Resuscitating Retirement Medical Insurance at Columbia

A Public Report with Recommendations

Eli Noam

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I. Introduction

Executive Summary

The 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. And there is a general unfamiliarity with the series of gradual decisions over the years which have 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 why 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 a plan 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. 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."[1] And a national survey of HR officers found 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."[2]

   To counteract the graying of its researchers and teachers, Columbia instituted several incentives for voluntary retirement. 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. And that means a 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, continuous 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 $8.6K - $13.5K (including income taxes.) For a couple, these numbers approximately double just as they stop earning a salary.

3. Over the years, Columbia's retiree medical coverage has changed significantly, something that is not well understood. The changes, taken together, have considerably 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. This generates major disincentives to retire.

[1] Columbia University, Provost's Working Group on Faculty Retirement, Final Report, December 2012.

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

4. In an abrupt communication in late 2022, the University ended medical plans for all Officers – a system that has existed for decades. New retirees will receive a tiny contribution ($18.33 per month, plus $9.17 for a spouse), while for current retirees, eligibility for that amount goes only to the small and shrinking number of grandfathered participants, whose current support was now cut by 75%. (For those who retired before 2011, the numbers are $36.66 and $18.34)

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

   Also by way of comparison, the support levels provided by peer institutions to their retirees are higher, and often substantially so. For a current retired Office with 20 years of service and a spouse, Columbia contributes $330. Harvard contributes $9,744. Harvard contributes 80% of medical insurance, while Columbia covers 4.2% of high-end plans comparable to its old ones. Harvard provides spouses with equal coverage, while Columbia offers them only one half of an already much smaller number. And in 2023, Harvard provides its support to almost all of its retired Officers while Columbia extends it to only about 22% of current retirees.

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.

   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 available on public and private websites. That contribution is valuable if done with sufficient resources, with advisors familiar with the Columbia transition, and without incentives to recommend high-priced plans.

6. However, there are several major structural problems. In particular, there are no alternative Medicare exchanges available to retirees if they wish to remain within the residual Columbia subsidy system. Having alternative service providers could :
   - protect against the potential negatives of the vertical integration of Columbia's service vendor Via, which is owned by Columbia's HR consultant WTW.
   - eliminate for grandfathered retirees the conditionality of receiving the Columbia subsidy, and for all other retirees the catastrophic drug support, in a highly objectionable tie-in based on a retiree's signing up with one company, Via;
   - give retirees options and provide competition in service quality;
   - encourage more diversity in plans offered and incentivize potential 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 individually in the market. There are no cost savings whatsoever.
   - Similarly, there are no additional choices to retirees over what they could already get on their own for years. Indeed, Via does not offer all plans available in the region, several of which are cheaper.
   - Via's business model is based on substantial 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. A more competitive exchange system would help to incentivize Via to offer such discounts.

8. Under the new system, there is no support at all for 78% of a retired Officers, namely those who have left the Columbia plans because they had the foresight to seek private plans that have now become the only option. An equitable system would enable them to return to the Columbia-supported exchange system and to receive the same subsidy as new retirees.

9. An alternative system of support would enable the support of retired Officers to receive the subsidy towards their medical plans *based on a point system* which would account for the retiree and spouse, and provide extra support for those with lower income as officers, for residual catastrophic prescription drug expenses, plus incentives for early retirement.

More fundamental is the funding system.

10. 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 to fund Columbia's support of retirees' medical and life insurance. The Trust pays for subsidies that reduce the cost of insurance.

11. In 2021, the Trust Fund held about $260 million in assets.[3] 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 3% of retiree medical support payments. The purpose and obligation of the Trust is to support all eligible retirees, not a particular arrangement with a particular intermediary company or a particular labor contract.

[3] Figures for 2022 are not available yet at the time of this writing; they are presumably lower, given the downturn in the financial asset markets.

12. Under the new system, 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.

13. This is a continuation of stepwise elimination of Officer retiree medical benefits, from full coverage of retirees in 1993 to a nominal amount now for most of current retirees. This 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 Trust Fund, the elimination of Officer support is not based on a financial emergency but on a unilateral policy decision.

14. The improvements proposed 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 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. 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 towards the level that existed in 2011, 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.

A constructive conversation is needed that engages the University and its consultants, the retiree community, and the University Senate, in a productive collaboration to make the system better and fairer. We all seek to balance retiree equity, budgetary affordability, and institutional rejuvenation. 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.

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 the majority of 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, included those created by the Trust Fund, and to those approaching emeritus 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.)

Although retirement plans benefit most immediately those who have already retired, the majority of the CU Officer community will reach that stage themselves, sooner or later. It is 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.[4]

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, with no bargaining power once they have given their productive years to Columbia, cautious of change, and with only a muted voice in Columbia processes.

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 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 gaps in Medicare coverage. Adding up the numbers, in terms of medical costs it is expensive to retire at 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 covers about 20 years adds up to a substantial amount in current net present value.

[4] For a popular overview, https://www.marieclaire.co.uk/life/how-different-countries-treat-the-elderly-20839

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.

About this Report

The report was prepared entirely using publicly available information. This was not the preferred choice. Going forward, a cooperative information-sharing process would help 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, 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[5].

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.

[5] From EPIC, helpful feedback was received from Roger Bagnall, Peter Messeri, Francoise Simon, Jeanne Stellman, Peter Strauss, and Frank Wolf. Others outside of EPIC contributed, too. Responsibility for this report is mine, however.

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 Columbia employee to a retiree 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.[6]

For *active Officers*, monthly individual medical plans have been administered by Aetna or UHC, at a cost of about $196 for Choice 90, the most popular plan[7]. When these premiums got raised there were loud complaints to the Administration, as has been 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.[8] [9] 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 , the Columbia plan premium payment for Choice 90, plus dental coverage, adds up to only 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% 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

[6] An earlier report on the subject of 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.

[7] 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.

[8] Assuming that they are not old enough for Medicare or poor enough for Medicaid.

[9] Group rates differ from individual rates, affecting the Columbia subsidy . https://www.peoplekeep.com/blog/group-coverage-vs-individual-health-insurance-cost

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.)

An Administrative Coordinator at Grade 9B – the highest Staff grade -- is paid $56.8K per year and would be paying union dues of $94.67 per month and would receive the Choice Plus 90 plan, which also covers their spouse and children.[10]

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, but were not at risk.

In parallel to the four Columbia sponsored plans, there are and have been a large number of 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 "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.[11]

After retirement, there were three basic options, each with several sub-options.[12]

Option 1: Columbia Plans (not available after 2022)[13] **with Medicare**[14]
Total: $972/month, or **$11,664/year**[15]

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[10] The union dues also entitle employees to legal representation in work-related issues, and other benefits.
[11] It is therefore not easy to compare prices.
[12] 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.)
[13] 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 x 12 = $6,574/yr, and for a couple: $13,584.
[14] 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
[15] *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.

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

Option 2: Original Medicare with Medigap[16]
Total: $836/mo., $10,032/year
This option has a relatively limited out-of-pocket expense coverage.

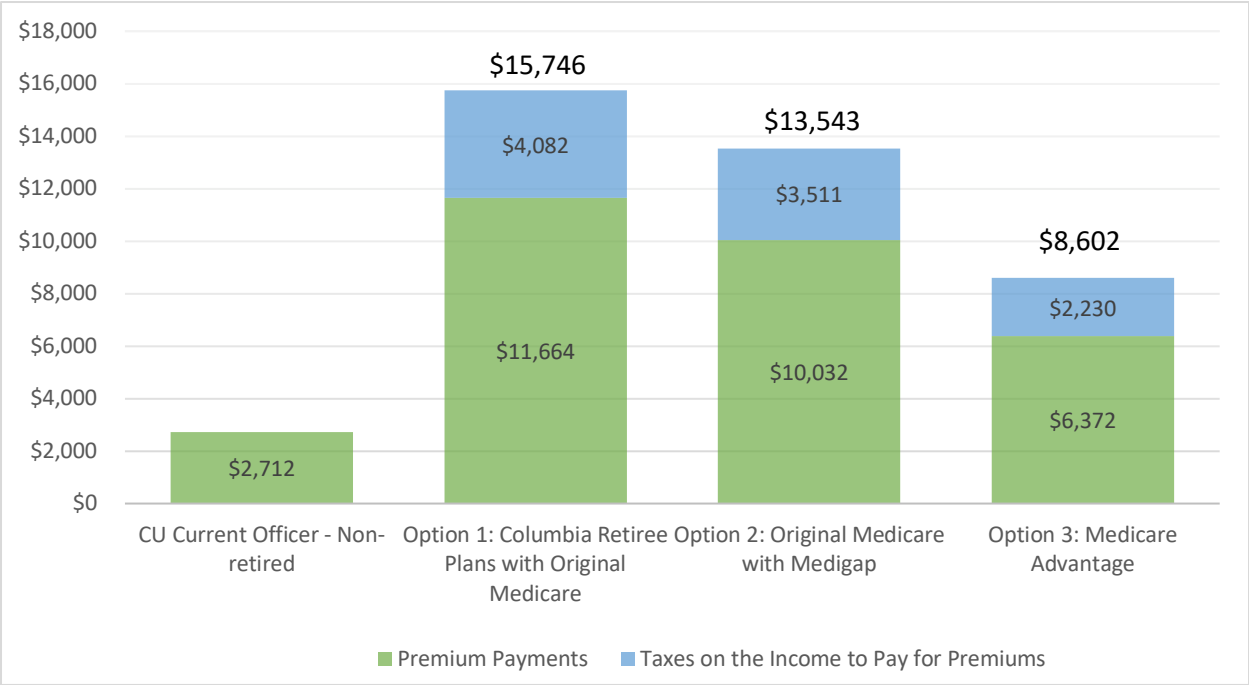
Option 3: Medicare Advantage[17]
Total: $531 per month or $6,372 per year.
This option has larger out-of-pocket expenses and more restrictions on access to doctors

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 an estimated 35% in marginal US, NYS, and NYC tax rates, which accounts for the taxes paid on withdrawal from retirement plans[18] or taxes paid earlier on income that was saved or put into a Roth retirement fund in order 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.[19]

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

-Dental: $30
[16] *Option 2*--Original Medicare - $442
-Medigap - $280
-Part D prescription drugs- $44
-Dental & Vision - $70
[17] *Option 3*-- Medicare payments- $442
Medicare Advantage extra- $19
Dental and Vision - $70

[18] If the withdrawal is from savings outside of 403b plans, taxes would have been paid during the active employment period.
[19] Adding Long Term Care insurance – an option taken by about 7% of people over 50 years of age – adds about another $2,500 to each option.



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

The numbers identify two major discrepancies.

1. ***The cost discrepancy between active and retired Officers.***[20]

For an individual Officer retiring at 65, and who chose the Columbia plans, the annual difference was $8,952. With the taxes considered, the difference is $13,034. With a life expectancy of 20 years,[21] the cumulative cost would add up over those years to $260,680.[22] 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.[23] 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.

[20] All numbers are for 2022 where available; when they are not available, earlier recent numbers are used and typically indicated.
[21] 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.
[22] Not counting general inflation, medical cost inflation, and the time value of money.
[23] Not counting general inflation, medical cost inflation, and the time value of money

An offset is that the retiree does not contribute anymore to Medicare by way of FICA payroll taxes.[24] 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.

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%.)

Given the significant cost difference, most retirees left the Columbia plans. The majority seems to have gone to Original Medicare plus Medigap option.[25] Indeed, why did anyone 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

[24] 1.45% of taxable income, plus 0.9% for incomes above $200K.

[25] 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).

30% or more. Thus, the out-of-pocket for a $6,000/month prescription drug 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 Support Staff. It is unlikely that this is due to Officers in general 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)[26] is categorized as "Support Staff" These employees are typically compensated at a lower rate, and most are represented by one of several labor unions.[27] (Of overall employees, Officers of Instruction account for 24%, their number having grown by 23% in a decade; Officers of Administration, of

[26] 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.

[27] 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.

Libraries, and of Research (no separate breakdown is published) account for 60% of the total, with an absolute growth of 41% over the decade. Support Staff accounts for about 17%,[28] with a growth of less than 3% over the decade.

Table 1: Take Rates of Medical Insurance Plan

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

	Overall Officer-Retirees (est.) (9)	Take Rate of Officer-Retirees on Columbia Plans/ Officer Retirees] (10)	Officer-Retirees on Columbia Plans/Total Active Officers (11)	Support Staff-Retirees on Columbia Plans/ Total Active Support Staff (12)

[28] The University's reported employee count does not add up exactly.

2010				
2011				
2012	2500	30.28%	6.71%	36.87%
2013	2556	30.40%	6.65%	36.24%
2014	2611	28.15%	6.08%	36.07%
2015	2666	26.29%	5.66%	35.60%
2016	2722	25.28%	5.34%	36.28%
2017	2778	25.34%	5.26%	34.05%
2018	2833	23.65%	4.83%	31.71%
2019	2889	23.61%	4.74%	30.46%
2020	2944	22.59%	4.42%	29.96%
2021	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.[29] 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).[30]

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[31] of which we estimate 150 are eligible for retirement benefits.[32]

[29] 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.

[30] 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.

[31] 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.

[32] 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%.

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.*[33]

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 accelerated the out-migration to cheaper outside plans. And the University also 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 is affected, too.)

- The four Columbia-sponsored plans were to be abolished by the end of 2022.
- Instead, an e*xchange* 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, 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). Via Benefits, the operator of the exchange, is a WTW subsidiary.

Analysis Of the New Plan

Positives of the new plan are:

[33] 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.

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 a fairly significant University's 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. Those who are currently enrolled in the Columbia plans are an aging minority which will inevitably shrink to zero.
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.[34][35]
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 will channel an available significant pool of Trust Fund money away from intended beneficiary Officers.

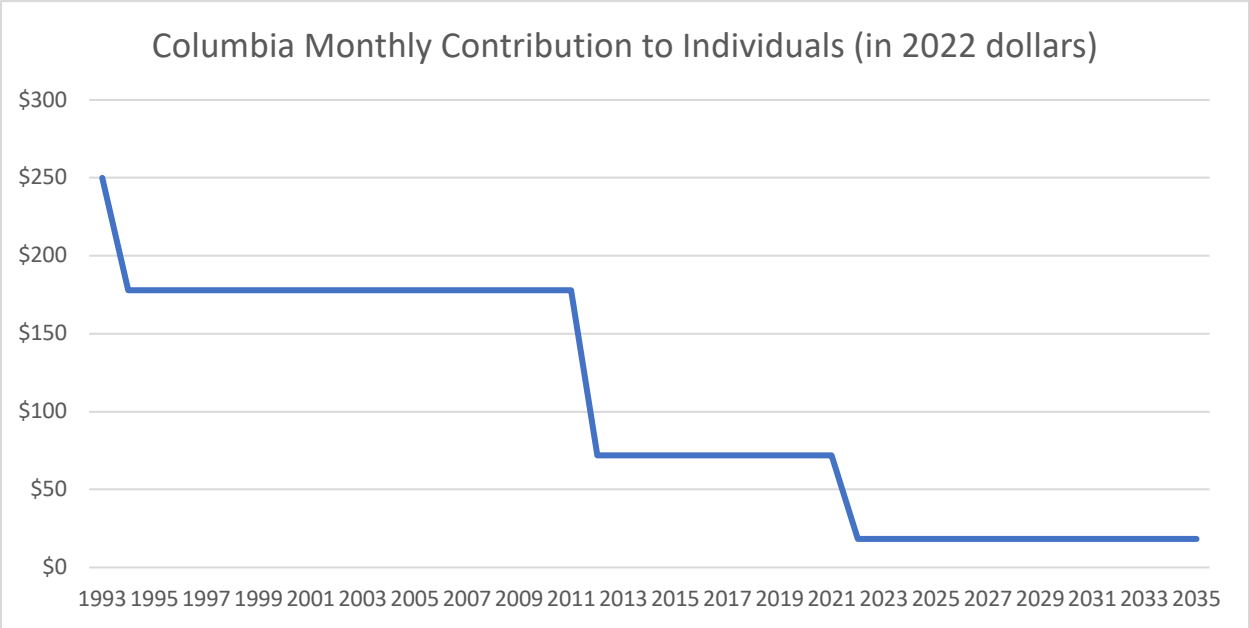
[34] Columbia's support would hence apply only in highly unusual situations such as a retired eligible employee not eligible for such Federal support, as might be the case for non-citizen on a Green Card who has lived in the U.S. for less than 5 years and is hence not eligible yet for Medicare but who 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.

[35] 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."

These issues will be discussed in the following.

The Overall Magnitude of the Contribution to Retirees

Graph 2: Columbia Monthly Contribution to Individuals



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 may call this "Plan #1"). Its value can be estimated as a monthly $160 (or **$250 + $125 for a spouse** in today's money[36].
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.[37] 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). [38] ("Plan #3")

[36] We assume that medical inflation is 2.5% above general inflation.
[37] Benefits were grandfathered for those who already received them.
[38] Benefits were grandfathered for those who already received them.

d. After 2022, the new plan provides an "HRA" (Health Reimbursement Arrangement") **$18.33 + $9.17** ($220 + $110 / year). ("Plan #4").[39]

By these numbers, a retired couple will receive in 2023 $4,170 less of 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 Social Security/Medicare payroll taxes in their active years.[40] 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. 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.

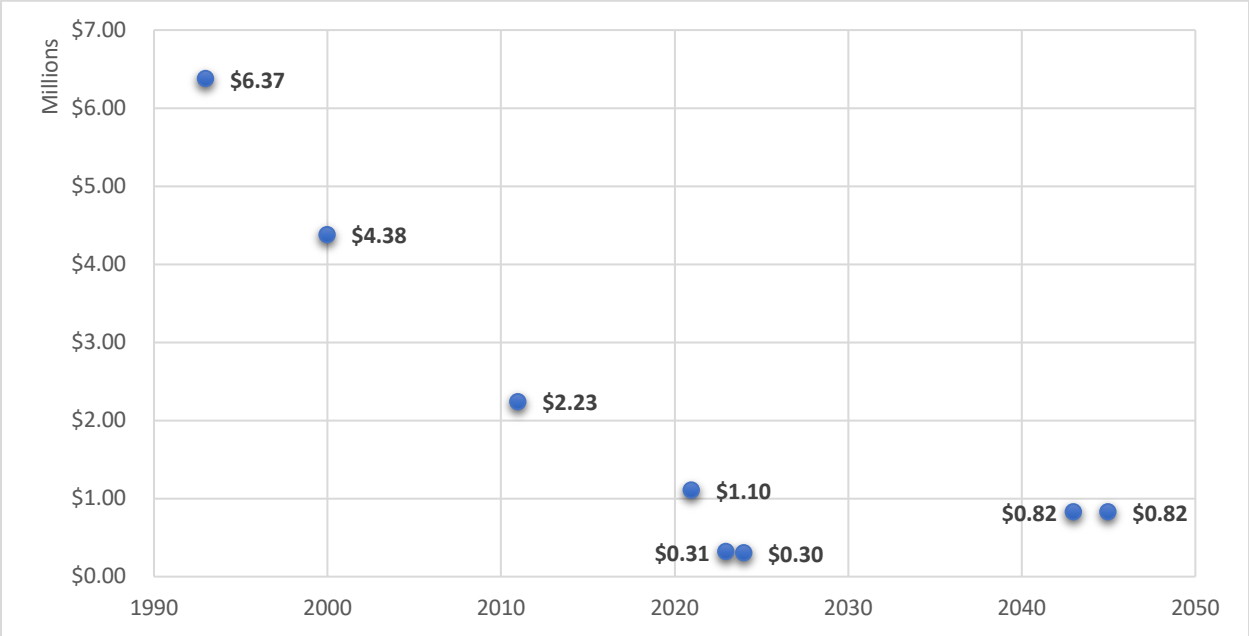
Presumably, a large share of current retired Officers were hired well before 1994, under agreements that provided, in some way, retirement arrangements. When it comes to retirement *savings* benefits such as the 403(b) plans with TIAA or Vanguard, the relevant date is the *hiring date*. But when it comes 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.

[39] 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.

[40] Payments were raised over time, including for higher retiree incomes in 2006, and by the ACA ("Obamacare") in 2010.

Contributions by the University

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



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.[41] 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,[42] and with spousal coverage, $312.[43] 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[44] and each of them received a monthly $144 contribution. In addition, a spouse would receive a $72 contribution. In todays' 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** milion in 2022 dollars.

[41] 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.
[42] We assume medical inflation to be 2.5% above general inflation.
[43] 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.)
[44] 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.

c. In 2011, before the transition to plan #3, there were an estimated 2,444 Officer retirees.[45] An estimated 772 of them chose the Columbia plans.[46] 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 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.[47] 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 Columba'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**[48], 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[49], the number of covered

[45] Extrapolating from the 2012 number in Table1
[46] Extrapolating from the 2012 number in Table1
[47] 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.
[48] 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 x 655 x (1 + (0.5 x 0.5)) x (1 +0.33) = $239,566
[49] We assume for the calculation no expansion in the number of people retiring each year.

retirees would reach 3,000 in 2043, for an overall expense, including spouses[50], of $825,000.

iii. To that must be added the cost of the catastrophic drug coverage, which we calculate, for the next year or two, as $69K[51] and soon near-zero.[52]

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.[53][54]**

g. Even that subsidy, if not regularly adjusted, would decline in actual value since it is not indexed to general rate of inflation (currently 7-9% annually), 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.

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[50] Here as elsewhere in this report, we estimate that half of retirees add a spouse's insurance.

[51] 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.

[52] 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 drug out-of-pocket cost 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.) Once can assume that the number of such cases will be so tiny as to make Columbia contributions a rounding error.

[53] 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.

[54] To that one must add to allow for an expanded number of Officers and a rising life expectancy, but 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.

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."[55]

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.[56] 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 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

[55] 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/

[56] 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.

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.[57] New York and other states list prices and providers, sometimes also by sub-region.[58] 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[59]:

- 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:

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

[57] For Medigap plans, Medicare.gov provides details, lists of available plans with the price, but customers then click to the website of providers

[58] 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

[59] 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."*

market if they switched.[60] This would imply an economic irrationality of 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.[61] [62]

In addition, "cost savings" is a meaningless concept without reference to benefits and service quality. A plan might be cheaper, but if it 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."[63]

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.

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

[60] The small HRA subsidy might affect a small number of plan participants on the margin.

[61] 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.

[62] 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.

[63] 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.

whatever health plans 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 a 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?[64] 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. *Alternative Exchanges*. Perhaps most effective and easiest to operate: give Columbia retirees access to 1-2 additional exchanges. 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 the saying goes for the digital economy, 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

[64]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.*

claims. It provides retirees with information about the options and routes them to the selected insurance company.

For that connection, the insurance companies pay a commission to the exchange. Via is not disclosing this information in its brochure to Columbia retirees, but its general 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."

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[65]:

> "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

[65] 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

> determine the exact compensation level they will pay agents, which can vary by product or contract.[66] 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 or another based on the compensation rather than the beneficiary's need. CMS could consider setting 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)

[66] 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.

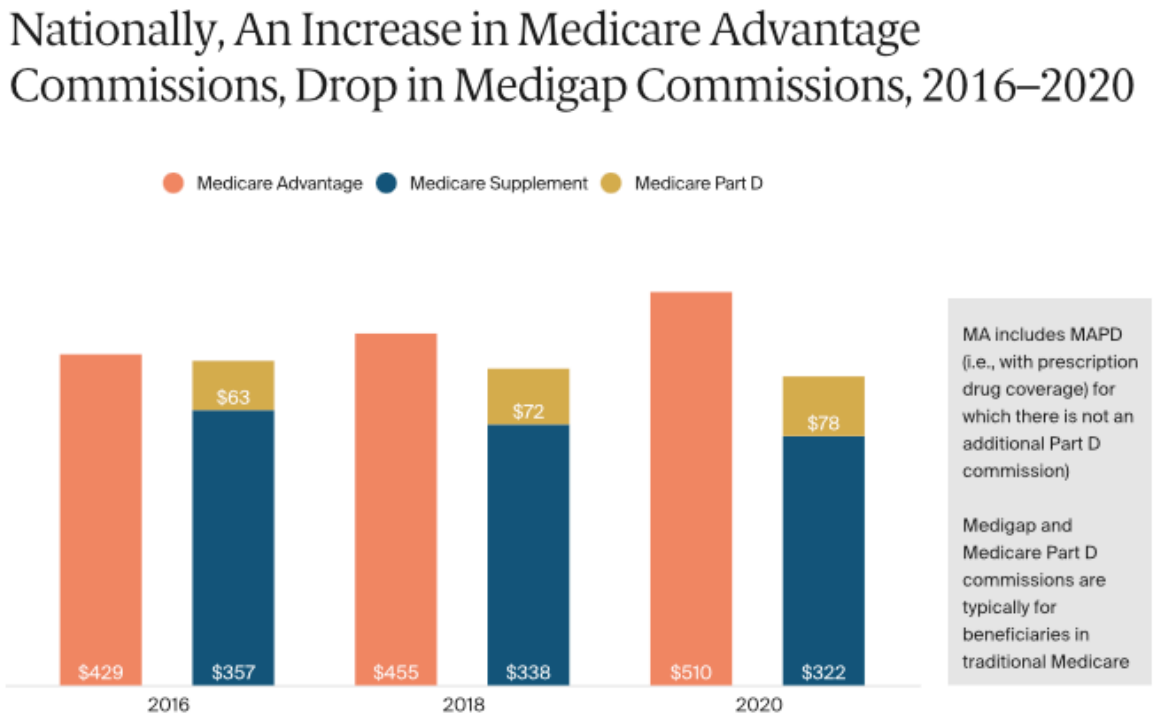
- Replacement commission (Switching): $287
- Renewal: $287

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.)

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.[67]

[67] 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



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% 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 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 $1,400 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[68]. 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.

Similarly, there is no sharing with Columbia itself in the payments from the insurance companies to Via, a benefit that could be passed on to retirees. If Columbia cannot, by law, accept such sharing, it surely can negotiate for the benefit to go to the retirees directly.

Examples for the Impact of Commission Incentives

1. Via offers plans from a number of 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. 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:

[68] 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.

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.[69]

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 beyond, 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 company, Via.[70]

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. If that is administratively too complex, as is likely, at a minimum there should be one or two alternative exchanges that could be picked by a retiree.

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.[71] Providing the option of one or two alternative exchanges would

- Create competitive pressures for service quality.

[69] 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.

[70] 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.

[71] For 457b plans, on the other hand, Vanguard has exclusivity, and the result is a service quality that is lower than for the competitive 403b plans.

- 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.

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.[72]

[72] **Via Reviews from *Trustpilot*—A <u>complete</u> 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…
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
Vía 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…

On the *Better Business Bureau* website, 195 comments averaged 1.06 on a scale of 1-5.[73]

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 assure 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.[74] But other retirees had complaints. The *Columbia Spectator* reported about several retirees who expressed difficulties interfacing with Via in the early stages of the rollout.[75]) 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 -

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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.

[73] https://www.bbb.org/us/ut/south-jordan/profile/insurance-consultant/via-benefits-one-exchange-1166-22242628/customer-reviews.

[74] 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.

[75] 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/

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 metric and financial penalties for unsatisfactory quality levels.[76] The question is who collects and interprets the data: Columbia, the vendor Via itself, Columbia 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 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[77]. The Medigap offerings are 19 plans by three companies.[78] 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 plan that are not offered.

[76] Performance metrics would include user satisfaction, resolution time, response speed, etc.
[77] Aetna, Empire Blue Cross (Anthem/Elevance), UHC/AARP, Cigna, Humana, and Wellcare.
[78] Humana, Empire, and UHC AARP.

Table 3: Cheaper Options not offered by Via

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

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 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.

A problem with the quality of information provided by Via to retirees is that at least some of it is contingent. The author, for example, was quoted by Via in November at open enrollment period a price of $291.75 per month for an Anthem Empire Blue Cross Blue Shield coverage, to start in January. He signed up and received a confirmation letter restating that price. But when coverage actually started he was billed right from the beginning almost $30 more per month, apparently without recourse. With prices so fluid even after a customer's commitment, how solid can the advising be?

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 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 4 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.[79]

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 [80]

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

The system is not easy to understand.[81] 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. 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

[79] 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.

[80] 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%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=agojv1brDos0BoHHaGCQubQtTCADcXMZTNIW2L7WSJA%3D&reserved=0%3E

[81] 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 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.

25% to 50%, whereas under a current Columbia plan[82] 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).[83] 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[84] 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 of such glaring unequal treatment beyond the desire to save money.[85][86]

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.[87]

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[82] E.g., the Indemnity plan.

[83] 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.

[84] 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.

[85] Recall that the purpose of ERISA is to protect retirees.

[86] Possibly, the University does not know their addresses, but that burden need not be on it but on those retirees to make themselves reachable.

[87] 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

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?'"[88] 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 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[89] looking for a brochure of a company they have never heard of, offering a service arrangement they are unaware of.

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.[90] Via Benefits is mentioned only once, in Appendix A.[91]

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confidence. Nothing in this report is information (confidential as well as non-confidential) that was obtained during the proceedings of that sub-committee.

[88] 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/

[89] 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.

[90] 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.

[91] 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.

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:

- 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

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.[92] Empirical research by the noted

[92] 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

labor economists David Card (Nobel Prize 2021) and Orley Ashenfelter[93] 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 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)[94] 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, and they found a drop at MIT from 57 per year to around 46.[95] 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%.

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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.

[93] 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.

[94] 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

[95] 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.

The Columbia Context

At Columbia, Provost John Coatsworth tasked in 2011 a Working Group on Retirement[96] 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:

> "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. Although it did not make specific recommendations about medical insurance, it observed a national finding that

[96] 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. A parallel committee also reported on Columbia's fringe benefits, Columbia University, Task Force in Fringe Benefits Programs, Preliminary Report, April 2011. A copy of that report could not be located yet.

> "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."[97]

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."

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 significant money was made available to pay for people to retire before age 74, support was actually lowered for 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 moderate cost item, the Big Picture of its interest in self-renewal appears to have been 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.[98] 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.[99] For Columbia, both the new system and the one that existed in 2022 are listed.

[97] Green, Kenneth with Jaschik, Scott and Lederman, Doug; The 2012 Inside Higher Ed Survey of College and University Human Resources Officers; September 2012

[98] 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.

[99] 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.

For the first set of universities -- Columbia, Harvard, Michigan, MIT, and Stanford—identifying the subsidies is straightforward since they are stated by the universities.[100] 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.[101] (Column 2). We list the top plan for each university. 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.[102]

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.[103] 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. For NYU, it shows a subsidy of $51.

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[104], 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.[105] Given these steps, the final numbers for these four universities are therefore more in the nature of

[100] 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.
[101] 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.
[102] See the preceding footnote.
[103] 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.
[104] 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.
[105] 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.

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 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 several universities provide the same subsidy to a spouse, while Columbia offers a one-half subsidy.[106]

A Comparison

- 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[107], almost 30 times as high.
- Harvard contributes 80% of medical insurance, while Columbia covers 4.2% of high-end plans roughly comparable to its old ones.
- Harvard provides spouses with equal coverage, while Columbia offers them only one half of an already much smaller number.
- At Harvard, one can assume that virtually 100% of current retirees[108] receive its support. At Columbia, of current retirees, only about 22% are eligible for it.[109]

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.

Table 4: The Contribution by Peer Universities to Retiree Medical Insurance

	Price to Retiree with 20 years of Service (1)	Pre-Subsidy Price, or Market Price of Similar Plan by	Difference Between Market Rate and Price Retiree Pays (**University Subsidy per Month**)	Est. Imputed value of university plan vs comparable outside plans in the	Free Dental Coverage, est. (5)	Est. Total Value of University-supported Benefit (6)

[106] We did not conduct a comparative investigation on the extent of inclusion of spouses across all universities.
[107] For current retirees who are about 68 years old. Younger cohorts receive about 11% less.
[108] Eligibility at universities typically begins after 10 years of service.
[109] Of current retirees, Columbia's HRA subsidy applies only to those who were on Columbia's plans in 2022, about 22% of overall retirees.

		same Insurer (2)	(3)	features of Maximum Out-Of-Pocket and Deductible [110] (4)		
Columbia Old Plan (2022)	$548[111]	$620	$72[112]			$72
Columbia New Plan (2023)	$413.30 [113]	$431.63 [114]	$18.33			$18.33
Harvard	$102	$508[115]	$406			$406
Michigan	$246	$523[116]	$277		$30	$307
MIT	$169.50	$565[117]	$395.50			$395.50
Stanford	$300.35	$582.07 [118]	$281.72			$281.72
University of California	$210.80	$312[119]	$101.20		$30	$131.20
NYU	$31	$82	$51			$51
Cornell	$38.72	$23[120]	-$15.72 plus better max out-of-pocket	$95		$79.28

[110] See the footnote slightly above for the imputation

[111] UHC Choice Plus 100, minus Columbia subsidy

[112] $144 for those retired before 2011

[113] The plan identified in Column 2, minus the Columbia HRA subsidy.

[114] Columbia's new plan relies on market-offered choices whose benefit coverage is not the same as the old plan, such as for drugs. There are different insurance options with different features and different prices, and the one chosen is a Medicare Supplement plan reputed to be the most popular, Plan Type G, at $320.63/mo. We chose a drug coverage (AARP at $111/mo) that is at the high end, to resemble the old coverage, though it is not reaching it. The plans of the other universities include drug coverage. Combined, the numbers add up to $431.63/mo.

[115] 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

[116] 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

[117] 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

[118] 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.

[119] Individual Market: Similar plan to Anthem Supplement Plan F, $312

[120] 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

			(MOOP) ($4750 lower) but higher deductible (by $45)			
Princeton	$125	$120[121]	-$5 plus better MOOP ($4450 lower) and lower deductible (by $150)	$101.5		$96.5
University of Pennsylvania	$228	$176[122]	-$52 plus better MOOP ($4050 lower);zero deductible	$81		$29
Yale	$56	$87[123]	$31 plus better MOOP ($6700 lower), and zero deductible (lower by $250)	$134		$155.8

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[121] 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

[122] 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

[123] 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.

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 501(c)3 organization, set up in 1994, that is run by 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.[124]

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) accumulated assets, as reported by Columbia, of almost $260 million dollars.

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.

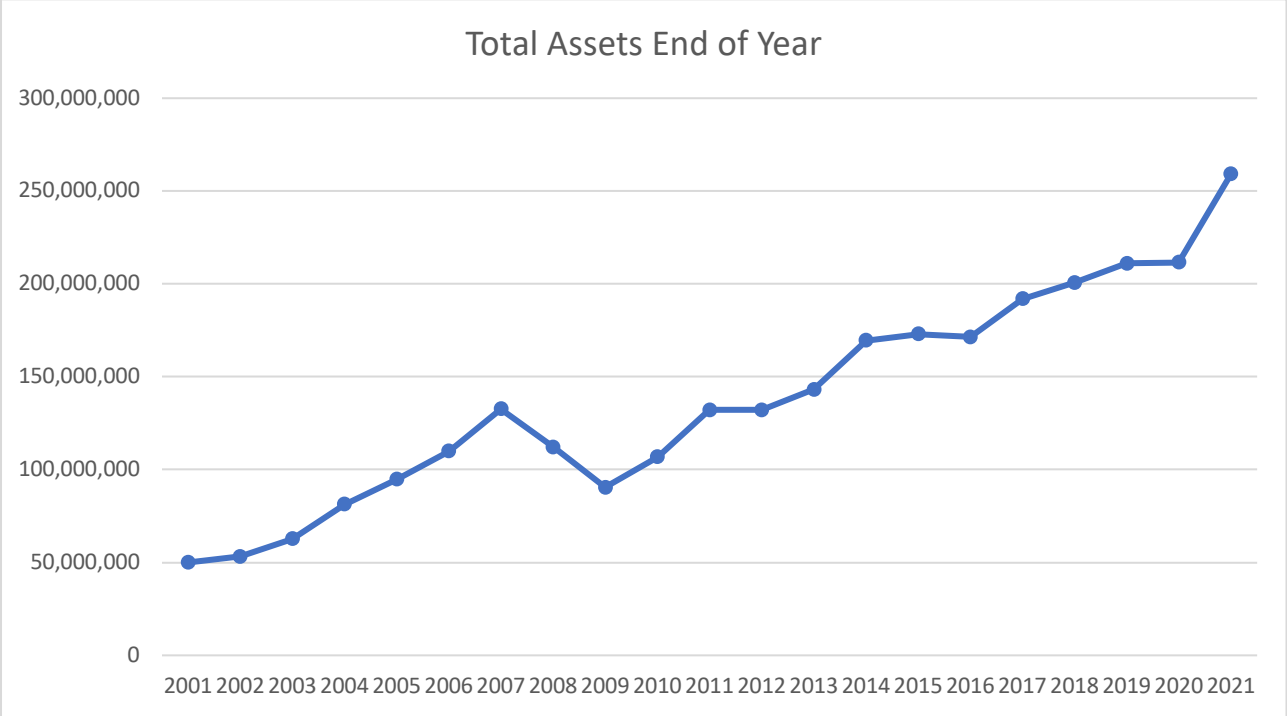
In each of the filings between 2012 and 2008, and probably earlier, the auditors (PriceWaterhouseCoopers) stated:

[124] The Trust document provided to the author did not show any amendments.

> "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.[125] There are also retirees with grandfathered higher benefits.[126] 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.

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.[127] 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.[128] If actual data would be provided it might might modify this estimate. But even it were 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 change 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**

[125] 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.

[126] 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..

[127] According to Kaiser Family Foundation's 2018 nationwide figure)[127], 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.

[128] 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.

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 can be used only on retirement medical and life insurance purposes -- but on a policy decision.[129]

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) 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.[130] The University is thus shedding its liability[131], contingencies, and administrative load.[132] In consequence, is there a need for a Trust Fund to be held against liabilities that do not exist anymore?

[129] There are, presumably, some regulatory rules on the allocation of retirement trust funds.
[130] 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.
[131] 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.)
[132] 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.

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 a cost saving to the Trust Fund.[133] 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[134]. 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.[135]

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.

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[133] 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.

[134] They also pay Medicare premiums as everyone does.

[135] The staff plan is a Columbia group plan administered by Empire.

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 by the fact that it is 18 times higher than that now provided to Officers (an estimated $330[136] 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[137] that is not extended to Officers; and all adjusted to inflation. Officer-employees should wish for such terms.

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.[138] Contributions to their retirement savings plans (403(b) plans such as TIAA or Vanguard) are lower. Retirement health benefits can thus be seen as a partial offset to lower compensation and savings. 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 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,

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[136] 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.

[137] Prior to 2018, with a different life insurance company as the underwriter, the per-person insurance was $240-$350.

[138] 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.

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.

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[139] 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%[140], 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.[141] 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.

[139] For example, a more sophisticated approach would recalculate life expectancy each year.
[140] The most recent rate is 4.5% for 2022
[141] As discussed earlier, the increase in retirees supported by the HRA raises the aggregate HRA each year by $32K.

The Financial Administration of the Trust Fund

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 4th 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[142] 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†	$13,037731	0.12%*	5.01%

[142] 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.

Bloomberg Roll Select Commodity IND	$13,207,785	0.29%	5.08%
Global Defensive Equity NL CTF	$36,451,784	0.75%	14%
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%
Total Assets	**$260,242,864**		
Weighted Average Expense Ratio		**0.25%**	

*Gross Expense Ratio

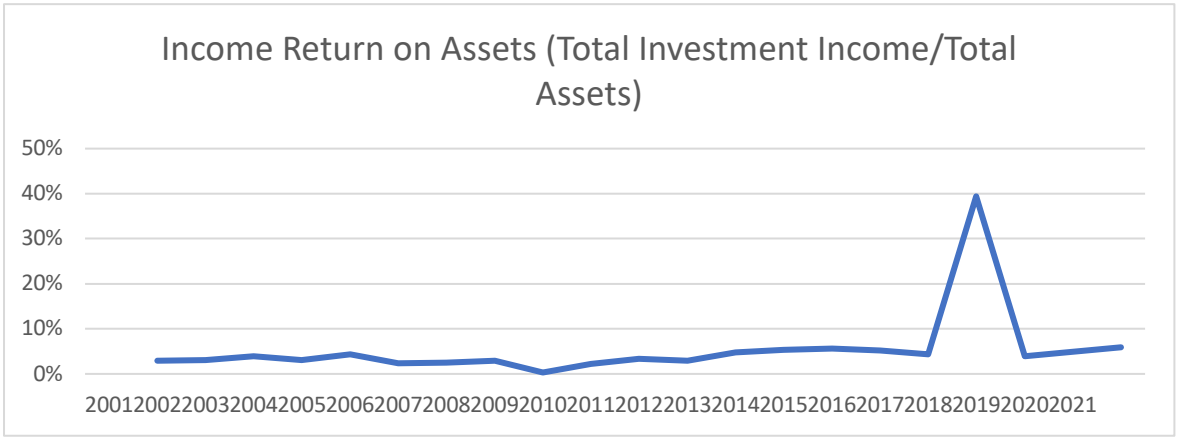
† One of the five funds prior to 2018

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. 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.)

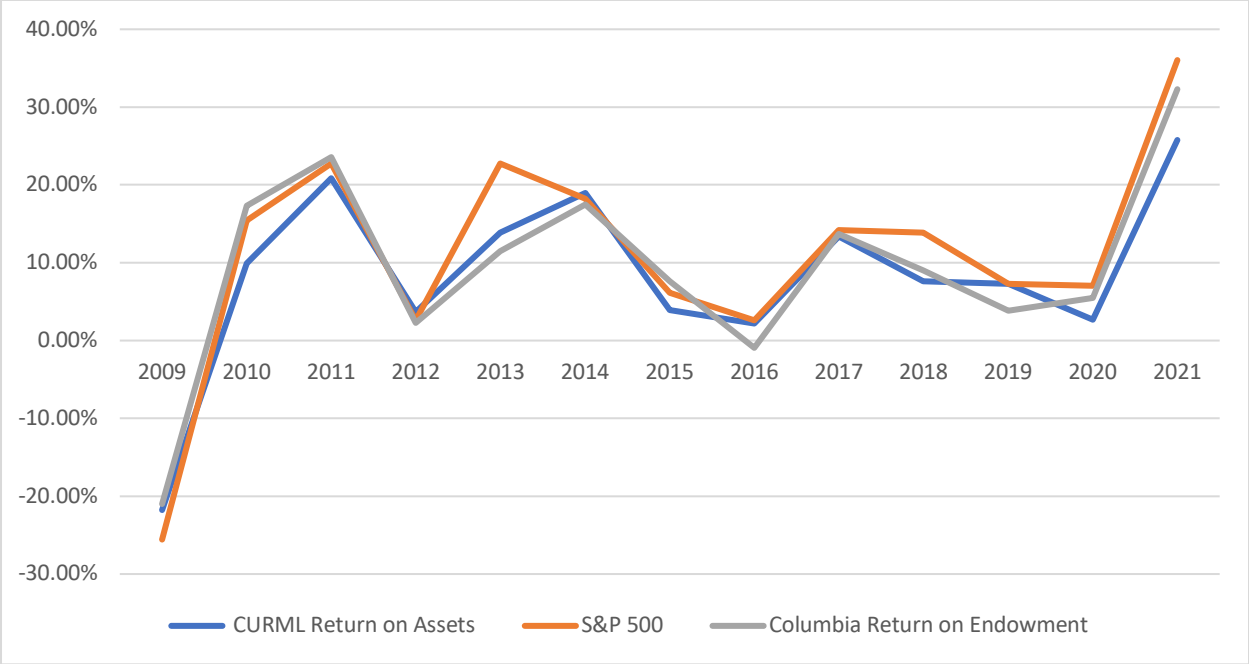
Graph 5: Income Return on Assets



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%.[143] 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, and with a lower return of 2.68%, which is about $7 million.

[143] From Table 5, the weighted average of the fees of the various funds.

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.[144] 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.

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%.[145] Together, this means an average overall State Street expense ratio of 0.48% of assets (Column 2 below).

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[144] 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.

[145] 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.

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

	State Street Management Fees (Tier 1) % of Total Assets (1)	**State Street Management Fees (Tier 1) plus Average Expense Ratio of Funds (Tier 2) (2)**	**Total State Street Management Cost (3)**	**Income Return on Assets (Total Investment Income / Total Assets Year$_{x-1}$) (4)**	**State Street Fees as a Share of Total Investment Income (5)**	**Investment Gain on Total Assets (6)**	**State Street Share of Investment Gain (7)**
2001							
2002				3.27%			
2003				4.59%			
2004				3.98%			
2005				4.98%			
2006				2.78%			
2007	0.22%	0.44%	$580,799	2.99%	14.72%		
2008	0.26%	0.48%	$542,238	2.47%	19.43%		

2009	0.23%	0.45%	$404,406	0.25%	180.00%	-21.77%	-2.07%
2010	0.20%	0.42%	$449,994	2.67%	15.73%	9.90%	4.24%
2011	0.21%	0.43%	$572,198	4.23%	10.17%	20.83%	2.06%
2012	0.22%	0.44%	$582,031	2.97%	14.81%	3.70%	11.89%
2013	0.23%	0.45%	$644,562	5.22%	8.62%	13.84%	3.25%
2014	0.22%	0.44%	$742,722	6.29%	7.00%	18.97%	2.32%
2015	0.24%	0.46%	$799,268	5.68%	8.10%	3.95%	11.65%
2016	0.25%	0.47%	$801,726	5.14%	9.14%	2.17%	21.66%
2017	0.22%	0.44%	$853,605	4.79%	9.19%	13.38%	3.29%
2018	0.22%	0.44%	$883,706	41.20%	1.07%	7.61%	5.78%
2019	0.23%	0.45%	$956,746	4.08%	11.03%	7.33%	6.14%
2020	0.24%	0.46%	$980,627	4.97%	9.26%	2.72%	16.91%
2021	0.23%	0.45%	$1,154,923	7.29%	6.17%	25.77%	1.75%
Averages	0.23%	0.45%	$729,970	4.14% (excluding 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 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, we offer an alternative plan that constructively deals with the shortcomings of the new plan and its funding.

The Proposed Plan

Operations

1. There would be at least one additional exchange beyond Via, with a status equivalent to that of Via in all respects.

Funding

2. Subject to legal rules, the assets of the Trust Fund would be divided equally for each of the two employee categories, and segmented from each other.[146]
3. The overall annual amount of support to Officers would be based on the University's payout rate on endowment accounts, applied to those assets.
4. 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.[147]

Allocation

5. 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 2023.
6. 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 two additional points.[148]
    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 more than two years before the median retirement age of their Officer category[149] will get an extra point for 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.[150]. That threshold would automatically rise by $3,000 each year, as a proxy for an assumed 2.5% rate of inflation.[151]

Cost

[146] 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.

[147] Assuming no special wrinkles in ERISA or other laws which would affect a 50:50 split.

[148] 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.

[149] About 64 for officers of Administration, 64 for research officers, and 67 for officers of instruction.

[150] This would follow another guiding principle from the same 2011 Senate resolution, namely to provide for progressivity.

[151] This would provide a greater simplicity and predictability than annual CPI-based indexing. Unpredictability would require reserves as a fallback

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 2/3 of them will join the exchange system.[152] This results in a total of 2,000 recipient retirees.

2. An average of 7.35 points per retiree, considering the spousal coverage and low income factor.[153] This would add up to 14,700 points

3. 1/3 of each new Officer cohort retire one or two years early, accounting for a total of 50 such claims for 2.5 years, for a total of 100 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 400 points. Note that the new Federal law aims to cap out-of-pocket expenses after 2024/5.

The total is therefore about 15,200 points per month.

If a point is valued at $25, this would add up to $380K/month or $4.56 million per year. If it is valued at $20, it would add up to $3.65 million.

Additionally, the existing plan's catastrophic support[154] adds about $69K.

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

At $25 per point, the individual retiree would receive $150/month. This would roughly restore the $144 per month that existed until 2011[155] ($178 in current dollars), though still lower than it was just a decade ago.

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[152] 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.

[153] 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.

[154] 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 $!000K.

[155] 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;

The aggregate contribution, at $25 per point, plus catastrophic drug support, would be about $4.6 million per year. This would be slightly more than the cost in 2011 ($4.375) prior to the changes instituted that year, but 22% lower if one adjusts for the larger number of officers since 2011. Such an amount would be only 1.8% 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 $4.56 million constitutes only 2.1% of these assets.

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[156], a figure that is over 4 times higher than it was in 2011.[157] 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, slightly above the $4.6 mil calculated above for a point system with each point worth $25.[158]

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.

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, Benefits, Faculty Affairs, and Research Officers) 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

[156] Using Total Expenses minus Benefits Paid, from Columbia's IRS filings.
[157] This is partly due to some of the major expenses directly linked to the asset base.
[158] If there is a deficit, the value of a point would be reduced in the next year to break even.

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 current 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 even 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. We also recognize the Fund's Trustees ability, going forward, to 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 $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 on this system are "Part C" ("Medicare Advantage") private insurance plans that offer some or all or 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, there are ceilings on the out-of-pocket, which vary, depending on the cost of the plan, between zero (no out-of-pocket) 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.[17] 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.[8]

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
Plan A			
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
Plan B			
Empire Blue Cross Blue Shield Plan B	$241.11	$241.11	$0
Humana Medicare Supplement Plan B	$363.61	$363.61	$0
Plan C			
UHC/AARP Medicare Supplement Plan C	$332.25	$332.25	$0
Humana Medicare Supplement Plan C	$439.46	$439.46	$0
Plan F			
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
Plan F High Deductible			
Humana Medicare Supplement High Deductible Plan F	$93.09	$93.09	$0
Plan G			
UHC/AARP Medicare Supplement Plan G	$280.25	$280.25	$0
Plan N			
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
Plan K			

UHC/AARP Medicare Supplement Plan K	$88	$88	$0
Humana Medicare Supplement Plan K	$209.34	$209.34	$0
Plan L			
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			11	13	8	10	19	10	19	20	11	16	10	9	5	16	17	18	19
71						10	11	6	10	16	7	17	19	10	13	9	8	5	16	14	17
72							8	11	5	9	16	6	15	15	9	11	9	7	4	15	13
73								8	9	5	9	16	5	12	12	7	11	9	7	4	13
74									6	8	4	9	16	4	10	11	7	10	8	7	4
75										5	7	4	8	13	3	10	11	6	9	8	7
76				1							5	6	4	8	9	2	9	9	6	9	8
77					1							5	5	3	7	8	2	9	9	4	8
78													5	4	2	7	6	2	7	7	4
79														3	4	2	6	6	1	5	6
80															3	3	2	6	6	1	4
81																2	2	2	6	4	1
82																	1	2	2	5	2
83																		2	2	1	5
84																			2	1	1
85																				2	1
86																					2
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.[159] 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%.[160]

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[161] but they would still be high.

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[159] 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.

[160] 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.

[161] 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)**
2001	50,008,339	**1,290,219**	**171,989**	1,462,208	**2.92%**
2002	53,262,818	**1,338,193**	**294,779**	1,632,972	**3.07%**
2003	62,691,493	**1,776,242**	**670,245**	2,446,487	**3.90%**
2004	81,374,181	**1,993,328**	**501,189**	2,494,517	**3.07%**
2005	94,755,785	**3,132,772**	**919,053**	4,051,825	**4.28%**
2006	109,908,751	**2,638,191**		2,638,191	**2.40%**
2007	132,655,607	**3,282,737**		3,282,737	**2.47%**
2008	112,182,418	**3,276,314**		3,276,314	**2.92%**
2009	90,382,217	**2,629,455**	**-2,346,960**	282,495	**0.31%**
2010	106,792,238	**1,811,443**	**597,768**	2,409,211	**2.26%**
2011	132,111,584	**2,872,642**	**1,643,630**	4,516,272	**3.42%**
2012	132,187,993	**1,485,246**	**2,444,540**	3,929,786	**2.97%**
2013	143,219,246	3,508,872*	**3,387,971**	6,896,843	**4.82%**
2014	169,597,630	4,155,142*	**4,850,118**	9,005,260	**5.31%**
2015	172,982,642	4,238,075*	**5,388,370**	9,626,445	**5.56%**
2016	171,431,662	4,200,076*	**4,694,348**	8,894,424	**5.19%**
2017	191,862,465	4,700,630*	**3,510,851**	8,211,481	**4.28%**
2018	200,629,721	4,915,428*	**74,133,450**	79,048,878	**39.40%**
2019	211,119,237	5,172,421*	**3,015,603**	8,188,024	**3.88%**
2020	211,562,684	5,183,286*	**5,305,522**	10,488,808	**4.96%**
2021	259,182,632	6,349,974*	**9,064,733**	15,414,708	**5.95%**
Avg.	137,614,350	3,330,985	**5,630,819**	5,4576,450 [excluding 2018]	**3.79 (Excluding 2018)**

*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 [162]
2009	-24,427,700	-21.77%	-25.57%	-21%
2010	8,951,706	9.90%	15.39%	17.3%
2011	22,245,512	20.83%	22.73%	23.60%
2012	4,893,441	3.70%	2.61%	2.30%
2013	18,294,655	13.84%	22.72%	11.50%
2014	27,171,056	18.97%	18.24%	17.50%
2015	6,697,719	3.95%	6.14%	7.60%
2016	3,757,591	2.17%	2.62%	-0.90%
2017	22,930,482	13.38%	14.20%	13.70%
2018	14,591,857	7.61%	13.84%	9%
2019	14,705,788	7.33%	7.25%	3.80%
2020	5,737,581	2.72%	7.06%	5.50%
2021	54,525,235	25.77%	36.04%	32.30%
Averages	**$13,851,235**	**8.34%**	**11.02%**	**9.40%**

[162] 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.