

- a catastrophic drug backstop;
- a separation of the administration of the HRA contribution from any particular plan or exchange, along the lines of NYU;
- A periodic adjustment for inflation.

### Plan A –Restoration to 2011 Levels, a Point System, and a Restructuring of the Trust Fund

This plan is the most thorough one in restructuring the system.

#### Allocation

1. All retired Officers who have left the Columbia plans, including those who left longer than 5 years ago, would be eligible to return, provided they do so in the first year of the new plan.
2. Retirees would receive an HRA subsidy *based on a point system*. (Each point would be currently the equivalent of \$25.)
  - a. The basic contribution to retirees would be 6 points.
  - b. Retirees with a spouse on their medical plan would get three additional points.<sup>167</sup>
  - c. In addition to the Columbia plan's catastrophic prescription drug contribution for out-of-pocket expenses over \$10,048, retirees would receive an extra point for each full \$5,000 of out-of-pocket cost, net of payments from insurances, Columbia, or governmental support, that exceeds \$5,000 in the previous year.
  - d. As a special incentive to retire, Officers who agree to retire before 67<sup>168</sup> will get an extra point for each of such years, up to 3 years.
  - e. Officers whose average Columbia full-time salary in their last 3 years before retirement was below \$120K would receive an additional point.<sup>169</sup> That threshold

---

<sup>167</sup> The spousal inclusion for retirees stems from a time where there was only one breadwinner. Today most spouses could have their own medical plans based on active or past employment of their own, and joining spousal plans together is mostly an economic decision (to reduce the combined premiums) rather than a dependency. Given these considerations, the spousal benefits are reduced from ½ to 1/3. Even so, in dollar terms, the proposal is much higher than the University's newly introduced subsidy level of \$9.17 per month.

<sup>168</sup> About 64 for officers of Administration, 64 for research officers, and 67 for officers of instruction.

<sup>169</sup> This would follow another guiding principle from the same 2011 Senate resolution, namely, to provide for progressivity.

would automatically rise by \$3,000 each year, as a proxy for an assumed 2.5% rate of inflation.<sup>170</sup>

## Cost

In calculating the overall cost of this, we assume the following:

1. A total count of Officer retirees of 3,000, as estimated above. We assume that 2,500 of them will join the exchange system.<sup>171</sup>
2. An average of 7.5 points per retiree, considering the spousal coverage. With the low-income factor for a certain percentage of the cohort,<sup>172</sup> this would add up to 19,500 points.
3. 15% of each new Officer cohort retires on average two years early, accounting for a total of 750 points.
4. 4% of retirees would exceed the catastrophic limit in Rx each year and would average \$20K in unreimbursed expenses. This would add about 300 points. Note that the new Federal law aims to cap out-of-pocket expenses after 2024/5.<sup>173</sup>

The total is therefore about 20,550 points per month.

If a point is valued at \$25, this would add up to \$513K/month or \$6.1 million per year.

If it is valued at \$20, it would add up to \$4.9 million.

Additionally, the existing plan's catastrophic support<sup>174</sup> adds about \$69K.<sup>175</sup>

Inflation-adjustment is pre-set and automatic and would be approximately \$100K/year.

---

<sup>170</sup> This would provide a greater simplicity and predictability than annual CPI-based indexing. Unpredictability would require reserves as a fallback. However, if the inflation experienced in 2023 seems to persist, an inflation adjustment higher than 2.5% would be in order.

<sup>171</sup> This number is generous, given that most people, especially older ones, do not easily switch from one medical plan to another, even with a moderate financial incentive. Nationally, 10% of Medicare Advantage users switch to another plan, according to Kaiser Family Foundation.

<sup>172</sup> We assume that 1/2 of retirees have a spouse on their plan; that 1/3 was at an income below \$120K when they retired.

<sup>173</sup> While this law has wide support in Washington, changes are always possible, and any future Columbia plan should be mindful of that possibility.

<sup>174</sup> The University's catastrophic Rx coverage deals with out-of-pocket expenses beyond the threshold of \$10,048. The co-insurance by patients beyond that threshold are 5% of expenses. Assuming an average of \$20K bills beyond the threshold, the cost to the patient, reimbursed by Columbia, is then about \$1,000, for a total of \$1000K.

<sup>175</sup> The cost of the catastrophic drug coverage will disappear after 2025 with the new law taking effect.

At \$25 per point, the individual retiree would receive \$150/month. This would roughly restore the \$144 per month that existed until 2011<sup>176</sup> (\$178 in current dollars), though still lower than it was just a decade ago.

The aggregate contribution, at \$25 per point, plus catastrophic drug support, would be about \$6.2 million per year.

Against this cost one must set the existing legacy Cost in 2022, with 650 plan participants @ \$72/mo = Total \$.56mil. The incremental cost of such a new 2024 Plan A over 2022 plan is thus about \$6.1 mil.

**Cost saving to Columbia:**

*High scenario:* 10% of retirement-age retirees retire on average 2.5 ys earlier, and with a salary differential vs newly hired young officers of \$100K, plus .34 fringes. The cost reduction would then be \$5.02 mil. per year.

*Low scenario:* 5% of retirees retire on average 1 year earlier, at a salary differential of \$50,000 plus fringes. The cost reduction would be \$.94 mil.

**The net cost to Columbia is hence between \$5.1 mil/yr (low retirement scenario) and \$1.02/yr (high retirement scenario.) We use the intermediate number, about \$3 mil/year.**

This would be still much lower than the cost in 2011 (\$4.375 in today's money) prior to the changes instituted that year, and even lower if one adjusts for the larger number of officers employed since 2011. Such an amount would be only 1.1% of the overall CURML Trust Fund of \$260.2 million. As we calculated earlier, \$221 million of that fund is attributable to the potential liability of Officers. With that amount set aside to support Officers, the \$3 million constitutes only 1.3% of these assets.

## Funding

1. Subject to applicable legal rules, the assets of the Trust Fund would be divided equally for each of the two employee categories and segmented from each other.<sup>177</sup>

---

<sup>176</sup> This would follow a 2011 Senate Resolution, presented by Senators Moss-Salentijn and Pollack, which stated:

THEREFORE BE IT RESOLVED that the University Senate affirm the following principles to guide the Provost's advisory group in its search for changes in Columbia's fringe benefits program:

--that major recommendations for changes should honor expectations that have been established over the course of the careers of current officers, and should assure grandfathering of essential health, tuition, and retirement benefits to the maximum extent possible;

<sup>177</sup> There are rules governing situations of asset allocations within such Trust Funds. But there seems to be also considerable leeway, as Columbia's past allocations demonstrate. To structure it properly requires ERISA legal expertise.

2. The overall annual amount of support to Officers would be based on the University's payout rate on endowment accounts, applied to those assets.
3. Once the University has allocated and segmented these assets, endowment-like, its contingent obligations to Officer retirees end, including the catastrophic Rx support, and are substituted by the income from the assets. Thus, going forward, the university would carry no contingent liability.<sup>178</sup>

The proposal is to divide the assets of the Trust Fund, one half for each of the two employee categories. It should be recalled that in terms of the actual numbers, they are 82.2%: 17.8%, a ratio of 4.6.

An equal division of Trust assets would mean an asset base for Officers (as well as for Support Staff) of \$130 million. At a payout rate of 4.5%, this would generate \$5.85 million. It would also have to cover overhead. (That overhead is currently \$ 3.4 mil<sup>179</sup>, a figure that is over 4 times higher than it was in 2011.<sup>180</sup> One should be able to cut overhead by 1/3, with each employee category left with \$1.1 mil in overhead. This would leave \$4.75 mil for actual benefits, well above the \$2 mil calculated above for a point system with each point worth \$25.<sup>181</sup>

For Support Staff, the Trust Fund could support, after overhead expenses, about \$4,764 per retiree per year, or \$397 per month. This exceeds the \$337.5/month estimated cost of retiree medical and life insurance cost, and still leave \$60/month. If there is a deficit in the future, the University would pay for such Support Staff retiree expenses as part of its general funding of labor costs.

While the above plan best meets the needs and resources in the long term, it might be complex to institute in the short term. In consequence, two alternative plans are offered.

## **Plan B – Restoration to 2022 Level, for All**

### **Elements**

1. Contribution at level that existed in 2022, i.e., \$72/mo., one-half for spousal coverage; Inflation adjustment every 5 yrs.
2. Coverage also to all current retirees who sign up in 2023.

---

<sup>178</sup> Assuming no special wrinkles in ERISA or other laws which would affect a 50:50 split.

<sup>179</sup> Using Total Expenses minus Benefits Paid, from Columbia's IRS filings.

<sup>180</sup> This is partly due to some of the major expenses directly linked to the asset base.

<sup>181</sup> If there is a deficit, the value of a point would be reduced in the next year to break even.

3. Special transition incentive for retirees between 65 and 70 years: double contribution until 70.
4. Catastrophic drug coverage same as now.

## Cost Calculation

Retiree pool: 3,000. Likely signups: 2,500. Spouse coverage half, for ½ of retirees. Total “retirement units” = 3125

Cost of Special Incentive: assume 10% of retirees younger than 70 will retire, on average for that sub-group, 2.5 years earlier. With 150 retirees/yr, and spouses, it is  $150 \times 0.1 \times 1.25 \times 2.5 = 47$

Total =  $3,125 + 47$  units = 3,172

HRA Contribution @\$72/mo. Total annual cost = \$2.74 mil

Catastrophic drug support (only needed until 2025): \$.069 mil

Total cost for 2024: \$2.8mil

Legacy Cost in 2022: 650 plan participants @\$72/mo = Total \$.56mil

### **Incremental cost of new 2024 Plan B over 2022 plan: \$2.2 mil**

The cost of the catastrophic drug coverage will disappear after 2025 with the new law taking effect.

#### **Cost saving to Columbia:**

*High scenario:* 10% of retirees retire on average 2.5 ys earlier, and with a salary differential vs newly hired young officers of \$100K, plus .34 fringes, the cost reduction would be \$5.02 mil.

*Low scenario:* 5% of retirees retire on average 1 year earlier, at a salary differential of \$50,000 plus fringes. The cost reduction would be \$.94 mil.

**The net cost to Columbia is hence between \$1.26 mil/yr (low retirement scenario) and an actual positive gain of \$2.82/yr (high retirement scenario.) We use the intermediate number, a gain of about \$0.8 mil/year.**

Funding sources: Columbia University Retiree Medical and Life Insurance Trust Fund, or general budget.

---

## **Plan C -- Matching the NYU Support Level**

## Elements

- NYU's plan provides an HRA of \$3,391 for post-2011 Officers retirees after a 20-year service and upon reaching an age threshold.
- NYU also covers spouses at the same level.
- The HRA can be spent on any medical expense, and is administered by Via

## Cost

\$3,391/yr times an estimated 2,700 takers (out of 3,000 retirees) = \$9.1 mil x 1.5 for spouse (1/2 of retirees cover spouses) = \$13.7 mil.

Catastrophic drug support (only needed until 2025): \$.069 mil

Total Cost: \$13.8 mil

Legacy Cost in 2022: 650 plan participants @\$72/mo = Total \$.56mil

**Incremental cost of new 2024 Plan C over 2022 plan: \$13.7 mil**

## Cost saving to Columbia:

Assume that the higher HRA will double the retirement effect of Plan B.

High scenario: 20% of retirees retire on average 2.5 ys earlier, and with a salary differential vs newly hired young officers of \$100K, plus .34 fringes, the cost reduction is \$10.04 mil.

Low scenario: 10% of retirees retire on average 1 year earlier, at a salary differential of \$50,000. The cost reduction is \$1.9 mil.

**The net cost to Columbia is hence between \$11.8 mil/yr (low retirement scenario) and \$3.65 mil/yr (high retirement scenario.). We choose the intermediate point, \$7.7 mil. If spousal coverage is reduced to ½ rather than full, total cost would be \$5.4mil/yr.**

Funding sources: Columbia University Retiree Medical and Life Insurance Trust Fund, or general budget.

To summarize:

## Estimated Cost of Plans per Year

---

**Plan A: Restoration to 2011 Levels, for all, with a Point System. Approximate support level for retiree: \$150/mo. Total net cost: \$3 mil**



***Plan B: Restoration to 2022 Level, for all. Support level for retiree: \$72. Total net cost: a cost saving of \$0.8 mil***

***Plan C: Matching NYU Plan. Support level for individual: \$280. Total net cost: \$7.7 mil***

## **Proposed Process**

As stated repeatedly, some of these numbers are back-of-the envelope estimates. They could be easily made into hard numbers by the University providing them. But even where the numbers and their analysis are improved -- as they surely can be -- this will not change the big picture.

EPIC, the Administration, the CURML Trustees, the University's consultants, and the University Senate's relevant committees (most notably those of Budget, of Benefits, of Faculty Affairs, and of Research Officers), as well as the Policy and Planning Committee of the Faculty of Arts and Sciences, and others affected by this issue, should engage soon in respectful discussions about how to improve the new system. There should also be meetings of the CURML Trustees with the retiree community. We are an academic community and not an adversarial set of stakeholders who can deal with each other only through lawyers or unions. The University officials are Officers themselves and hence sensitive to these issues, and they have the best interest of the institution in mind. There is no need to engage in an antagonistic process when it comes to seeking practical solutions to improve a new but imperfect plan.

## **Outlook**

The proposed plan might cost \$4.56 million but it is a tiny amount in comparison to the University's 2022 operating budget of \$5.5 billion, and it would come from a segmented and earmarked Trust Fund, not the general budget. Basically, we would go back to the contribution level that existed in 2011, plus a differentiation by income, and with minor tweaks. It is a fair and reasonable proposal.

As our analysis has shown, our peers among universities do more for their retirees than Columbia. **At Columbia, for a retiree with 20 years of service and a spouse, the annual subsidy is \$330. At Harvard, it is \$9,744, almost 30 times as high.**

Given that there are thousands of institutions of higher learning, no doubt one can find some that do less than Columbia. But this is not an argument for a university community that prides itself on leadership. And on top of it, Columbia is in a relatively exceptional situation insofar as it has an already funded, use-directed, and ample Trust Fund to draw upon, rather than having to cover everything from current and tight budgets.

Especially given the existence of that Trust Fund, the plan is affordable, it incentivizes retirements and thus raises opportunities for younger officers, and it meets the obligations of the fiduciary of a Trust Fund. The University's position is that the Trust Fund is a common pool, and as long as it is used for *some* retirees it is within its rights and can act with its own

discretion. The Fund's Trustees can going amend the Trust document. But is this the right thing to do? Is it justified to keep 80-year-olds who have given Columbia the proverbial best years of their lives, and who face very high medical premiums, while there is a pool of money specifically created to benefit them and which supports another category of employees while still growing in asset value? Is there any other significant Columbia benefit that has been cut by 95%, while its real cost has risen far beyond inflation? That this was done in the past to the frailest and least vocal members of the community, even if unintentionally, only puts the responsibility on us to do better today.

# Appendices

## Appendix A: A Sketch of the American Old-Age Medical Insurance System

This section can be skipped by all those with a full grasp on the American system of old-age medical insurance, an admittedly small group.

Most active employees believe that their current cost of medical coverage will be similar in retirement as it had been before, and that Medicare would take up where Columbia's plans for active employees left them. This is not so.

The main safety net for old age medical coverage is the governmental Medicare system. There is also Medicaid, which adds coverage for the blind, disabled, or poor, on top of Medicare. "Original Medicare" consists of Part A (hospitalization) and Part B (doctors' offices, etc.) It covers 80% of expenses after deductibles and coinsurance. The remaining 20% liability and other fees explains the need for supplemental coverage. Also, Medicare does not cover certain items, such as dentures, hearing aids, eyeglasses, long term care, and preventative health programs. It has other limitations such as ceilings on the payment for various procedures.

Medicare is not free. Part B requires a monthly payment that is graduated by income, ranging from a basic \$170 to \$578 per month.

To deal with the limitations in governmental coverage, which can add up to substantial fees, there are private "Medigap" insurance providers. They offer various packages of coverage. In 2020, the [average Medigap premium](#) was about \$138 per month, but there were multiple different types at different prices. To protect consumers and enable price comparison, the various types of Medigap plans are standardized into Types A-N.

For medications there are also "Part D" plans, also offered by numerous insurance companies. In 2022, the average monthly premium for a stand-alone Part D plan was \$44, nationally.

Unsurprisingly, New York prices are higher.

An important variation of this system are "Part C" ("Medicare Advantage") private insurance plans that offer some or all of Parts A, B, and D in one package. In return for covering the government's Part A and B obligations, the federal government pays these companies over \$1,000 per month in 'capitation fees' for each enrolled individual. The companies often add services such as drug coverage, hearing aids, or wellness programs. By regulation, there is a ceiling on annual out-of-pocket expenses. But Medigap insurers are [prohibited from selling policies](#) (that would cover such out-of-pocket costs) to those with Medicare Advantage plans.

Medicare Advantage provision is a competitive and apparently lucrative business, given that the average number of plans available per county is 39.

There is no free lunch. The lowering of overall cost is accomplished primarily by reducing the choice of doctors and access to them, in comparison to Original Medicare. Most Medicare Advantage plans are either HMOs, which cover only care that is provided by in-network doctors, hospitals, and other health providers (often within a limited region), or by PPOs, which are less restrictive and also cover out-of-network providers but at a lower rate than in-network providers. There are also limitations on access to specialists. One must typically get prior approval, or authorization, for coverage of some treatments or services. There are also limitations on foreign coverage. And apparently, denials of coverage are higher than for Original Medicare. There are also hybrids between HMOs and PPOs, known as HMO-POSs.

There are co-pays for medical services such as doctor visits, lab-work, hospital stays, surgeries, durable medical equipment, diagnostic imaging, etc. Those payments can add up, but some people – especially those with good health and less needs for care-- prefer the lower monthly premium. There are services where one must assume an out-of-pocket 20% co-payment, as is the case frequently for chemotherapy, and, as mentioned, getting a supplementary medigap plan to protect against such contingencies is not permitted. Depending on the plan and its price, there are ceilings on the out-of-pocket cost, which vary between zero and almost \$8,000.

According to *Investopedia*, “Since Medicare Advantage Plans can’t pick their customers (they must accept any Medicare-eligible participant), they discourage people who are sick by the way they structure their copays and deductibles. Many enrollees have been hit with unexpected costs and denial of benefits for various types of care deemed not medically necessary.” Thus, as *Consumer Reports* describes, “a recent Kaiser study found that about half of all Medicare Advantage enrollees would end up paying more than those in traditional Medicare for a seven-day hospital stay.”

The average premium for a Medicare Advantage plan that includes Part D coverage in 2022 was \$19 per month. Many plans cost nothing, others go up to \$100 or more. And one must also pay the regular Medicare Part B premium to the government. This is typically accomplished by an automatic deduction from Social Security benefits.

In 2021, [43 percent of Medicare beneficiaries](#) were enrolled in such Medicare Advantage plans.

For retirees, the choice between traditional Medicare and a Medicare Advantage plan, between individual Medicare Advantage plans, and for Medigap and prescription drug programs can be [frustrating, complex and confusing](#).<sup>17</sup> To assist them in their choice there are State Health Insurance Assistance Program (SHIP), brokers and exchanges, HR departments, and private and nonprofit organizations. There is a rating system run by the governmental CMS agency. It rates Medicare Advantage plans based on more than 40 quality measures. In 2021, 80 percent of enrollees were in plans with an overall quality rating of four or more stars out of five stars.<sup>8</sup>

For low-income retirees there is also *Medicaid*, a Federal/State insurance program for various categories of people in need. In New York, the income ceiling for an individual to be eligible is \$18,075. One can be “dual-eligible” for both Medicare and Medicaid. For example, Medicaid may cover expenses not reimbursed by Medicare such as home care. Military veterans also have some medical coverage.

## Appendix B: Table 2: Health Insurance Plans Offered on the Via Exchange, and their Market Price

### 1. Medicare Advantage Plans with Prescription Drug Coverage— Monthly Premium

	VIA Price	Market Price	Price Difference
Empire MediBlue HealthPlus Select (HMO) H1732-007	\$0	\$0	\$0
Cigna True Choice Medicare (PPO) H7849-082	\$0	\$0	\$0
Wellcare No Premium (HMO) H4868-019	\$0	\$0	\$0
Wellcare No Premium Open (PPO) H0088-003	\$0	\$0	\$0
Wellcare Giveback Open (PPO) H0088-002	\$0	\$0	\$0
Wellcare Assist (HMO) H4868-016	\$16.90	\$16.90	\$0
UHC/AARP Medicare Advantage Mosaic Choice (PPO) H3418-001	\$0	\$0	\$0
UHC/AARP Medicare Advantage Prime (HMO-POS) H3307-015	\$0	\$0	\$0
UHC/AARP Medicare Advantage Plan 2 (HMO-POS) H3379-001	\$34	\$34	\$0
UHC/AARP Medicare Advantage Plan 1 (HMO-POS) H3307-002	\$52	\$52	\$0

HumanaChoice H5970-024 (PPO)	\$0	\$0	\$0
Humana Gold Plus H3533-032 (HMO)	\$23	\$23	\$0
Humana Gold Plus H3533-027 (HMO)	\$0	\$0	\$0
Aetna Medicare Value Plan (HMO) H3312-072	\$0	\$0	\$0
Aetna Medicare Discover Value Plan (PPO) H5521-312	\$30	\$30	\$0
Aetna Medicare Elite Plan (PPO) H5521- 120	\$0	\$0	\$0
Aetna Medicare Elite Plan 3 (PPO) H5521- 310	\$23	\$23	\$0
Aetna Medicare Premier Plan (PPO) H5521-040	\$97	\$97	\$0

## 2. Medicare Advantage Plans without Prescription Drug Coverage—Monthly Premium

	VIA Price	Market Price	Price Difference
Cigna True Choice Courage Medicare (PPO) H7849-086	\$0	\$0	\$0
UHC/AARP Medicare Advantage Patriot (HMO-POS) H3307- 018	\$0	\$0	\$0
Humana Honor (PPO) H5970-016-000	\$0	\$0	\$0
Aetna Medicare Eagle Plan (PPO) H5521-320	\$0	\$0	\$0

### 3. Medigap Plans—Monthly Premium

	Via Price	Market Price	Price Difference
<b>Plan A</b>			
Empire Blue Cross Blue Shield Plan A	\$179	\$179	\$0
UHC/AARP Medicare Supplement Plan A	\$188.50	\$188.50	\$0
Humana Medicare Supplement Plan A	\$321.19	\$321.19	\$0
<b>Plan B</b>			
Empire Blue Cross Blue Shield Plan B	\$241.11	\$241.11	\$0
Humana Medicare Supplement Plan B	\$363.61	\$363.61	\$0
<b>Plan C</b>			
UHC/AARP Medicare Supplement Plan C	\$332.25	\$332.25	\$0
Humana Medicare Supplement Plan C	\$439.46	\$439.46	\$0
<b>Plan F</b>			
Empire Blue Cross Blue Shield Plan F	\$337.83	\$337.83	\$0
UHC/AARP Medicare Supplement Plan F	\$320	\$320	\$0
Humana Medicare Supplement Plan F	\$448.38	\$448.38	\$0
<b>Plan F High Deductible</b>			
Humana Medicare Supplement High Deductible Plan F	\$93.09	\$93.09	\$0
<b>Plan G</b>			
UHC/AARP Medicare Supplement Plan G	\$280.25	\$280.25	\$0
<b>Plan N</b>			
Empire Blue Cross Blue Shield Plan N	\$207.60	\$207.60	\$0
UHC/ AARP Medicare Supplement Plan N	\$211.25	\$211.25	\$0
Humana Medicare Supplement Plan N	\$284.05	\$284.05	\$0
<b>Plan K</b>			



UHC/AARP Medicare Supplement Plan K	\$88	\$88	\$0
Humana Medicare Supplement Plan K	\$209.34	\$209.34	\$0
<b>Plan L</b>			
UHC/AARP Medicare Supplement Plan L	\$182.75	\$182.75	\$0
Humana Medicare Supplement Plan L	\$298.98	\$298.98	\$0

\*\*\*Humana Medigap Supplement Market Prices are provided only by call-back, which was requested repeatedly but did not happen.

# Appendix C: The Aging of the Columbia Faculty

## Change in Age Profile of Full-time Tenured Faculty, 1990 to 2010

### Change in Age Profile of Full-Time Tenured Faculty, 1990 to 2010

Age	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<55	347	360	360	353	348	349	359	364	373	385	398	385	368	353	369	369	371	384	405	413	404
55	19	11	26	27	25	22	24	20	35	16	14	38	33	22	26	30	31	34	32	28	35
56	15	19	10	26	27	23	22	24	19	34	15	15	38	32	22	25	31	34	35	31	28
57	26	15	19	11	26	28	22	23	23	20	34	15	16	38	33	24	25	33	35	34	33
58	27	25	16	19	11	26	28	21	23	25	19	34	15	15	38	33	24	26	34	35	34
59	37	28	24	15	18	11	27	28	22	23	25	18	36	15	14	38	31	28	28	33	36
60	28	36	27	24	16	18	11	27	29	23	23	27	18	36	15	13	38	35	29	29	32
61	25	28	36	27	24	17	17	11	24	27	22	20	28	16	36	16	15	38	34	29	29
62	30	25	28	34	27	24	18	17	11	24	27	21	21	28	16	36	17	16	37	34	31
63	22	28	25	28	33	25	23	16	17	10	24	27	20	22	28	15	36	16	16	40	33
64	19	20	26	20	26	30	24	21	16	14	9	23	26	20	24	28	14	34	15	16	39
65	25	16	18	24	19	26	28	24	22	15	14	9	22	24	20	25	28	15	33	15	16
66	24	24	14	16	22	19	26	27	19	21	14	14	9	22	24	20	24	28	15	30	15
67	19	21	22	14	13	22	17	26	26	19	20	12	14	9	20	21	19	22	28	16	30
68	15	18	18	19	13	10	21	16	25	24	15	19	12	13	8	20	22	19	21	26	15
69	7	1	6	14	17	11	10	19	13	22	20	15	17	11	11	5	18	19	19	21	25
70		1																			
71					11	13	8	10	19	10	19	20	11	16	10	9	5	16	17	18	19
72						10	11	6	10	16	7	17	19	10	13	9	8	5	16	14	17
73							8	11	5	9	16	6	15	15	9	11	9	7	4	15	13
74								8	9	5	9	16	5	12	12	7	11	9	7	4	13
75									6	8	4	9	16	4	10	11	7	10	8	7	4
76										5	7	4	8	13	3	10	11	6	9	8	7
77				1							5	6	4	8	9	2	9	9	6	9	8
78					1							5	5	3	7	8	2	9	9	4	8
79													5	4	2	7	6	2	7	7	4
80														3	4	2	6	6	1	5	6
81															3	3	2	6	6	1	4
82																2	2	2	6	4	1
83																	1	2	2	5	2
84																		2	2	1	5
85																			2	1	1
86																				2	1
Grand Total	685	676	675	672	677	684	704	719	746	755	760	775	781	764	786	799	823	872	918	935	950
Total 55 to 86	338	316	315	319	329	335	345	355	373	370	362	390	413	411	417	430	452	488	513	522	546
% of Grand Total	49%	47%	47%	47%	49%	49%	49%	49%	50%	49%	48%	50%	53%	54%	53%	54%	55%	56%	56%	56%	57%

Age Group	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<55	347	360	360	353	348	349	359	364	373	385	398	385	368	353	369	369	371	384	405	413	404
55 to 64	248	235	237	231	233	224	216	208	219	216	212	238	251	244	252	258	262	294	295	309	330
65 to 69	90	80	78	87	84	88	102	112	105	101	83	69	74	79	83	91	111	103	116	108	101
70 to 74	0	1	0	0	11	23	27	35	49	48	55	68	66	57	54	47	40	47	52	58	66
>74	0	0	0	1	1	0	0	0	0	5	12	15	22	31	28	34	39	44	50	47	49
Grand Total	685	676	675	672	677	684	704	719	746	755	760	775	781	764	786	799	823	872	918	935	950

% of Grand Total	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<55	51%	53%	53%	53%	51%	51%	51%	51%	50%	51%	52%	50%	47%	46%	47%	46%	45%	44%	44%	44%	43%
55 to 64	36%	35%	35%	34%	34%	33%	31%	29%	29%	29%	28%	31%	32%	32%	32%	32%	32%	34%	32%	33%	35%
65 to 69	13%	12%	12%	13%	12%	13%	14%	16%	14%	13%	11%	9%	9%	10%	11%	11%	13%	12%	13%	12%	11%
70 to 74	0%	0%	0%	0%	2%	3%	4%	5%	7%	6%	7%	9%	8%	7%	7%	6%	5%	5%	6%	6%	7%
>74	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	2%	2%	3%	4%	4%	4%	5%	5%	5%	5%	5%

Source: Columbia University, Provost's Working Group on Faculty Retirement, Final Report, December 2012

## Appendix D: Allocation of CURML Trust Fund Assets

One way to allocate the CURML Trust Fund assets is to quantify for whose contingent liability the assets in the funds have been created. The following table looks at the two employee categories, and at the fund as a contingency against the liability of future claims.

**Table 3: Shares in Trust Fund Claims**

	Total Employees (1)	Share of Employees (2)	Share of 2021 Trust Fund on Per-Capita Basis (3)	# of Cohorts (est.) (4)	Member of Cohort (est.) (5)	Eligible for Plan (est.) (6)	% sign-up (PwC assumption) (7)	# in plan per cohort per PwC assmpt.(8)
Officers	15,255	82.2%	\$213,048,124	40	381	286	40%	114
Staff	3,313	17.8%	\$46,134,509	39	85	64	82.5%	53
Ratio	4.6	4.6	4.6	1.05	4.5	4.5	0.48	2.2

**Cont.**

	Avg. Retirement Age (9)	Life Expectancy at Retirement (10)	# of Covered Retirement Years (11)	% Covered Years (12)	Share of 2021 Trust Assets, based on covered years (13)	Average Per Capita Claim (14)	Avg. Per Capita Claim * # of Participants (15)	% of Claims Overall (16)	Allocation of Assets Weighted by Contingent Claims (17)
Officers	65	19.5	2,223	67.7%	\$176 mil	\$6,291	\$13,984,893	85.1%	\$221.3 mil
Staff	64	20	1,060	32.3%	\$84 mil	\$2,318	\$2,457,080	14.9%	\$38.7 mil
Ratio			2.1	2.1	2.1	2.7	5.7	5.7	5.7

The first column 1 shows the total number of individuals on the payroll. There are 4.6 times as many Officers as Support Staff. The second column shows the shares of these employee categories, with the Officers accounting for 82.2%. The third column translates this share into a share of the overall Trust Fund in 2021, if it were allocated on a per-employee basis.

Columns 4 and 5 adjust for retirement age and length of service.<sup>182</sup> The next columns try to capture the potential liability associated with the actual categories of employees, and against which the Trust Fund is the backstop. (The actual actuarial projections are more sophisticated, but for purposes of this discussion, the simpler projections are adequate for orders of magnitude.) Column 7 shows the sign-up rate for the Columbia plans, as part of contingency calculation reported by PwC. These rates are, respectively, 82.5% and 40%.<sup>183</sup>

According to these assumptions, Support Staff employees sign up at more than twice the rate of Officers since their medical coverage is fully paid for. This, adjusted for slightly different average ages at initial hiring and at retirement, then translates into an annual cohort of participants in the insurance pool Column 8. For Officers, it means 114 sign-ups, and for Support Staff, 53. The ratio of participants is 2.2. Adjusting for life expectancies, one gets an expected number of years of insured health coverage (Column 11) that is 67.7% vs 32.3%, i.e., a ratio of 2.1.

A further important adjustment is needed. As mentioned, the pool of retired officers that stay in the Columbia plans is a high-cost population. Its annual per capita claims are, by the filed PwC numbers, \$6,291. This contrasts to the healthier Staff pool, whose average annual claims per capita are \$2,318. Thus, the total claims for each of the two groups are, respectively, \$13,984,893 vs. \$2,457,080, for a ratio of 5.7. (Column 1). These are the expected claims listed by PwC in 2021 against which contingency assets of \$260.2 million were held. These shares (85.1% vs 14.9%) are then applied to allocate the respective shares of the total assets held in the Trust Fund to deal with these contingencies.

This calculation then yields contingency assets of **\$221.3 million** for the officer pool. (Column 17.) This is a considerable number. It is the result of the underlying officer population being much larger, and those who choose the Columbia plan to be much sicker. This more than offsets the staff's much higher sign-up rate and slightly longer life expectancy at retirement.

The alternative is the allocation on a per-capita basis, which imputed a share of \$213 million, which is almost the same amount.

These calculations do not aim to be definitive, but to sketch orders of magnitude. A professional actuary might possibly come to lower numbers<sup>184</sup> but they would still be high.

---

<sup>182</sup> Employee numbers are aggregated into cohorts, based on estimated hiring and retirement ages of the number of employees at any given time. For Officers, this is an annual cohort of 38, and for Support Staff, 85. We assume that at retirement age, of each cohort as it retires, 75% have earned a retirement benefits eligibility.

<sup>183</sup> Note that these numbers do not necessarily track reality. But they do track the assumptions used by the University and its advisors to calculate the required contingency funds to cover possible liabilities, which is what counts in legal terms. Previously, the projections for the take rate of Officers were much higher. Until 2013, the participation rate for Officers was assumed by PwC, in its IRS filing, to be 75%, before it was dropped down to 40%. If we chose the earlier number the end result would be still further affected in the direction of the Officers.

<sup>184</sup> For example, a more sophisticated approach would recalculate life expectancy each year.

## Appendix E: Table 6: Income Return on Total Assets

	Total Assets (End of Year)	Investment Income (Dividends, Interest, etc.)*	Net Realized Capital Gains	Total Investment Income*(Dividends, Interest, Realized Capital gains)	Income Return on Assets (Total Investment Income/Total Assets)
<b>2001</b>	50,008,339	<b>1,290,219</b>	<b>171,989</b>	1,462,208	<b>2.92%</b>
<b>2002</b>	53,262,818	<b>1,338,193</b>	<b>294,779</b>	1,632,972	<b>3.07%</b>
<b>2003</b>	62,691,493	<b>1,776,242</b>	<b>670,245</b>	2,446,487	<b>3.90%</b>
<b>2004</b>	81,374,181	<b>1,993,328</b>	<b>501,189</b>	2,494,517	<b>3.07%</b>
<b>2005</b>	94,755,785	<b>3,132,772</b>	<b>919,053</b>	4,051,825	<b>4.28%</b>
<b>2006</b>	109,908,751	<b>2,638,191</b>		2,638,191	<b>2.40%</b>
<b>2007</b>	132,655,607	<b>3,282,737</b>		3,282,737	<b>2.47%</b>
<b>2008</b>	112,182,418	<b>3,276,314</b>		3,276,314	<b>2.92%</b>
<b>2009</b>	90,382,217	<b>2,629,455</b>	<b>-2,346,960</b>	282,495	<b>0.31%</b>
<b>2010</b>	106,792,238	<b>1,811,443</b>	<b>597,768</b>	2,409,211	<b>2.26%</b>
<b>2011</b>	132,111,584	<b>2,872,642</b>	<b>1,643,630</b>	4,516,272	<b>3.42%</b>
<b>2012</b>	132,187,993	<b>1,485,246</b>	<b>2,444,540</b>	3,929,786	<b>2.97%</b>
<b>2013</b>	143,219,246	3,508,872*	<b>3,387,971</b>	6,896,843	<b>4.82%</b>
<b>2014</b>	169,597,630	4,155,142*	<b>4,850,118</b>	9,005,260	<b>5.31%</b>
<b>2015</b>	172,982,642	4,238,075*	<b>5,388,370</b>	9,626,445	<b>5.56%</b>
<b>2016</b>	171,431,662	4,200,076*	<b>4,694,348</b>	8,894,424	<b>5.19%</b>
<b>2017</b>	191,862,465	4,700,630*	<b>3,510,851</b>	8,211,481	<b>4.28%</b>
<b>2018</b>	200,629,721	4,915,428*	<b>74,133,450</b>	79,048,878	<b>39.40%</b>
<b>2019</b>	211,119,237	5,172,421*	<b>3,015,603</b>	8,188,024	<b>3.88%</b>
<b>2020</b>	211,562,684	5,183,286*	<b>5,305,522</b>	10,488,808	<b>4.96%</b>
<b>2021</b>	259,182,632	6,349,974*	<b>9,064,733</b>	15,414,708	<b>5.95%</b>
<b>Avg.</b>	137,614,350	3,330,985	<b>5,630,819</b>	5,4576,450 [excluding 2018]	<b>3.79 (Excluding 2018)</b>

\*2013-2021 Investment Income (Dividends, Interest, etc.) were not listed in Columbia's filings, and were estimated for this table by averaging the Investment Income/Total Assets for 2001-2012 (2.45%) and applying it to the Total Assets for the years 2013-2021.

## Appendix F: Table 7—Investment Gains

	Net Investment Gain (from Columbia filings)	Return on Asset [Net Investment Gain / Total Assets preceding year]	S&P 500 Percentage Change (Mid-Year)	Columbia Return on Endowment <sup>185</sup>
<b>2009</b>	-24,427,700	-21.77%	-25.57%	-21%
<b>2010</b>	8,951,706	9.90%	15.39%	17.3%
<b>2011</b>	22,245,512	20.83%	22.73%	23.60%
<b>2012</b>	4,893,441	3.70%	2.61%	2.30%
<b>2013</b>	18,294,655	13.84%	22.72%	11.50%
<b>2014</b>	27,171,056	18.97%	18.24%	17.50%
<b>2015</b>	6,697,719	3.95%	6.14%	7.60%
<b>2016</b>	3,757,591	2.17%	2.62%	-0.90%
<b>2017</b>	22,930,482	13.38%	14.20%	13.70%
<b>2018</b>	14,591,857	7.61%	13.84%	9%
<b>2019</b>	14,705,788	7.33%	7.25%	3.80%
<b>2020</b>	5,737,581	2.72%	7.06%	5.50%
<b>2021</b>	54,525,235	25.77%	36.04%	32.30%
<b>Averages</b>	<b>\$13,851,235</b>	<b>8.34%</b>	<b>11.02%</b>	<b>9.40%</b>

<sup>185</sup> Jechinger, John. "Columbia Endowment Falls 21%." *Wall Street Journal*. September 12, 2009. <https://www.wsj.com/articles/SB125268835271803725>; Fabrikant, Geraldine. "Columbia's Endowment Posts 17% Return." *New York Times*. September 15, 2010. <https://www.nytimes.com/2010/09/16/business/16columbia.html>; Barth, Chris. "Columbia Endowment Performance Tops Ivey League for Second Straight Year." *Forbes*. October 18, 2011. <https://www.forbes.com/sites/chrisbarth/2011/10/19/columbia-endowment-performance-top-ivy-league-for-second-straight-year/>; Columbia News Staff. "Endowment Investments Earn 2.3 Percent Return in 2012, Capping Decade of Above Market Growth." *Columbia News*. October 14, 2012. <https://news.columbia.edu/news/endowment-investments-earn-23-percent-return-2012-capping-decade-above-market-growth>; Hornsby, Robert. "Columbia's Endowment Investments Generate 11.5 Percent Return in Fiscal 2013, Continue Leading 5- and 10-year Performance." *Columbia News*. October 10, 2013. <https://news.columbia.edu/news/columbias-endowment-investments-generate-115-percent-return-fiscal-2013-continue-leading-5-and>; Fabrikant, Geraldine. "Columbia University Reports 17.5% Return on Endowment." *New York Times*. October 1, 2014. <https://www.nytimes.com/2014/10/02/business/columbia-university-reports-17-5-return-on-endowment.html>; Lorin, Janet. "Columbia University's Endowment Posts 7.6% Investment Return." *Bloomberg*. October 14, 2015. <https://www.bloomberg.com/news/articles/2015-10-14/columbia-university-s-endowment-posts-7-6-investment-return>; Columbia News. "Columbia Endowment Investments Return a Negative .9 Percent in Fiscal 2016." October 5, 2016. <https://news.columbia.edu/news/columbia-endowment-investments-return-negative-9-percent-fiscal-2016>; Katz, Michael. "Columbia Endowment Reports 9.0% Return for 2018." *Chief Investment Officer*. October 12, 2018. <https://www.ai-cio.com/news/columbia-endowment-reports-9-0-return-2018/>; Steyer, Robert. "Columbia endowment returns 5.5% for fiscal year." *Pensions & Investments*. October 7, 2020. <https://www.pionline.com/endowments-and-foundations/columbia-endowment-returns-55-fiscal-year>; and Columbia Finance. "IMC CEO Statement on FY21 Endowment Returns." October 21, 2021. <https://www.finance.columbia.edu/content/imc-ceo-statement-fy21-endowment-returns>.