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College and University Benefits Study Examines the Benefits Component of Total Rewards on Campus

Higher education institutions grappling with the challenge to compensate faculty and other staff in a manner that can attract and retain top talent continue to request recent data on how their benefit plans compare to benefit offerings from their peers. Sibson Consulting's *College and University Benefits Study* (CUBS) collects detailed information about higher education institutions' benefits, including differences among the benefits offered to faculty, administrative and clerical staff.[1] CUBS shows that generous medical, tuition and retirement benefits (as well as non-traditional and voluntary benefits) are provided to help lead the effort to offer attractive compensation packages. Institutions may want to use the detailed study results which covers 2015 offerings of more than 450 private and public institutions, to benchmark their own offerings and identify what benefits could be added, changed, or simply promoted to gain an edge for top talent.

This report gives an overview of the study results and, for the first time, notes certain year-over-year changes in health care and other benefit plans. It concludes with observations on the findings and provides comments on opportunities that institutions may want to consider in the coming years.

What CUBS Covers

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

- Key Findings for Benchmarking
- Medical Plan Coverage
- Wellness Initiatives & Health Plan Strategies
- Prescription Drug Coverage
- Medical/Prescription Drug Plan Employee Contributions
- Medical/Prescription Drug Premium Rate & Employee Contributions Increases
- Dental & Vision Coverage
- Dental Premium Rate & Employee Contributions Increases
- Retiree Health & Life Insurance Coverage
- Retirement-Income Plans
- Tuition Benefits
- Leave Programs
- Employee Assistance Programs
- Life Insurance Benefits
- Non-Traditional & Voluntary Benefits
- Opportunities
- Methodology & Institutions Studied

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

Key Findings for Benchmarking

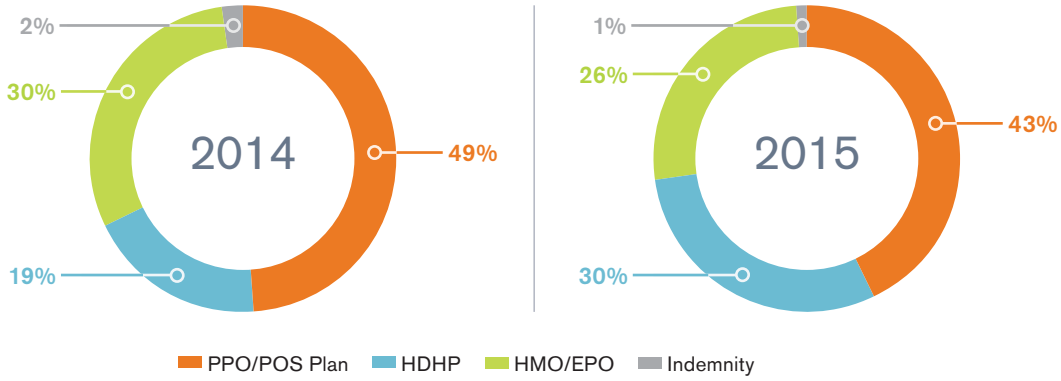
Sibson's key findings include the following:

- The trend of institutions reducing or eliminating their retiree health benefit offerings continues. Between 2012 and 2015, the percentage of institutions offering retiree health benefits to new hires declined by 13 percentage points in the public sector and 17 percent in the private sector. Among institutions that still offer retiree health and welfare plans to new hires, there has been significant movement to account-based defined contribution (DC) health plans as the vehicle to provide the benefits.
- From 2014 to 2015, there was a significant increase of 11 percentage points in the prevalence of high-deductible health plans (HDHPs). For 2015, 59 percent of institutions offered an HDHP, and HDHPs represented 30 percent of all health plan offerings.
- Institutions are starting to incorporate deductibles into their health maintenance organization (HMO)/exclusive provider organization (EPO) plan designs. For 2015, 28 percent of institutions in the study offered an HMO/EPO with a deductible.
- The average copayment for emergency room visits is now $121.
- For 2015, 62 percent of HMO/EPOs had a per-confinement copayment with a median of $250 and an average of $286.
- Institutions continue to expand wellness initiatives with 82 percent offering wellness programs for 2015. There were 10 initiatives used by more than 50 percent of the institutions.
- The percentage increase in employee payroll-contribution requirements for medical coverage between 2014 and 2015 was greater than the increase seen in total medical/prescription drug costs (after design changes). Also, employee contributions by clerical and support staff for medical/prescription drug and dental coverage increased less than for faculty and administrative staff.
- The percentage of institutions that offer retiree health coverage to new hires has declined from nearly 90 percent a few years ago to 74 percent.
- A large majority of private institutions (91 percent) offer *only* DC retirement plans, while most public institutions (79 percent) offer *both* DC and defined benefit (DB) plans.
- In 2015, the median institution contribution to DC retirement plans was 9 percent.
- In 2015, 29 percent of DC retirement plans included a schedule whereby vesting is not always full and immediate, up from 22 percent in 2012.
- Seventy-seven percent of institutions now include a matching feature in their DC retirement plans, up from 72 percent in 2012.
- For tuition reimbursement plans year-over-year waiting periods reflect less immediate eligibility, with more institutions requiring coursework to be job-related for employees, and more institutions requiring minimum grades for any reimbursement. These measures help keep the cost of offering this benefit down as tuition increases.
- The median number of vacation days for employees with fewer than 10 years of service was 20 days for administrators compared to 11-15 days for clerical staff.

Medical Plan Coverage: HDHP Growth

Although traditional preferred provider organization (PPO)/point-of-service (POS) plans, those with deductibles less than $1,000, continue to be the most prevalent type of medical plan offered, growth in offerings of HDHPs, which have deductibles of $1,000 or more — most of which are PPO/POS plans[2] — is strong. HDHPs now represent 30 percent of all medical plans offered (up from 19 percent one year earlier). That makes HDHPs the second most prevalent offering behind the standard PPO/POS plans (43 percent).

Prevalence of Medical Plan Types by Total Number of Plans Offered, 2014–2015*

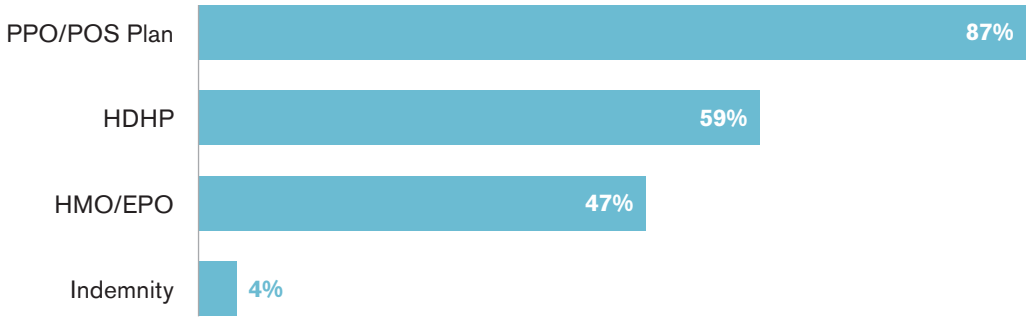


* Note CUBS caps each plan type at three plans maximum, so there may be minor underreporting of HMO/EPO prevalence.

Source: Sibson Consulting, 2016

Moreover, HDHPs are now offered by nearly 60 percent of *institutions*. In 2015, a greater percentage of institutions offered an HDHP than offered an HMO/EPO.

Prevalence of Medical Plan Types in 2015 by Number of Institutions Offering Each Type



Source: Sibson Consulting, 2016

> "HDHPs now represent 30 percent of all medical plans offered."

[2] This report uses "PPO/POS plans" to refer to the traditional, non-high deductible design.

Sibson Observations Historically, higher education medical plans have tended to be somewhat more valuable to the employee than plans offered by corporate employers. Changes over the years have narrowed the gap. Health benefit trends continue to exceed the Consumer Price Index for All Urban Consumers (CPI-U), which is used as an estimate for cost-of-living increases. The Affordable Care Act and its influence, as well as the financial strain that institutions have been experiencing in this economy, have led more institutions to offer HDHPs and add additional cost-sharing provisions to current plans, and increasing employee contributions more than the overall health premium rate increased (after design changes) for PPO/POS plans and HDHPs. The growth in HDHP plan offerings may be helped by the increased awareness that qualified health savings account HDHP plans can cover an expanding list of preventive care services and even many maintenance drugs without being subject to the high deductible, thus creating greater appeal to more employees as a viable choice.

Cost-Sharing Features

Deductibles vary significantly by plan type. PPO/POS plans have deductibles of less than $1,000 whereas HDHPs, as defined by the study, have deductibles of $1,000 or more. In contrast, most HMO/EPOs (72 percent) do not require a deductible. For those that do (28 percent), the deductible is low (around $100).

Annual Deductibles for Employee-Only Coverage by Medical Plan Type

	Average	Median
PPO/POS Plans: In Network	$341	$300
PPO/POS Plans: Out of Network	$756	$500
HDHPs: In Network	$1,806	$1,500
HDHPs: Out of Network	$2,905	$2,500
HMO/EPOs*	$85	$100

* There is only one set of data for HMO/EPOs because that plan type generally does not cover out-of-network care.

Source: Sibson Consulting, 2016

Coinsurance has not changed much for traditional PPO/POS plans since Sibson's report of 2012 CUBS results. As shown in the table below, institutions' median in-network coinsurance for PPO/POS plans is high for all service types. The median out-of-network employer coinsurance applicable to most services is 70 percent. HDHPs are a different story, however. The table below shows the coinsurance for those services within HDHPs. Note that for these plans the median *out-of-network* employer coinsurance is only 60 percent.

Median In-Network Coinsurance by Medical Plan Type by Type of Service

	PPO/POS Plans	HDHPs	HMO/EPO Plans
Physician Visits	None (Copayment Only)	85%*	None (Copayment Only)
Inpatient Services	90%	80%	100%
Outpatient Services	90%	80%	100%

* Although it is not common, some HDHPs have 100% coinsurance where copays exist for physician visits, therefore this is not 80%.

Source: Sibson Consulting, 2016

Sibson found that 60 percent of PPO/POS plans (up from the 57 percent reported for 2012) differentiate between copayments for office visits to primary care physicians (PCPs) and specialists. A majority of HMO/EPOs (64 percent) also have different PCP and specialist copayments. Only 25 percent of institutions' HDHPs have office-visit copayments, and very few have per-hospitalization, in-network copayments. That is because HDHPs tend to use coinsurance as the cost-sharing mechanism for those plan provisions after the high deductible is met. The table below shows the median copayments, which are identical for PPO/POS plans and HMO/EPOs. The averages are very similar to the medians. For example, PPO/POS plans' copayments for PCP in-network office visits average $21 while specialist in-network office visits average $31.

Median In-Network Copayments for Physician Visits by Medical Plan Type

	PPO/POS Plans	HDHPs	HMO/EPO Plans
PCP Visits	$20	None (Coinsurance Only)	$20
Specialist Visits	$30	None (Coinsurance Only)	$30

Source: Sibson Consulting, 2016

PPO/POS plans' emergency room (ER) copayments shown in the table below are up 25 percent from what Sibson reported for 2012 (average of $97). This increase is partially attributable to plan sponsors' interest in discouraging employees who have non-emergency service needs from visiting the ER. Additionally, 35 percent of PPO/POS plans and 68 percent of HMO/EPOs have a per-hospitalization, in-network copayment.

Average In-Network Copayments for Hospital Services by Type of Service and Medical Plan Type

	PPO/POS Plans	HDHPs	HMO/EPO Plans
ER Visits	$121	None (Coinsurance Only)	$112
Inpatient Stay	$282	None (Coinsurance Only)	$286

Source: Sibson Consulting, 2016

> "PPO/POS plans' emergency room (ER) copayments ...are up 25 percent from what Sibson reported for 2012 (average of $97)."

While out-of-network out-of-pocket maximums continue to be between 1.5 to 2 times their in-network counterparts, the in-network out-of-pocket maximums have increased significantly since Sibson reported PPO/POS plan results for 2012 (which reflected an average of $1,851, median of $1,500).

Out-of-Pocket Maximums (Excluding Deductibles) by Medical Plan Type

	Average	Median
PPO/POS Plan In-Network Services	$2,616	$2,300
PPO/POS Plan Out-of-Network Services	$3,820	$3,000
HDHP In-Network Services	$3,132	$3,000
HDHP Out-of-Network Services	$5,273	$5,000
HMO/EPO In-Network Services (Only)	$2,864	$2,000

Source: Sibson Consulting, 2016

Sibson Observation The fact that the differential for the out-of-pocket maximums for PPO/POS plans and HDHPs is shrinking (averaging around $500 in 2015) makes HDHPs a more viable option for employees who tend to be risk averse.

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

Educating employees about how to use their health plans can make health plan use more efficient and cost-effective, and give employees a greater sense of security when they need to use their plans, a time when they may not always be able to think rationally. Communications campaigns play a vital role in how health benefits programs are positioned, explained and understood.

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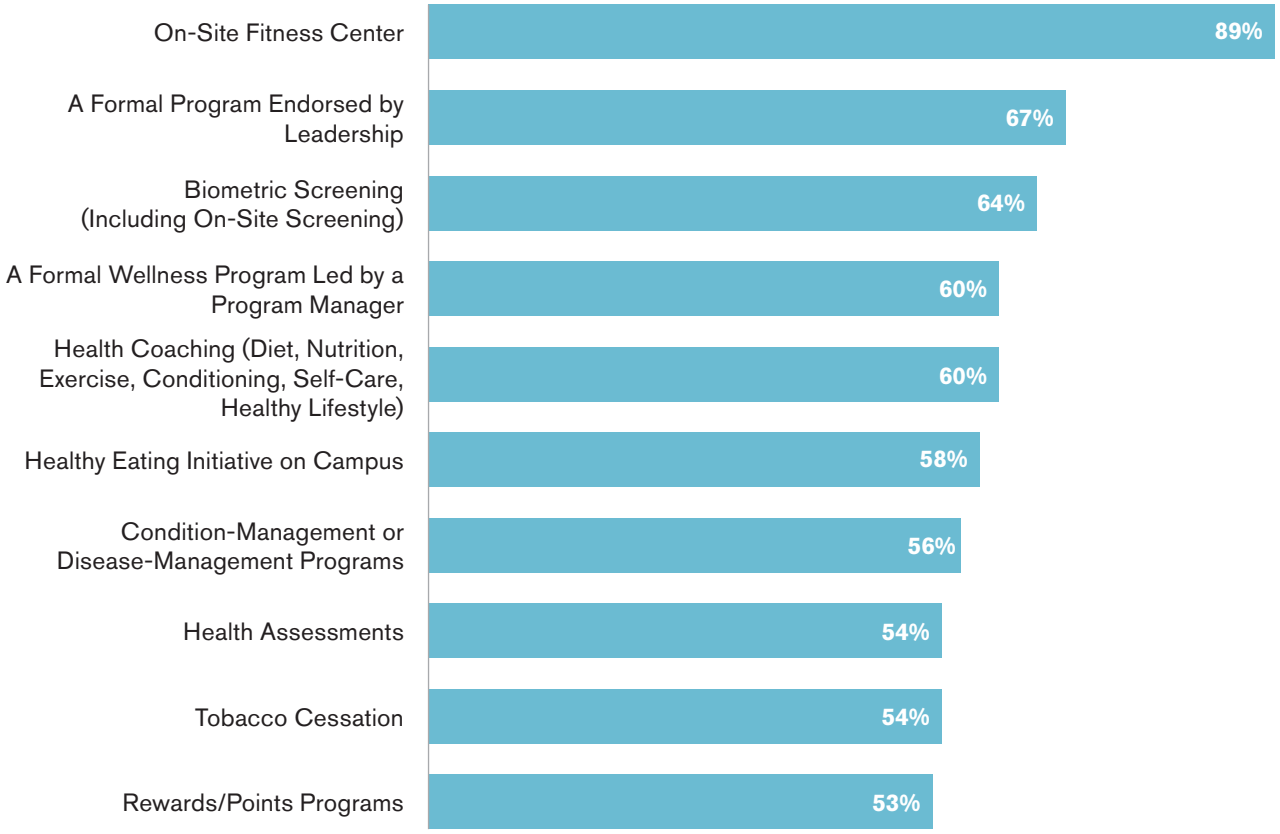
Wellness Initiatives & Health Plan Strategies

To supplement CUBS, Sibson conducted an online survey in 2015 focusing on wellness initiatives and health plan strategies. That survey found a particularly significant increase in the number of wellness activities being included in and/or added to current health plans. This strategy can help institutions with both cost-management and staffing because healthier employees have lower health claims and a focus on employees' well-being can help attract and retain talent. Where only two of the initiatives were prevalent at more than 50 percent of the institutions as of 2014 (health-risk assessments and on-site fitness centers), in 2015 there were 10 initiatives being used by more than 50 percent of the institutions. The top 10 are listed in the table below with their prevalence percentage.

Top 10 Wellness Initiatives by Percentage of Institutions Offering Them

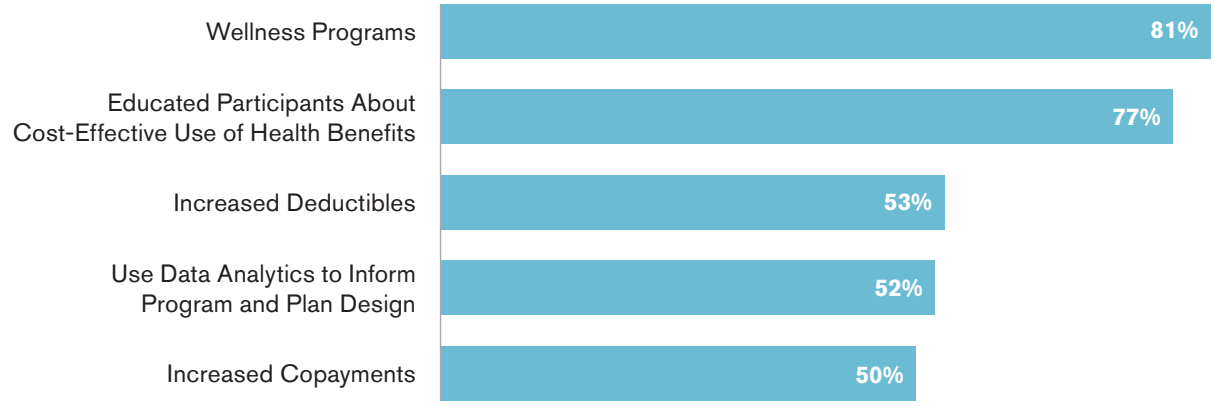


Source: Sibson Consulting, 2016

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

In terms of strategies used in 2015 to control health plan cost increases, most institutions stressed wellness programs and employee education about the cost effective use of their health benefits. These two strategies were clearly the top choices, with various cost-sharing strategies and data analytics rounding out other prevalent methods used. See the graph below for the top five strategies institutions are using to control health plan cost increases.

Top Five Strategies for Managing Health Plan Cost Increases by Percentage of Institutions Using Them



Source: Sibson Consulting, 2016

Use of data analytics to inform program and plan design, and new utilization review and disease management programs were tied for third (at 58 percent) on the list of *future* strategies to be used to control health plan cost increases, behind wellness programs and educating participants about cost-effective use of health benefits.

Sibson Observations Institutions can use behavioral economics principles to enhance the effectiveness of wellness programs leading to a dramatic increase in program participation. The most successful programs integrate the medical and wellness programs, with some institutions achieving a program participation rate as high as 95 percent.

> "Institutions can use behavioral economics principles to enhance the effectiveness of wellness programs leading to a dramatic increase in program participation. The most successful programs integrate the medical and wellness programs."

> Prescription drug costs continue to soar and are now 20 to 30 percent of total health plan costs.

Prescription Drug Coverage: Growth in Use of Cost-Management Programs

Sibson found the following about institutions' prescription drug coverage:

- ***Deductible*** Relatively few prescription drug plans (15 percent) had a stand-alone deductible.
- ***Coinsurance*** There was a significant increase in the percentage of plans that include coinsurance for at least some of brand-name drugs. For 2012, 15 percent of plans required coinsurance; however, due to the significant increase in number of HDHPs (nearly half of which include coinsurance for their prescription drug benefits), 26 percent of plans overall now include coinsurance to pay for at least some brand-name drugs. The average institution coinsurance level was 74 percent for brand-name, formulary drugs and 68 percent for brand-name, non-formulary drugs.
- C***opayments*** The weighted average three-tier copayments across PPO/POS plans, HMO/EPO plans and HDHPs collectively are $10 for generic drugs, $28 for brand-name formulary drugs and $49 for brand-name non-formulary drugs. The average and median 90-day mail-order copayments are very close to two times the 30-day retail copayments for all three plan types.
- ***Out-of-Pocket Maximums*** Over the past couple of years, Sibson's CUBS found the prevalence of stand-alone, out-of-pocket maximums increased from 7 percent in 2012 to 35 percent in 2015. This increase is attributable to the Affordable Care Act mandate that prescription drugs must be covered under the government-indexed, out-of-pocket maximum.[3]
- ***Prescription Drug Cost-Management Programs*** There has also been growth in the use of several mainstream prescription drug cost-management programs. More than half of prescription drug plans (PPOs/POS plans, HMO/EPOs and HDHPs) have a mandatory generics program (57 percent, higher than the 47 percent shown for 2012 for PPO/POS plans). Step-therapy programs[4] are also used by 57 percent of the plans. Mandatory mail-order drug programs are used by 22 percent of plans (higher than the 10 percent shown in 2012 for PPO/POS plans).

Sibson Observations Prescription drug costs continue to soar and are now 20 to 30 percent of total health plan costs. Institutions have taken many steps to help mitigate future increases. In addition to the steps mentioned above, institutions have been joining a higher education prescription drug coalition, considering alternative formularies which provide significant savings with minimal employee disruption, educating faculty and staff about the drivers of prescription drug costs, providing transparency tools and apps that allow for on-the-spot cost comparison of alternatives when physicians are writing the prescription, and conducting pharmacy benefit manger claim audits and contract reviews to ensure competitive pricing.

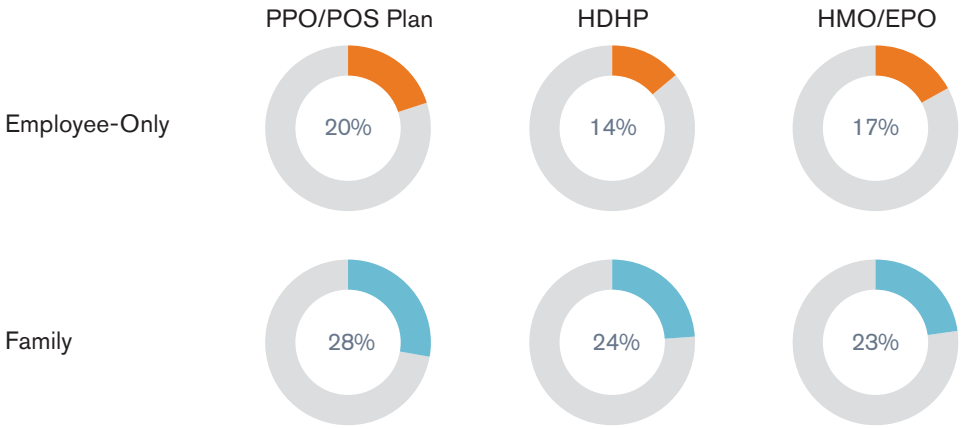
[3] Under the Affordable Care Act, plan sponsors could either include prescription drug out-of-pocket maximums combined under the medical plan out-of-pocket maximum, or they could create a stand-alone out-of-pocket maximum for the drug coverage. Note, though, that the prescription drug and medical out-of-pocket maximums, when added together, cannot exceed the government mandated indexed out-of-pocket maximum level of $6,850 for an individual, $13,700 for a family.

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

Medical/Prescription Drug Plan Employee Contributions: Incenting the Use of HDHPs

Sibson found that the percentage of medical plan premiums paid by employees is lowest for those covered by HDHPs for employee-only coverage. Employee contributions are lowest for HDHPs and highest for PPO/POS plans, in general. See the set of charts below. Also, note that clerical and support staff pay as much as 1 percent to 2 percent less than faculty or administrative staff, on average.

Average Percent of Total Medical Plan Costs Paid by Employees for Contributory Plans by Medical Plan Type and Coverage (Employee-Only or Family)



Source: Sibson Consulting, 2016

Sibson Observations Although higher education institutions' subsidy continues to be more generous than the subsidy offered by employers in other industries, the gap has narrowed. Additionally, with the rising cost of health care, employee appreciation for this generous benefit has eroded as the cost to participate is harder to afford. As a result, institution initiatives to educate and enable consumerism have become prominent and will continue to be emphasized going forward.

> "Institution initiatives to educate and enable consumerism have become prominent and will continue to be emphasized going forward."

Medical/Prescription Drug Premium Rate & Employee Contributions: Year-Over-Year Increases

The table below shows the increase between 2014 and 2015 in medical/prescription drug premium rates and employee contributions by two employment groups for only those plans in CUBS for both years. For details about the analysis that generated this data, see the methodology section on page 27.

Average Percentage Increase Year Over Year of Medical/Prescription Drug Premium Rates and Employee Contributions by Medical Plan Type

Medical/Prescription Drug Increase 2014 – 2015	PPO/POS Plan	HDHP	HMO/EPO
Total Premium Rate	6.5%	7.4%	7.9%
Employee Contributions			
Faculty, Administrative & Professional Staff	8.3%	11.4%	3.9%
Clerical & Support Staff	6.6%	8.5%	3.5%

Source: Sibson Consulting, 2016

Data from the above table shows that:

- Medical (including prescription drug) rate increases, after plan design changes and excluding plan replacement where identifiable, are seeing increases of less than 8 percent on average. This is true across the higher education industry and is consistent with what employers in other industries are experiencing. More design changes tend to be made to PPO/POS plans, and sometimes the change is to convert a PPO/POS plan to an HDHP.
- Employee contribution increases are, by percentage of total cost, higher than the medical/prescription drug premium rate increases for PPO/POS and HDHPs. HMOs/EPOs reflect lower employee contribution increases than the premium rate increases.
- Sibson found that clerical and support staff are not asked to pay the same contribution increases as the other employment groups, on average. They will pay anywhere from 0.5 percent to 3.0 percent lower increases than faculty, administrative and professional staff (who pay contribution increases that are similar to each other). Among institutions for which there is year-over-year data, 9 percent charge lower payroll contributions for clerical and support staff in 2015, up from 3 percent in 2014.

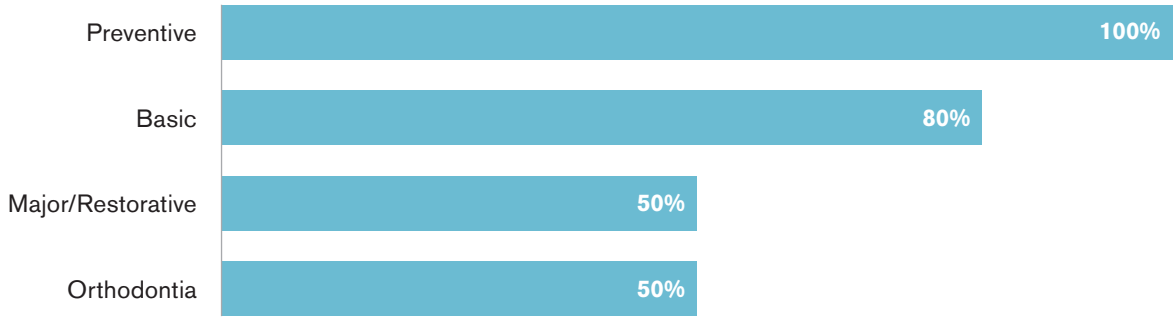
Note that increases in HDHP employee contributions appear higher as a percentage than those of the PPO/POS plans and HMO/EPOs because these contribution amounts are starting off at a much lower dollar amount. (In other words, the percentage increase may seem more significant than it actually is because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

Dental & Vision Coverage: Maximum Benefits Increase

Sibson found that, by far, the most common dental plan offered continues to be the dental provider organization (DPO). Eighty-five percent of institutions offer a DPO, and these plans make up 63 percent of all dental plans offered by institutions. The predominant out-of-pocket costs for the institutions' DPOs are noted below:

- ***Deductible*** The median dental deductible is $50 for DPOs.
- ***Coinsurance*** Ninety-three percent of institutions that offered DPOs cover in-network preventive services at 100 percent. The graph below compares that median level of institution-provided coverage to the somewhat lower median coverage for basic services and the much lower median coverage levels for major/restorative and orthodontia services. Out-of-network and in-network median coverage levels were the same.

Predominant (Median) Dental PPO Coverage Levels by Category of Service



Source: Sibson Consulting, 2016

- ***Annual Benefit Maximum*** The median DPO in-network annual benefit maximum is $1,500 (up from $1,250 for 2012).
- ***Lifetime Orthodontia Maximum*** A lifetime maximum for orthodontia is typical. The median DPO in-network lifetime orthodontia maximum is $1,500 (higher than the $1,200 as of 2012).
- ***Dental Plan Employee Contributions*** DPO contributions can vary. Many institutions (38 percent) offer dental as an employee-pay-all optional benefit. For institutions that offer subsidized dental coverage, the average employee contributions for a DPO across all employee groups (faculty, administration, clerical staff) is 31 percent for single coverage and 51 percent for family coverage.
- ***Vision Coverage*** Vision plans are usually structured in a way where there are copayments for exams, and allowances for material benefits. That is true of carve-out/stand-alone plans (offered by 86 percent of institutions) and vision benefits that are provided through a medical plan (offered by 25 percent of institutions). Most institutions that offer a vision plan (66 percent) offer it as an optional employee-pay-all benefit.

Dental Premium Rate & Employee Contributions: Year-Over-Year Increases

The table below shows the increase between 2014 and 2015 in dental premium rates and employee contributions by two employment groups. As with the increase data about medical/prescription drug plans presented on page 11, the increase data about dental plans is only for dental plans in CUBS for both years.

Average Percentage Increase Year Over Year of Dental Premium Rates and Employee Contributions by Plan Type

Dental Trend 2014 – 2015	PPO/DPO Plan	HMO	Indemnity
Total Premium Rate	1.1%	1.5%	1.0%
Employee Contributions			
Faculty, Administrative & Professional Staff	3.5%	1.9%	1.8%
Clerical & Support Staff	2.7%	1.9%	1.8%

Source: Sibson Consulting, 2016

Dental premium rate increases, after plan design changes and excluding plan replacement where identifiable, are very low and in the realm of 1 percent to 1.5 percent, however what cannot be accounted for within those low premium rate increases is the fact that dental contracts are often multi-year contracts where premiums and/or administration are held flat for two or three years. Similar to medical plans, dental employee contribution increases are greater than the adjusted premium rate increases, and favor clerical and support staff to a small degree.

Retiree Health & Life Insurance Coverage: Slow but Steady Decline

Many institutions appear to be exploring alternatives to retiree coverage. The most prevalent changes institutions have adopted include:

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

Sibson found some dramatic differences in the retiree health coverage that public and private institutions offer to new hires. Although a large majority of the public institutions still offer retiree health benefits to new hires, there has been a significant decline in that offering (74 percent in 2015, down from 87 percent in 2012). In contrast, a much smaller percentage of private institutions (49 percent) offer that benefit to new hires (compared to 66 percent in 2012). Among private institutions that offer coverage to new hires, 44 percent use an account-based DC plan (compared to 29 percent in 2012) whereas only 19 percent of public institutions offer that option (7 percent in 2012). The CUBS data clearly shows movement away from DB retiree health coverage and movement towards DC account-based retiree health coverage.

Percentage of Institutions Offering Retiree Benefits for New Hires, by Institution and Plan Type

	2015		2012	
	DB	DC	DB	DC
Public	74%	19%	87%	7%
Private	49%	44%	66%	29%

Source: Sibson Consulting, 2016

The table below shows variation in the 2015 cost sharing by coverage tier and pre- and post-Medicare for retiree health coverage among institutions that still offer subsidized defined benefit retiree health.

Average and Median Retiree Contribution Ranges* for Pre-Medicare and Post-Medicare Health Coverage

	Average	Median
Pre-Medicare		
Retiree-Only	21%	20%
Spouses and Dependent Children	34%	28%
Post-Medicare		
Retiree-Only	31%	36%
Spouses and Dependent Children	42%	31%

* Averages and medians do not include those institutions that charge 100% for coverage.

Source: Sibson Consulting, 2016

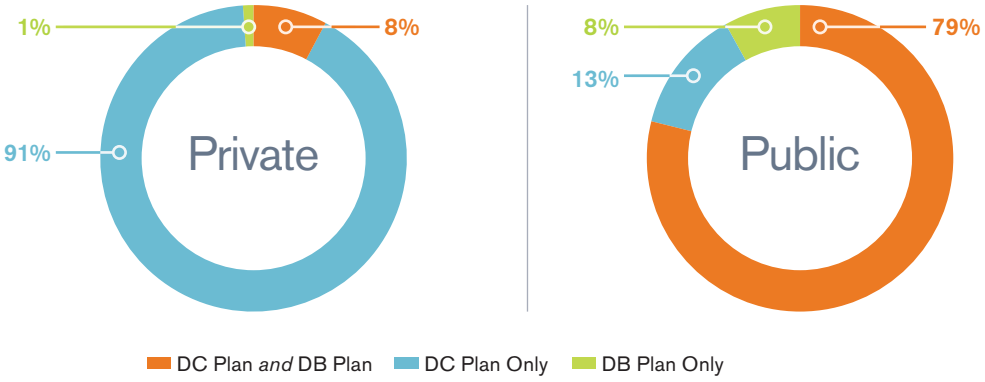
Sibson found that relatively few institutions offer either retiree dental coverage (13 percent), which are mostly retiree-pay-all programs, and retiree life insurance (24 percent).

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

Retirement-Income Plans: Dramatic Differences Among Private & Public Institutions

Sibson found differences in retirement benefits offered by private and public institutions. Very few private institutions (only 9 percent) offer defined benefit (DB) plans. In contrast, a majority of public institutions offer a DB plan (87 percent). See the set of charts below.

Retirement Plans Offered by Private and Public Institutions



Source: Sibson Consulting, 2016

Practically all (99 percent) private institutions offer a defined contribution (DC) plan. Moreover, 91 percent of public institutions that offer a DB plan also offer a DC plan. It is common for state retirement plans to offer a DB plan with the ability for some groups to opt out and select the state DC plan (Optional Retirement Plan) as an alternative.

Among all DC plans, 77 percent include an employer match. For institutions where the primary retirement plan is a DC plan, Sibson found that the median institution contribution to their DC plans is 9 percent of compensation, with a 25th percentile at 7.1 percent of compensation and a mean contribution of 8.7 percent of compensation. This continues to be close to three times greater compared to corporate contributions to 401(k) plans.[5]

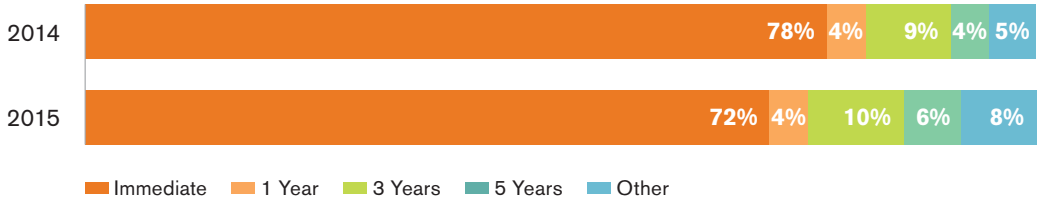
Sibson Observations When newly hired faculty and staff in public institutions are asked to choose from among a DB plan, a DC plan and hybrid models they are faced with a challenging analysis that few perform well. Many may "give up" and accept the default plan. For some, it works out well; others may later regret their decision as they face challenges in preparing financially for retirement.

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

[5] According to the Bureau of Labor Statistics' *2014 Employee Benefits Survey* (pgs. 215-224) (http://www.bls.gov/ncs/ebs/detailedprovisions/2014/ownership/private/ebbl0056.pdf), the median match for all private sector employees is 50 percent of the employee contribution up to 6 percent, and the median employee contribution is 5 percent. The median maximum employer contribution is only 3 percent.

Sibson's study continues to see movement away from immediate vesting in DC retirement plans. Nearly 30 percent of institutions now have a service requirement, most requiring three or more years of service. The graph below shows the year-over-year comparison of DC retirement vesting schedules.

Vesting Schedules for DC Retirement Plans, 2014–2015



Source: Sibson Consulting, 2016

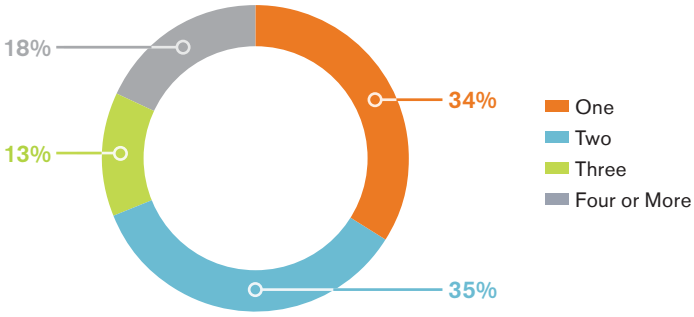
Sibson Observations Every institution should consider including a schedule whereby vesting is not always full and immediate, which has a low impact on employee retention while offering significant cost savings. With high turnover commonplace in higher education in the first five years of employment, this can be a good source of savings — while still rewarding those employees who do not leave after only a few years.

Institutions are often redesigning their investment options around a "best-in-class" menu that includes a family of target-date funds as the default option.

"Sibson's study continues to see movement away from immediate vesting in DC retirement plans. ...Every institution should consider including a schedule whereby vesting is not always full and immediate, which has a low impact on employee retention while offering significant cost savings."

Vendor consolidation continued in 2015 although at a somewhat slower pace than the last few years. As shown in the graph below, Sibson found that more than two-thirds of institutions have only one or two DC plan administration vendors.

Number of DC Plan Administration Vendors Used by Percentage of Institutions



Source: Sibson Consulting, 2016

Sibson Observations More vendors does not necessarily mean better choice. Vendor consolidation often allows for reduced expenses while still offering significant choices of investment options. Vendor consolidation will continue particularly at institutions with more than four active vendors. When consolidating investment options, institutions often add a brokerage account to give faculty and staff access to almost any mutual fund in order to mitigate the misconception that vendor consolidation is a reduction of choice. Institutions may want to provide counseling for employees about retirement planning to get faculty and staff ready to retire. Recordkeepers may provide on-campus counseling, but often those that need it most do not take advantage of the service. Coordinating these educational efforts with your recordkeeper can significantly improve success and overall employee outcomes. This approach, in combination with bank/credit union programs and group legal services, can help promote fiscal responsibility of both personal and institutional resources, while reducing the stress of financial wellbeing to employees. Additional avenues may include retirement-readiness reports and incorporating behavioral economics by adding a matching feature and improved communications. Data available from your DC plan recordkeepers can be helpful in developing a strategy.

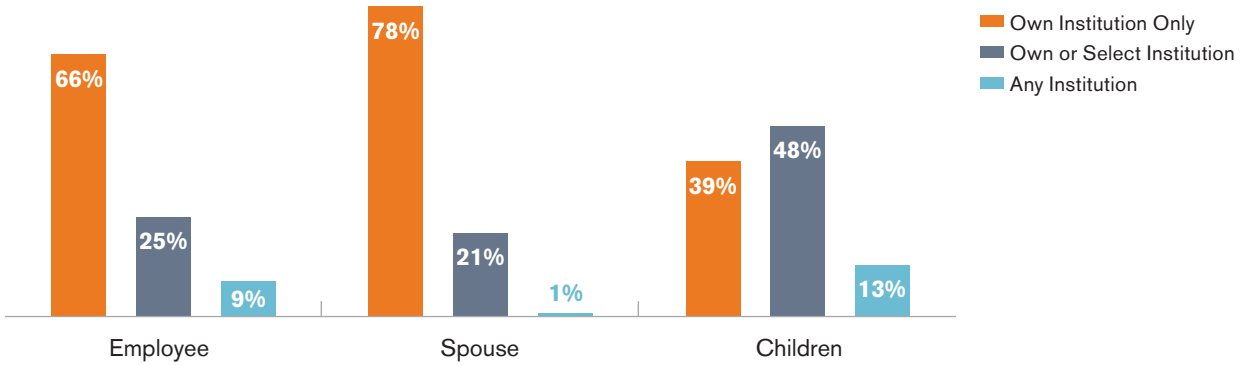
> "More vendors does not necessarily mean better choice. Vendor consolidation often allows for reduced expenses while still offering significant choices of investment options."

Tuition Benefits: One of Higher Ed's Unique Recruiting Advantages

Tuition benefits align with the institutional teaching mission, are unique to higher education, and are commonly viewed as one of the most valuable benefits offered by the institutions. As a result, it is one, and perhaps the most significant, of many incentives to draw employees to higher education. Tuition benefits can play an important role in the intellectual health of the workforce and their families.

Virtually all institutions offer tuition benefits to employees and their dependent children and approximately 90 percent offer tuition benefits to dependent spouses. The graph below shows where those benefits are offered.

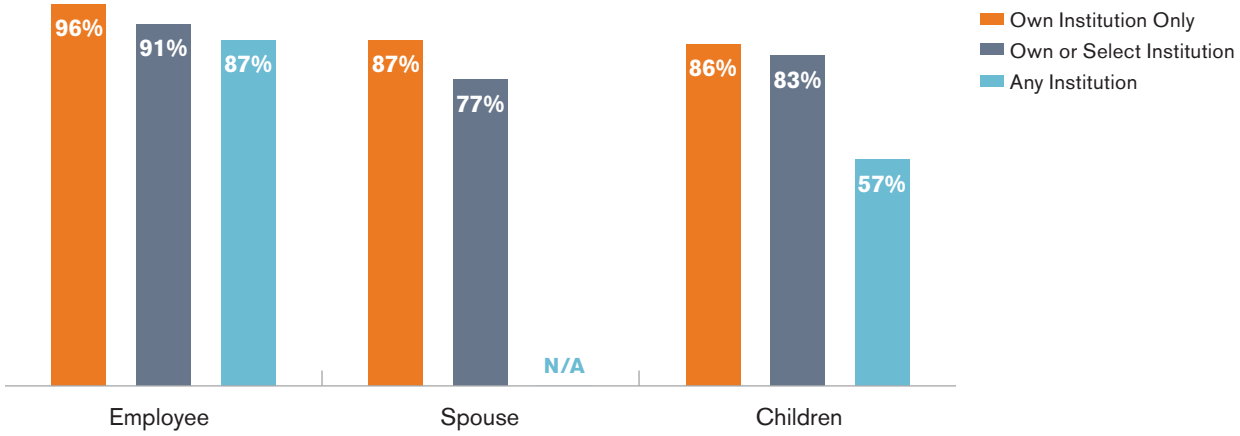
Where Tuition Benefits Are Offered



Source: Sibson Consulting, 2016

The graph below shows how the average percentage of tuition reimbursement varies by where the benefit is used.

Average Tuition Levels Reimbursed*



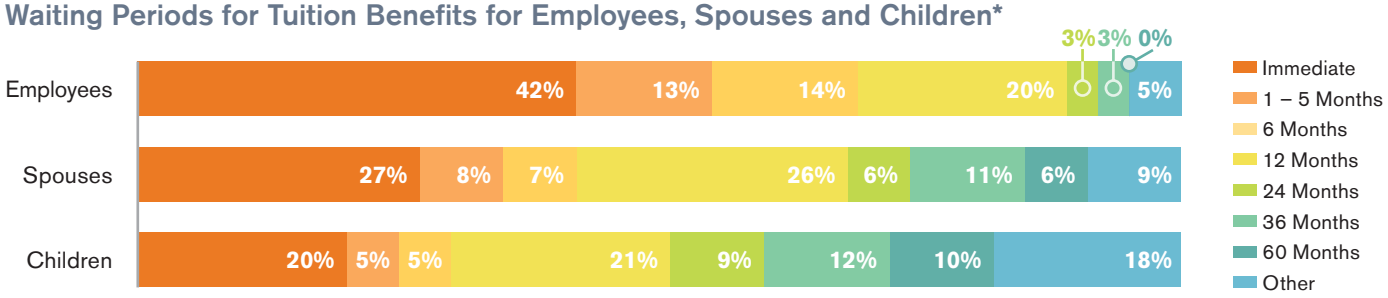
* The variance among faculty, administrative staff and clerical staff was negligible, so the results shown represent the average.

Source: Sibson Consulting, 2016

On average, after health and retirement, tuition benefits are the third largest benefit cost as a percentage of operating budget with most of the cost subsidized by the institution. To keep this cost down, there are usually credit-hour, or sometimes dollar, limits to the benefits particularly when used by an employee or spouse. Sibson found that the median credit hour limit for employees and spouses is 14 hours per year, or 7 hours per semester. When used by a dependent child, however, the median limits are much greater: 27 credits per year or 13 credits per semester. This estimate assumes there are two semesters per year. As shown in the first graph on the previous page, employees and spouses are usually required to use this benefit at their own institution. In contrast, dependent children usually have more options. Sibson found that the percentage of institutions limiting the tuition benefit for dependent children to the employee's institution of employment was higher in 2015 (39 percent) than in 2012 (30 percent).

Sibson found that the waiting period among the institutions is significantly spread out, particularly for dependent children. This indicates that institutions place a different emphasis on the role tuition benefits play in employee retention. It also found slight differences among the average waiting periods for faculty, administrative staff, and clerical staff. Of the three groups, faculty have the shortest waiting periods with a large percentage of that group (44 percent for employees, 29 percent for spouses and 22 percent for children) having immediate access or no waiting period. (See the first set of bars in the graph below.) This is 2 percent higher than those with no waiting period who are administrative staff, and 4 percent higher than those with no waiting period who are clerical staff. The graph below shows the average waiting periods for tuition benefits for administrative staff, which is representative of all employees.

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



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

Source: Sibson Consulting, 2016

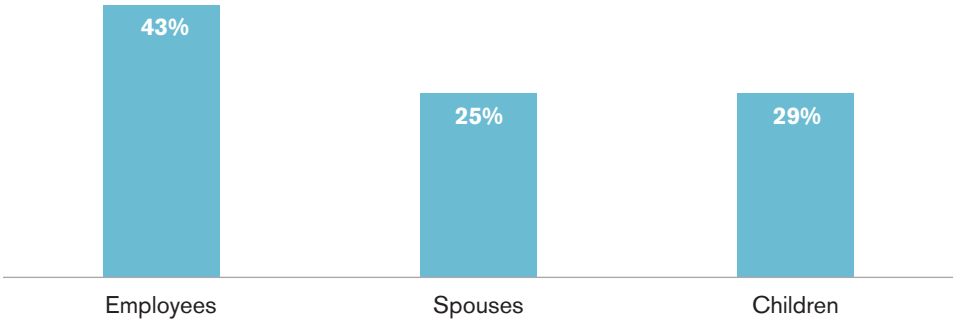
> "Sibson found that the waiting period among the institutions is significantly spread out, particularly for dependent children."

Sibson found an erosion of the immediate waiting period over time. In 2012, Sibson reported faculty employee immediate tuition benefits (no waiting period) at 51 percent, which is now down to 44 percent in 2015. Administrative staff employees had immediate tuition benefits (no wait) at 46 percent, which is now down to 42 percent in 2015. Clerical staff also saw this similar decline, falling from 45 percent in 2012 to 41 percent in 2015 for immediate tuition benefits. Similar declines hold true for spouses and children of employees.

Only 22 percent of the institutions require coursework to be job-related for employee tuition reimbursement. This is higher than the 14 percent reported in 2012, and reflects another way institutions have changed tuition benefits with an eye on controlling cost.

The graph below shows how the percentage of institutions with a minimum grade requirement differs depending on who is requesting reimbursement. These percentages are all higher by 5 to 10 percentage points across each tier from what Sibson's CUBS reported for 2012.

Percentage of Institutions with a Minimum Grade Requirement by Family Member



Source: Sibson Consulting, 2016

Sibson Observations Consideration must be given to whether the investment in tuition benefits is optimal as part of total compensation expenditures and, if so, how to communicate its value to current and prospective employees. Is it drawing the talent your institution seeks, or adding significant cost without building a noticeably distinct workforce? Tuition benefits can include features that preserve the value of this very rich and attractive benefit while reducing program costs. Longer service requirements, credit or dollar limits and making the employee benefit tied to job-related coursework for eligibility to receive reimbursement are all commonly used ways to keep the cost of this benefit from growing too quickly. We have seen a shift toward providing tuition at only the employee's institution. The biggest drop-off is in the number of institutions providing tuition benefits at any institution. Of course, institutions must consider the impact of any of these changes on recruitment and retention.

> "Tuition benefits can include features that preserve the value of this very rich and attractive benefit while reducing program costs."

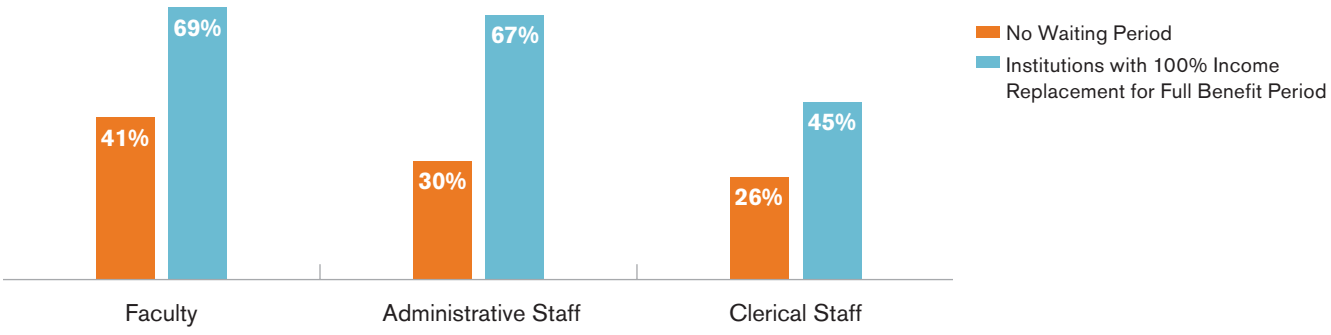
Leave Programs: Offerings Differ by Employment Groups

Leave programs play an important role both in protecting faculty and staff from financial hardship and in promoting personal and professional renewal. At colleges and universities, leave programs tend to be a bundle of benefits that might include some or all of the following: salary-continuance plans, holiday leave, vacation time, personal days, sick leave, short-term disability plans, long-term disability plans, maternity/paternity leave, and sabbatical leave. Some institutions also offer bereavement and military leave. (Formal paid time-off programs[6] are not common in higher education).

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

- ***Vacation Time*** On average, administrative staff at the institutions in the study receive four to six more days of vacation time than clerical staff receive in the first 10 years of employment. This difference diminishes as service increases. By 15 years of service, the difference in time off becomes negligible. These differences were also reported by Sibson's CUBS for 2012. Administrative staff accrue a median of 20 to 22 days of (median) vacation per year, depending on service, while clerical and support staff accrue 11 to 21 days per year, also depending on service.
- ***Sabbatical Leave*** Faculty are much more likely than other employees to be eligible for sabbatical leave. Among the institutions, 85 percent offer fully paid sabbaticals to faculty, compared to 37 percent that extend it to administrative staff and a smaller percentage (27 percent) that offer it to clerical staff. Faculty receive a median of 20 weeks, or 1.25 semesters, of sabbatical leave. Administrative and clerical staff, who work all year, receive a median of 26 weeks, or 1.0 semesters (given they work all year), of sabbatical leave. CUBS does not collect data on how often faculty may take sabbatical leave.
- ***Salary-Continuance Plans vs. Short-Term Disability Plans*** Salary-continuance plans[7] are not typically offered to all employment groups. Sibson found that 42 percent of institutions offer that benefit to faculty and 39 percent offer it to administrative staff, but only 28 percent offer it to clerical staff. Instead, clerical staff are offered short-term disability at a higher rate than faculty and administrative staff (by 3 to 4 percent). A majority of institutions require a waiting period before employees can participate in salary-continuance plans, but among those that do not, faculty are more likely than either administrative staff or clerical staff to not have a waiting period, as shown in the following graph.

Aspects of Salary-Continuance Plans by Employment Group



Source: Sibson Consulting, 2016

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

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

Virtually all institutions offer long-term disability (LTD), with 43 percent integrating their LTD programs with their short-term disability program.

The 25th, median and 75th percentile benefit percentages were all 60 percent, with the median monthly maximum of $8,000/month and a 180-day elimination period.

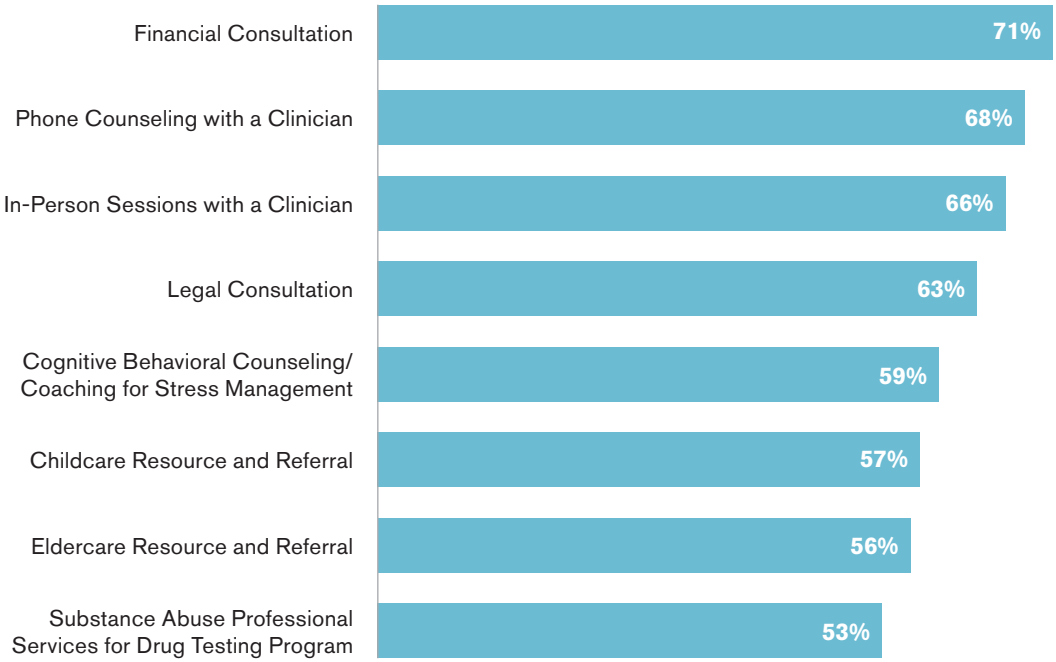
Sibson Observations Variation of leave benefits for administrative and clerical staff is most prevalent in institutions' paid time-off policies. With the Department of Labor's final rule on overtime pay under Fair Labor Standards Act (FLSA) potentially resulting in the shifting of certain positions to non-exempt from exempt, institutions will need to plan for the potential impact on their benefit offerings. With the new FLSA rules effective December 1, 2016, now is the time to review these differences and to consider homogenizing the benefits offered to exempt and non-exempt employees through either decreases or increases in the programs that differ today.

Integrating short-term disability and long-term disability (LTD) programs could save 10 to 15 percent of LTD premium costs.

Employee Assistance Programs: The Key Is How to Use Them

Sibson found that in 2015 at least 50 percent of institutions in the study offer the eight employee assistance program (EAP) services listed in the table below. EAPs can vary in value based on how many face-to-face sessions an employee can schedule, and how connected the EAP is to other benefit plans, such as the wellness plan, or the medical plan. The EAPs offered by the institutions allow for nearly five in-person visits each year, on average.

Most Prevalent EAP Services by Percentage of Institutions Offering Them



Source: Sibson Consulting, 2016

Sibson Observations EAPs can play an important role in supporting the wellbeing of a workforce, but they are often not promoted and communicated properly, and may be underutilized if they are designed only to support those in distress.

Life Insurance: Nominal Increase in Benefits

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

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

Group Term Life Insurance Provisions by Percentage of Institutions Offering Them

* Under this provision, benefits are paid when the employee is diagnosed with a terminal condition.

** Under this provision, no premium payment is required during the period of disability.

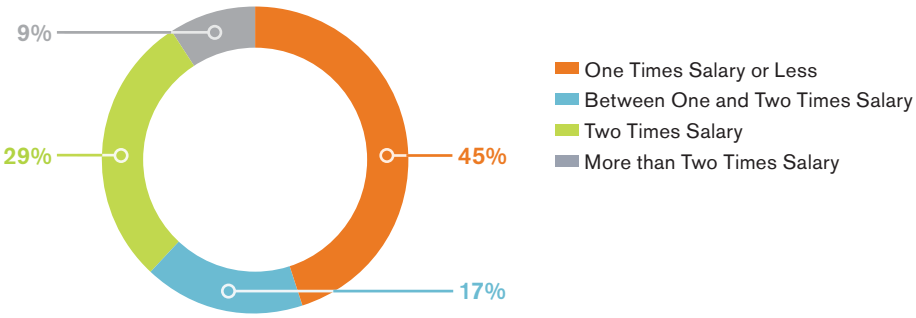
Source: Sibson Consulting, 2016

> Sibson found that basic group term life insurance does not often vary by employment group, and most institutions include similar provisions tied to this benefit.

> [Basic life salary] multipliers are higher for 2015 than what Sibson previously reported for 2012.

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

Multiple of Salary Used to Calculate the Level of Group Term life Insurance by Percentage of Institutions in the Study that Calculate the Level of Basic Life Insurance Using a Multiple of Salary



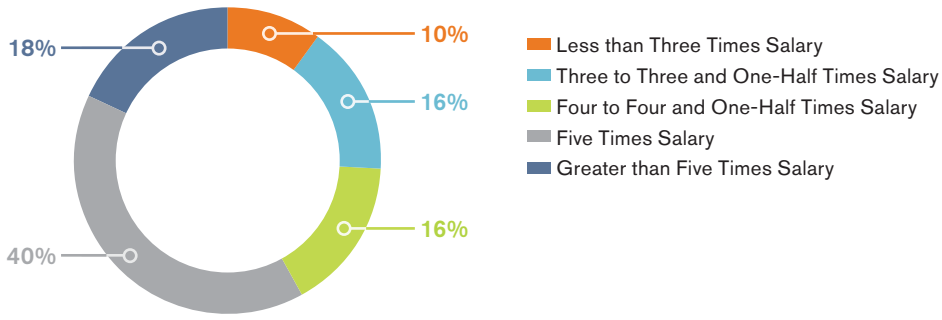
Source: Sibson Consulting, 2016

Note that these multipliers are higher for 2015 than what Sibson previously reported for 2012, as benefits based on two times and more than two times salary are now more prevalent by 3 to 4 percent.

Eighty-one percent of the institutions reduce life insurance benefits when employees reach a specified age. The median age at which that reduction takes place is 65. Of those with benefit reductions by age, 87 percent of the reductions are by some percentage of the benefit, while the other 13 percent are reductions by or to a particular dollar amount.

Among institutions that offer optional life insurance, Sibson found considerable variety in the maximum benefit level allowed. The breakdown for 2015 levels is shown in the following graph.

Multiple of Salary Allowed for Optional Life Insurance by Percentage of Institutions



Source: Sibson Consulting, 2016

The maximum multiplier on average is higher than what was reported for 2012.

Non-Traditional & Voluntary Benefits: Creative Edge Offerings & Considerable Variety

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

Selected Non-Traditional Benefits Offered by at Least 50 Percent of Institutions by Percentage of Institutions Offering Them

Access to Campus Fitness Center(s)		89%
Long-Term Care Insurance		82%
Group Home and Auto Insurance		71%
Day-Care and Eldercare Referral Services		62%
On-Site Day-Care/Eldercare (or Reimbursement)		62%
Group Legal Services		54%

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

Source: Sibson Consulting, 2016

Key to Symbols:

 Benefits that Save Employees Money or Provide Additional Financial Security

 Benefits that Can Play an Role in a Healthy Campus Initiative

 Benefits that Support the Work/Life Needs of Faculty and Staff

Sibson Observations Voluntary benefits, such as group home and auto plans and bank/credit union programs, offer significant value for little to no additional cost to the employer. Non-traditional benefits that build affiliation among employees, the institution, and the surrounding community can be particularly attractive. Benefits such as internet and phone discounts, discounts to local businesses/vendors, and discounts to local museums, performing arts and sporting events all tie the employee to the institution's culture and environment. However, in order to reap the rewards of offering low-cost, non-traditional benefits, it is critical that they be wrapped into a broader total rewards strategy and communicated clearly, consistently and frequently to the employees and in recruiting and retention materials.

Opportunities

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

- Focus on wellbeing.
- Enhance the benefit package at little or no cost through non-traditional and voluntary benefits.
- Continue to review generous tuition, medical, time-off and retirement benefits as part of their total compensation offerings.
- Emphasize retirement-income investment assistance and retirement-planning tools and services.
- Determine benefit competitiveness as part of their total compensation offerings.

It is essential to measure how well current benefits meet employees' needs. Peer comparisons and employee surveys can help determine need and satisfaction, while showing that the institution is looking out for the wellbeing of its employees.

All decisions about changes to benefits and/or the introduction of new benefits should be made as part of an overall strategy that takes into account the institutions' needs of current and prospective employees and what other employers are offering, within both higher education and other industries. Another important consideration in this planning process is how legal requirements will or might change. The Affordable Care Act continues to be a driving influence of health benefits, with new inclusions on mandated coverages and changes to restrictions such as the maximum amount of wellness incentive dollars that may be provided for certain employee actions. The use of public and private health insurance Exchanges/federal Marketplace and the infiltration of more and more accountable care organizations as health insurers will likely help shape the coming landscape.

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

Methodology & Institutions Studied

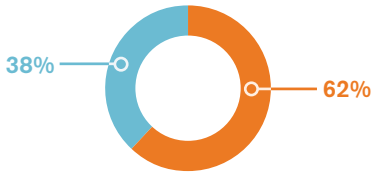
Sibson conducted the latest *College & University Benefits Study* in 2015. The study reflects data from more than 450 institutions.

Sibson collected 2015 benefits data from institutions' websites and from work with numerous college and university clients. In addition, through direct institutional outreach, Sibson obtained data that was not publicly available. To the extent that benefits differed by employment groups — faculty, administrative and professional staff, and clerical staff — Sibson compiled data on those differences. Sibson also invited human resources professionals at colleges and universities to participate in an online survey about their institution's strategies to manage health care costs for faculty and staff.

To calculate medical/prescription drug and dental rate increases, Sibson looked at only those plans for which premium and contribution data was gathered for both 2014 and 2015. Additionally, Sibson chose only those plans that appeared to be structurally similar to the previous year. Moreover, institutions that offered a different number of plans within each plan type in 2015 than in 2014 (*e.g.*, where two PPOs were offered in 2014 and three were offered in 2015) and those that replaced a plan with a significantly different plan were excluded.

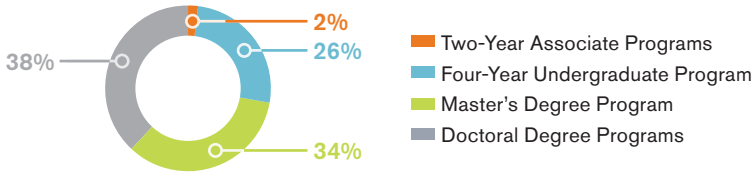
Type of Institution

A majority of the institutions in the study are private.



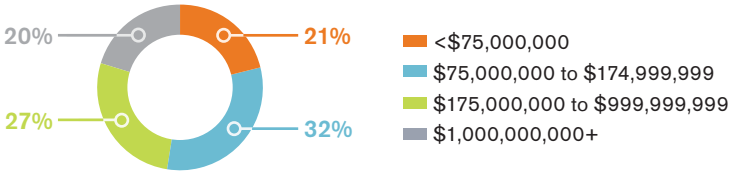
Type of Program

Nearly three-fourth of institutions in the study confer graduate degrees.



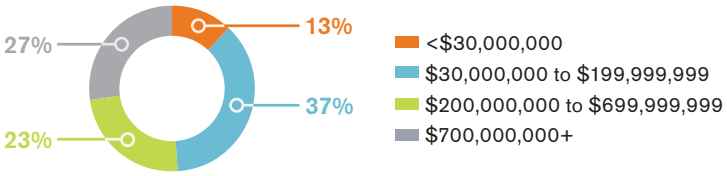
Annual Operating Budget

The institutions in the study vary significantly by annual operating budget.



Endowment

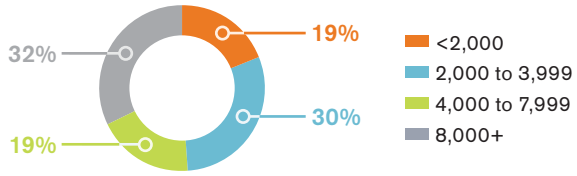
Endowment size of institutions in the study also varies.



Source: Sibson Consulting, 2016

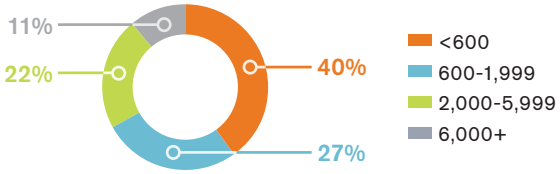
Undergraduate Enrollment

Just under one-third of the CUBS institutions have at least 8,000 undergraduates, but a similar percentage of the institutions have undergraduate enrollment between 2,000 and 3,999.



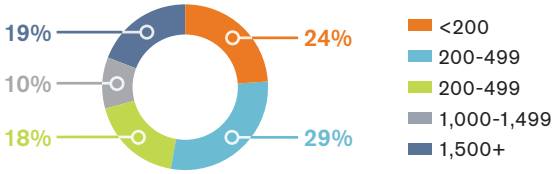
Graduate Enrollment

CUBS institutions' graduate enrollment is lower: under 600 for the largest segment of the institutions.



Size of Workforce by Number of Full-Time Faculty

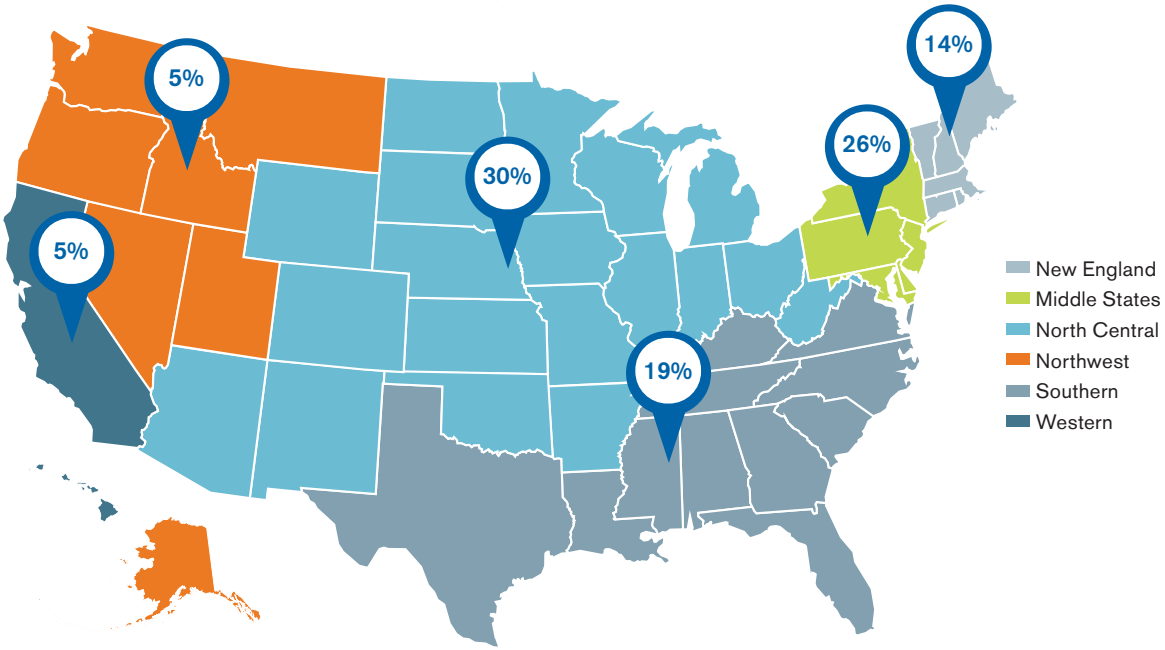
More than half of institutions in the study have fewer than 500 full-time faculty.



Source: Sibson Consulting, 2016

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

Region of Accreditation as Defined by Accrediting Agencies*



* Regional Accrediting Organizations 2015-2016, Council for Higher Education Accreditation, accessed January 5, 2016. Regionally Accredited Colleges/Universities, State of Washington Office of Superintendent of Public Instruction, accessed January 5, 2016.

Source: Sibson Consulting, 2016

Join Our Email List. Share Your Feedback.

This CUBS report does not cover all of the information in Sibson Consulting's extensive database of benefits offered by higher education institutions. Sibson can be retained to provide custom data reports, including comparisons among benefit designs, regions, institution type, institution size, number of full-time faculty, number of undergraduate or graduate students, operating budget and/or endowment. For more information about Sibson's college and university database and the CUBS data discussed in this report or to find out how to participate in the next CUBS, contact one of the following experts:

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

Sibson Consulting

Sibson Consulting Understands Higher Education

Strategic Consulting Services for Higher Education

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

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

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

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