(1) My biggest health care concern is that half of the faculty in my department have no health benefits at all because we are adjunct. Most of us teach 3/3 here, and many of us teach elsewhere, as well, or have other part-time jobs. Nevertheless, despite our hard work, we have no medical, no retirement, no benefits at all, not even a living wage. Please remember when you send emails to Faculty-All that many of us, perhaps a majority of us, lack basic employment protections and privileges. We are not even allowed to vote or have a voice in shared governance, despite having PhDs, years of experience, and the responsibility for most undergraduate general education classes.

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(2) I have some suggestions for Fac Welfare. Perhaps these are things the faculty welfare survey (if the committee is doing one this year) could address, but I also think it's an issue that should be raised by senate. That is, how is the university going to evaluate its change in health care plan?

Several years ago, the committee agreed to invest in a Wellness program on a three-year trial basis. But we defined how to evaluate the success of the program only loosely, suggesting we were hoping to start with a 40% participation rate in the first year but not really defining (if my memory serves) what participation level would constitute success in year three. As Claus points out, we can't prove a negative: we can't show how many heart attacks have been avoided. And such benefits of Wellness are long-term. So there was a logic to using participation. But we never did an evaluation: it has been assumed since adoption by Tony, Wade, and Kari that Wellness would continue indefinitely. There has not even been any suggestion we should evaluate our Wellness vendor, which is strange, given that the success of such programs in terms of ROI varies greatly.

And we cannot now evaluate how attractive the Wellness program is to employees given that there is now a significant cost to not participating that has no doubt significantly driven up participation. So perhaps the Faculty Welfare Survey could ask about whether employees find the program valuable--ie has it actually helped them live a healthier lifestyle. And another question (or option) asking if they are participating just for the $.

A bigger concern I have is that decreased use of medical care will be read as success of both Wellness and the Consumer-Driven health plan. It has been emphasized repeatedly in Benefits meetings that we need to keep employees from overusing healthcare and from using more expensive versions (i.e., ER rather than Urgent Care visits). While the latter makes sense in theory (though price comparisons are virtually impossible, IMHO), the former assumes that WKU employees are overusing health care and, to cite an oft-repeated example, getting more things done at the end of the year b/c they've reached their deductible. While there are no doubt instances of both over- and under-use, the committee has been told that the actuaries say that WKU's use of health care is what would be expected for this size group. So we have made a bunch of decisions based on a premise that our own evidence does not support.

My biggest concern is that the employees who have chosen the no-cost option are in reality just not going to be able to seek healthcare b/c they have no HSA or HRA. (I don't really know how the employee assistance program works, and I'll bet some of them don't, either.) Yes, they can get an annual physical & related tests for free, but as one staff member asked me, "What's the point of a mammogram if I can't afford the follow-up care if they find something?" Now, this is the kind of thing HR could get actual numbers for: how many doctors' visits for 2014 v. 2015, and I'll be they could get it broken down by income level (they definitely could by type of plan). But that still does not show the cause of the decrease I'm assuming.

I guess my first question for the president and Tony Glisson is how are we going to evaluate the effect of the consumer-driven health plans on employees. Tony assumes the evidence shows such plans (consumer-driven w/ a Wellness component) work, but that is not the case. Everything I've read suggests that the data is not in & the results are mixed. Of course, Tony is getting his evidence from the Wellness vendor & Sibson Consulting (heavily invested in such plans). I also get the impression these plans are the hot new thing at Human Resources conventions.

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(3) We cannot go back to an all PPO system (as in 2014) unless we find a source of new money. The key - that is what the senate needs to insist on - is the overall cost-sharing (as a percentage employee vs employer). This should NOT change - and it does not according to our consultants. This would have been my main point for the senate. I personally saw a shortcoming in the cost comparison tools and I foresee difficulties in the cost estimation. This are things that I will push to improve - and where I see that something can be done.

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(4) The first thing I found out is that in addition to probably having to pay more out of pocket, esp. because of a new Rx deductible (a common gripe you'll get, I'm sure), I now have to find a new eye doctor for my yearly vision exams. And it's going to drive up the cost to the university.

I have an extreme dry-eye condition that mandates I see an MD for its management. But my MD doesn't participate in our new vision plan, so I'll now have to make two appointments, take two afternoons off work, pay two copays—one for my vision check

(filed on the vision plan), one for my dry-eye check (filed on the medical plan)—instead of the one since she used to do the dry-eye management at the same time as my vision check each year. She used to file it on my vision for me, but now she won't do that part because she doesn't participate in that new plan. She's at Graves-Gilbert Clinic, so I know I can't be alone in this conundrum… but I'm betting a lot of people haven't noticed yet!

[….] Highly annoyed with having to find another eye care provider. And having to take extra time off of work.

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(5) You may share my experience if you wish. I am currently paying 160.00 to insure myself and my [child], a [student] at WKU.

To keep the same plan I currently have, I will now be paying—I think it is around 230.00—or about 70.00 a month more.

I have been a divorced, single, full-time working [parent] for the past […] years. I know how to stretch a dollar, however, for those of us who are not [on] two income households an additional $840 is truly a significant hit.

As an aside, I have always found it interesting to compare the salary of some of WKU's lowest paid faculty with what they would make teaching K-12 in the BG Independent school system http://www.bgreen.kyschools.us/userfiles/992/Salary%20Schedule%202013-14.pdf

I taught high school…and I do not think some realize they are making the same, or very little more than their colleagues teaching elementary and high school. Don't get me wrong. I think K-12 teachers should have a starting salary of $70K. I also think that if we truly are a "leading university with international reach," WKU should make sure ALL of their collegiate faculty are making at LEAST a few thousand more than their colleagues at McNeil Elementary, located on the edge of campus.

My […] issue with the new plans is that you must pay for prescription medications in full until the medical deductible is met. This is a hardship on myself and many employees who must take medicines that are very costly. We would love to not have to take any medications and cannot control some of the reasons these medicines are needed. The rest of it actually makes sense and is doable with the HSA money provided.

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(6) I am a single [parent] with no assistance. I do live paycheck to paycheck, and I certainly do not have it in my budget to "find" an extra thousand dollars a month. In addition, it is apparently frowned upon for faculty to have second jobs, so I'm not quite sure what I'm going to do.

Thank you so much for requesting this input.

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(7) Hello,

I wanted to clarify regarding my medications. I am signed up for the Healthy Saver 2,600 plan. With the healthy life challenge, I am credited $2,300 initially that will go toward my deductible, including Rx. I am on 5 medications, all generic. It has taken YEARS for my Drs. to find the right combination of medications, so I am not able to change prescriptions. I have already spoken to the Rx people about how to "get my prescription costs down." After going to my pharmacy today, all of my GENERIC prescriptions will total $1065 per month. I have checked the "preventative no cost" prescriptions, and the only one that is eligible is a $4 scrip. So, for the purposes of this illustration, I will just keep the total at $1065.

So starting with $2,300:

January: I will have no "out of pocket" costs as what is in my HSA will cover this.

February: I will have no "out of pocket"

March: HSA will pay $170 and be exhausted. I will then pay $895 out of pocket.

April: I will pay $1065 out of pocket.

May: I will pay $340 out of pocket to meet the deductible, then whatever copays apply.

Is this correct?

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(8) My [spouse] and I just learned that we have a deductible on our drugs of $3500. We have to buy this much before we have any coverage. This is ridiculous! I feel like the faculty are getting the shaft with this year's health "benefits."

The deductibles are ridiculous, and a number of prescriptions that were covered are no longer included or count toward meeting our deductible. That being said, I've checked around with other people in other industries and it seems they are facing the same issues. Unfortunately I feel like while there is now help for those who were uninsured and those with pre-existing conditions, it's coming at the expense of us in the middle-income range.

(9) My [spouse's] medication will be $425.00 per month until I reach the $1000 threshold at which point it will be $40 a month. That is not horrible--but finding this out at the November benefits fair did not give us much notice to amend our January and February and March household budgets.

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(10) Regarding your request for information, I can say, I think speaking objectively, that many corporations and companies, outside of academia, are doing this sort of thing for health benefits. I say this really just based on my own conversations with friends or family outside of academia. I would say that the issue seems to me to be a lack of easy comparisons between plans. I think the HR people did a very good job of handling the transition, considering they were given such a short time to deal with this.

… I would ask that the HR … provide members with cost comparisons for each of the plans, based on their previous year's benefit usage. It was kind of provided this year, but it did not really help me make the decision. I know for Warren county schools, where my [spouse] works, it is a bit similar and they are sent a simple comparison each year around benefits time. Somehow it is much easier to decipher and choose.

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(11) I want to make a general observation. As a single person I have not felt the need to look deeply into insurance coverages in the past, and in any case find such efforts mentally trying (I don't think I'm an idiot, but I just find financial stuff extremely tedious). I could live with the system as set up until this year, but it is now complicated to an extent I no longer feel comfortable with. On the basis of advice from one of my colleagues (who is much more 'up' on these matters), I came into one of the support meetings ready to sign up for one of the systems, but was told when I got there I hadn't taken into account the fact that I am [over 60] years old, and that the one system I'd selected was a bad idea on that basis. I switched to another.

I am trying the 'healthy plan' stuff (at the urging of my colleague) to get a savings, but am not convinced yet it doesn't include enough additional red tape to increase the 'tediosity' level to make me drop it in the future, no matter the savings. I am not so interested in saving a few hundred bucks as I am in having to deal with this stuff as little as possible.

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(12) It is even worse than I thought. Though the information is written in jargon and might as well be Greek, it appears that the deductible is $3500 EACH for my [spouse] and me. The material WKU gives us is almost indecipherable, and we could use information in clear English. My [spouse] uses Nasenex which has no generic and it is going to cost us $200 a month. [My spouse] can go to [the] doctor and ask for a generic which may not be as effective. [My spouse] has 4 prescriptions and I think only two are generic. I have two prescriptions which, fortunately are generics. This is appalling. Is WKU in this much trouble that we effectively remove drug coverage as a part of our health benefits?

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(13) …I'm truly excited about this program initiative and hope that WKU reaps a healthier work environment because of its commitment to the workforce.

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(14) I have a rare medical condition that requires me to be treated … at Vanderbilt. The drugs and treatments used are often experimental and expensive. Because my condition is life-threatening at times, I have to be monitored carefully, even with something as simple as the common cold. Prior to becoming symptomatic several years ago, I spent summers writing articles and grant proposals. After becoming symptomatic, even with good health insurance, I had to start teaching summers in order to pay for the many expenses incurred living with a disabling condition that were not covered by insurance. This has affected my career trajectory, but for the first few years, I was at least able to maintain relatively the same standard of living. This is no longer the case. Between lack of raises, increases in cost of living, and decreased medical coverage, I now teach the maximum number of courses allowed (summer and winter) and have been falling behind financially. The recent change in health insurance coverage will have an even more devastating impact. My paycheck will take a [another] hit now that the top-tier employee-only coverage is no longer fully-funded. However, the maximum out-of-pocket is where I will take the biggest hit, compounded by the rising costs of my non-covered medical expenses. Perhaps the only positive thing I have to say is that once I've crossed the maximum threshold, I've been assured (by Anthem) that approved medical expenses are then covered at 100%, and thus no co-insurance or other out-of-pocket expense. I hope this is true.

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(15) I have an experience that might be of interest. On 8 Jan 15, Kari Aikins sent out a message about a new FSA-like program called a Waiver HRA. As…someone who opted out of the WKU health coverage, I am not eligible for the new Waiver HRA account since, for some reason, government health programs...do not qualify. So, WKU proposed to offer me a cash payment of $1500 for

the FSA-like benefit. The problem is that I will have to now pay federal, state, and local taxes on this $1500 ($2000 with the Top Life Wellness program). This will effectively reduce the value of this benefit by ~35%. This appears to be a material breach in commitment to my level of compensation.

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(16) It may very well be the case that Benefits Committee & Administration did the very best job possible given the restrictions imposed by new healthcare insurance mandates, but there are a couple of concerns that I would like to mention. One deals with procedures, and the second with costs, in particular, prescription drug costs.

It is my understanding that we will no longer make co-pays when using our benefits, but rather pay the entire cost associated with the product or service (e.g., doctor office visits) until our deductible is met. I suspect that a provider will have no access to real time information regarding whether a patient has met the deductible, and will thus require payment in full -- many practices have signs posted stating that "Payment is Required at the Time of Service". When I mentioned this to representatives from HR, I was told that I should not pay anything until I receive an EOB (Explanation of Benefits). There doesn't seem to be a middle ground here -- the provider wanting payment in full at the time of service, and HR suggesting not paying anything until the EOB is provided.

The second concern deals with the cost of prescription medications. When I checked with Know Your Rx Coalition (KYRx) and with Express Scripts, I received different prices for the same medications. More importantly, the prices for two of my meds, before deductibles are met, were SIGNIFICANTLY higher than prices paid in the past. To quantify: for the 90-day supply via mail order, one went from $50 to $630.60 (Express Scripts) or $732 (KYRx), an increase of 1161% or 1364%. Another one went from $70 to $1227.50 (Express), an increase of 1654%. Even going with a generic equivalent would still have my prices increasing by over 1100%.

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(17) My [spouse] just called in tears because for the second time this month our pharmacy bill was over $200. Prescription and preventative medications that used to cost $35 are now SIX TIMES MORE. The first instance was for my son who, like every other child in town, was diagnosed with the flu. The Tamiflu bill was $241. Second bill was for monthly preventative meds for our other son – Focalin used to be $35/month, today it was $196!

Yes, we used the Wageworks card and we appreciate that, but in all our preparation meetings I don't remember anyone telling us that drug costs would skyrocket. I remember being told to "review your current medical costs and choose the plan that best fits your spending." These numbers are NOT reflective of past drug costs. We have already spent close to $500 at the drugstore and the month is not over yet. Based on this information we must now prepare to absorb significant drug costs once the Wageworks card runs out – which at this rate will be in three months.

I am very concerned about the sudden rise in drug costs. When a pharmacy bill is over $200 I question whether I actually need the medication or not. I have talked to other faculty and while we have obviously just started with this plan, I have heard a number of comments that reflect not wanting to go to the doctor, not wanting to get tests/procedures done (some tests are not even covered anymore), and not wanting to fill prescriptions. All of these concerns seem to come from a fear of what it will cost in meeting our new deductibles. As a result, the new benefit plan is effectively a DETERRANT for subscribers to get medical care!

[subsequent email, same individual:] I still have significant concerns but I'm not sure my knee-jerk reaction to high drug costs is a complete view of the new plan. Time will tell on that front….

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(18) Obviously, I haven't had much experience with the new system, so I need more data before I can give you the specifics. Please keep the new benefits system on the agenda.

This is what I know so far:

- While the system might work for those who are young, healthy and don't need to see a doctor, it will not work for those who are older like myself [in the 55-65 range] and have various conditions that need regular maintenance. WKU's emphasis seems to be on leading a healthy life style to prevent diseases that might be expensive. Given that I will have to pay full price for my medication (which is around $560 per month initially) and full price to see a doctor (e.g. one initial visit to my eye doctor was $1450 last year, but I only paid $50 for it - even the $50 seemed pricey) before my insurance kicks in, I will avoid seeing a doctor. I can't afford paying a few hundred, let alone thousand dollars upfront even if I were reimbursed later. This situation will likely result in developing a disease that I am supposed to prevent by going to regular check-ups. In other words, the new system will probably make me sicker in general than healthier.

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(19) I don't even know where to start with the insurance thing - the online assessment and the biometric screening and the out-of pocket expenses and the ridiculously clumsy roll-out all make me livid.

But I do have one suggestion to add to your list. With the current attempts to appear sensitive to transgender/transsexual individuals on campus, I would like to see some sort of third (or more) option included in the online assessment and any other places at which it is required that gender be declared.

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(20) Here are some of my concerns that I hope the Senate will address with the Benefits Committee (BC).

* There is INSUFFICIENT REPRESENTATION of faculty (and staff) on the BC. This is the most important issue that has to be addressed, because it is at the core of how this committee works now and how it will work in the future.

* The way the BC operates is NOT in the best interest of the employees because it is very top-down and it is NOT COLLABORATIVE. The BC makes decisions about employee benefits and then presents them to us for discussion, at which point there is no room for negotiation or change. These conversations simply amount to them presenting the plan to us and answering our questions. There should be more dialog with employees (and I mean all employees, not just the faculty and staff reps on the BC) DURING THE PROCESS of developing and evaluating benefit options before decisions are made. In sum, employees are extremely un-empowered regarding our benefits. It is very demoralizing and frustrating.

* Because of the substantial deductibles that were instituted this year, the current health care benefits essentially and fundamentally constitute a CUT IN COMPENSATION for employees. Given that salaries have been largely stagnant for years, this compensation cut is really hard to absorb. This also is very demoralizing and frustrating.

* I find it problematic that reductions in health care premiums/deductibles are tied to employee disclosures of sensitive personal information. While I don't mind it so much (I enrolled in the initial version of the wellness program), I know it is a big concern for many employees. As a personal story, I cover my [spouse] through WKU. [My spouse] absolutely refused to enroll in the wellness program, despite the savings […] we would get in this new benefits package. And there is no option for one spouse to enroll but not the other, so I don't have the option to enroll myself and get at least some of the savings. Besides that, we both are very healthy and we consistently do not use the health benefits as much as less healthy people do. Perhaps the discounts could be based on prior years of health benefits utilization, which is another indicator of wellness (the less you used, the healthier you were/are), as an alternative to participation in the wellness program/disclosing personal health info and stats. * On the positive side, I am satisfied with life insurance, disability, and those types of benefits that we receive.

(21) Problems just related to wellness, the portal, and completing the biometric testing:

- The promised access the website with any device hasn't panned out (phones, tablets)
- People, including me, regularly can't get onto the website successfully from home even when using a computer
- Spouses of employees who opted for coverage weren't notified about how to log onto the website and sign up for insurance, including the wellness, by the stated deadline in December. At least some only received e-mails last week.
- They may not have lost more than 1 blood sample, but apparently the results of blood samples for at least a few people have also been temporarily misplaced

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(22) More concerning is a colleague talking about stopping taking meds because they require a monthly drs visit - which now is altogether too expensive.

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(23) Has anybody experienced technical difficulties with their insurance? I found out last week that my family was dropped January 1 and HR said it was a mistake I made when at my session signing up for insurance. That's strange to me because both my [spouse] and one of the HR representatives checked over the website and we thought it was correct. Everything has been fixed now but it sure was scary last week finding out that three of my family members had no health insurance.

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(24) I waive health insurance due to my [spouse] being able to carry us on […] insurance at a reduced rate. When I first began doing this in the late 90's or early 00's I received my entire "benefit". After a few years, the benefit decreased by half, now I receive $150/mo into an HRA. I think this is unfair. I am a full time benefits eligible employee yet I don't receive my "full benefit". I am no risk to the health plan yet I don't even receive the benefit that is a part of my "benefit's package". I realize I am blessed to have my [spouse]'s plan; however, it is unfair to not be able to have the same benefit as other employees.

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(25) I have hesitated to email because I am so frustrated I was not sure I could control my language. I am not stupid. I am actually quite learned and have several diplomas to that account. However, I understand so little about this new plan that I just go in to

medical facilities and dump whatever paraphernalia they have sent in a pile for them to look through – then I blindly, without question write a check for whatever they say. I do have several serious health problems – after much angst I finally picked a plan assuming the most catastrophic illness possible is in my future. However, I have no idea if I picked the right one or if I will have the wherewithal to work the plan. I have received some sort of orange credit-card-looking thing that I have NO idea what to do with and treat it like a snake in my purse. There is something about some sort of $1000 that I owe or might have to pay back or something. I have done the biometric screening — got an email saying I did it — but when I log into whatever kind of place we are supposed to go to check on our "complacence" it says I have not submitted one. I feel bad for me if I live to have to have to worry about this and bad for my family if I die in the midst and they have to figure it out. I have considered getting fired, getting Obama-care, and living the good life. No amount of trainings, coffees, blogs, or videos are going to explain this to me as it is convoluted and ridiculously couched in some sort of ponzi scheme. I work for benefits. Period. I work so that [my [spouse] and I] have insurance. Now I am not sure why I am working as I do not know if I actually have insurance or if it works, or (God help us) HOW it works.

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(26) My experiences so far:

Tried to find a family physician from the Anthem website. The first six I called no longer are with Anthem or aren't taking new patients or are no longer practicing medicine.

Trying to find a walk-in clinic. The phone number on my card sent me to the website. The website said to call the 24-hour nurse number on the back of my card. There is not one on my card.

Have had 3 or 4 conversations with a nutritionist for a lifestyle coaching to meet top life requirements but not sure how to enter this information into my page data online.

Participated fully in biometric screening but not all info is on my page. - says I am doing 98% well but doesn't specify what 2% is lacking.

Haven't secured a physician yet. Will keep trying.

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(27) I would like to see WKU take back control of our health services bldg. after the contract with Graves Gilbert expires. It would be wonderful to have WKU hire an administrator, a couple of family physicians, a nursing staff, and then allow WKU Faculty, staff, and students to visit the clinic either free of charge or at a greatly reduced rate – say a $5 or $10 co-pay. If set up correctly, this facility could handle all typical office visits for the WKU community when people need to see a physician for a physical, flu shot, simple office visits for children with sore throats, colds, etc. When something more serious is detected/needed, a referral to a specialist at Graves Gilbert or another facility could be made. It seems to me that an investment from WKU towards something like this would go along way to reducing out of pocket expenses for faculty and staff under the current health plan options, AND help to restore morale across campus. At the very least, the Graves Gilbert folks housed at WKU should offer WKU employees a discount for services. If an office visit is going to cost me $75 or more to see a physician on campus at Graves Gilbert, I might as well go and see the guy across town that I have been seeing for years and pay the same rate.

I am extremely frustrated with our current health plan options. It is a little like "bait and switch." The WKU health insurance plans that helped attract me to WKU back in 2008 are VERY different than what we have to choose from presently. This coupled with a lack of any significant pay increases over the past 7 or 8 years is rather unfortunate.

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(28) I [have] a son who recently suffered a fairly bad head injury…and had to visit the emergency. Under the previous plan I was in for $100 and the insurance paid the vast majority of the remaining balance if not all. I received the EOB from Anthem which disclosed that I had to meet my deductible for *him* so "the plan" paid $0.00 (zero) and my responsibility was nearly $1300. This tells me that I'm in for the first $4000+ no matter what. This is not how it was. Given our meager increases in pay (actually decreases as they didn't keep pace with inflation), I've lost much buying power in the market over the past decade making it all the more objectionable.

At a minimum the literature should clearly indicate to the consumer (WKU employees in this case) that the "plan" is not going to pay anything until you've met your deductible of $xxxx.xx at which time the plan will pay X%. The literature may have read exactly that way, but I missed it. My complaint is more of a "let's be more clear" […] that we are getting less coverage and it's costing more money.

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(29) Preston Center must be FREE for faculty/staff and their spouses who take "The Pledge."

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(30) I have made trips to the pharmacy, doctor, and lab. Two of my prescriptions were cheaper, the other four prescriptions were significantly higher. The doctors visit went from $25 to $68…once again significantly higher. The oxygen machine I use is now $89, it was $8. The lab work that had no charge in the old system is now over $200. Additionally, I am paying around $100 more per month than I did last year. The new insurance is a disaster for anyone that has a chronic condition.

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(31) I have noticed two things which are important.

I notice, and have talked to others who have expressed similar sentiments, that there is a hesitancy to go to the doctor for fear of using up my HSA funds early in the year. I think the new plan discourages people from going to the doctor with such high out of pocket cost and such high deductibles. I never thought I'd have to be someone who worried about health care costs, but I am and it is stressful.

Secondly, this new prescription program has been an incredible hassle. I went to get my birth control filled, which should be free, and they wouldn't refill it, saying I wasn't due for a new prescription for two months, which is incorrect because I get new prescriptions every 21 days and I had been doing that for six months. I had to pay out of pocket in order to get my prescription, and I cannot get Express Scripts to help me. They send me form letters to my questions. Not only that, I can't get them to tell me if the problem is fixed so it won't keep happening.

It seems as thought they purposely don't help in order to frustrate you so much that you give up.

I hate to be so negative because I know everyone is working hard to find a plan that make sense financially for the university, but it is really quite stressful and expensive for faculty who are already paid below market wages.

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(32) In addition to the obvious downsides to the new plan, like the huge out of pocket costs, I think the switch to such a different format is both insulting and counter-productive for all of us. I would venture to guess that the University has had a huge loss of productivity due to the time invested by each faculty and staff member trying to actually understand the new plan enough to pick one, (I can't say with confidence I still understand how it really is supposed to work) let alone the amount of time HR and other people who work directly with benefits have had to spend. All the complicated bells and whistles to save $500 by doing the healthy plan feel insulting to me. I feel like a trained seal competing for herring. And, how much did the university spend for the new benefits and wellness websites, and the "health coaches" and etc which supposedly save us money?

I understand that having each member of the WKU staff and faculty be healthier saves us all money, but as someone already healthy, my and my [spouse]'s options to save the $500 are kind of ridiculous. I don't need to quit smoking or lose weight, and I already eat a healthy diet and walk 4 miles every day and work out 3 times a week. My only option to save the money is to get coaching I don't need, and waste my time and the time of these coaches. I can also jump through one of the hoops by getting a mammogram, which is ok. But for the men, are they supposed to get a colonoscopy yearly?!? That would never be medically advisable the way a yearly mammogram or cervical screening might be for women. If, God forbid, we still have this health plan next year, the men are in a ridiculous situation.

By having such a large deductible upfront, it seems also like the number one goal is to keep people from seeking out medical treatment, because they don't want to pay the whole cost of doctor visits, rather than having the traditional co-pays. Most likely, this will raise costs in the long run, since it's been well proven that preventative care saves money. (I realize the plan covers "preventative" care 100%, but their definition of preventative is very limited) People will wait until their conditions are really bad, which will then be more expensive to treat. Ditto with medications.

Overall, I admit to being embarrassed that I didn't learn about the details of our new health plan sooner, and embarrassed that I personally, and we as a faculty, did not object more strenuously when it was rolled out. Honestly, it seems like the extremely complicated nature of it is expressly designed to keep people so busy being confused that we are too busy to protest, and to make it harder to see right away how unfavorable it is. I hope that there is a way to next year go back to a traditional health plan like we had before.

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(33) Here are just a few things I have gathered from colleagues.

1. One faculty member did not receive her WageWorks card until the end of January and found out that the request for it only went in in the middle of January. She can get reimbursed of course, but was just disappointed she didn't have it sooner.

2. One faculty member does not think there is clear enough information on the types of documentation that are required for the Tier 2 wellness activities.

3. One faculty member just offered a word of caution in evaluating some of the comments we may receive this early in the year. Given the structure of the new plans, costs are essentially frontloaded so people may be seeing bigger bills right now until they

reach their deductible and the co-insurance kicks in. If people don't really understand how the plan works, they may be mad about that but as the year progresses, they will see a reduction in costs. He warned that trying to evaluate the changes this early in the year is likely not going to be beneficial. I personally agree and think that we need to get through one year of these new plans to truly see how people feel about them.

4. My own comment is that I think that HR has done a fabulous job handling the changes and answering questions. I have been to their information sessions, read all the emails, watched a few of the webinars they have posted, and as a result feel like I have a good handle on everything. Many of the questions that I have heard people ask have been answered by HR – so it really seems more like some people simply have not taken part in all that HR has tried to do to keep people informed. I hope that as we move this discussion forward that HR is not made out to be "the enemy" – after all, they are university employees who are on the same plans as us! Also, I LOVE WageWorks. Their website is so user-friendly and informative and their customer service is excellent – much better than the company from last year.

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(34) Glad you asked. As you probably know, I have been very vocal in complaining about the needless complexity, hidden and higher costs, and "Rube-Goldberg-esque" manner in which the health care plans have been devised and disseminated this year. I do not fault the WKU HR Benefits staff, they appear simply to be doing their (difficult) jobs.

I am, however, appalled at the 2015 benefit plans, for all of us, but most especially for those staff at the lowest end of the pay scale. The Building Service Attendants are by far the lowest paid individuals eligible for health insurance, and they are forced into an untenable situation with regard to the costs of health plan options. The no-premium PPO $1500 (even with the "Healthy" option), leaves them with EXORBITANT "co-insurance," deductibles, and out-of-pocket maximums—bad for individual subscribers, ruinous for families or couples needing the plan. Why should our lowest-paid employees have to bear the brunt of an unfair health care system?

Additionally, I would like to make the point that one of the "perqs" of working in nonprofits is that, although the salaries are generally lousy compared to the corporate sector, the benefits packages are usually much more generous and offer better health plans and retirement packages. This has always been an attraction of working in the nonprofit sector, in addition to the other, political and social reasons to do so.

With this new health plan, that "perq" has gone the way of the dodo. This is one dramatically lowered incentive to commit to a career in the nonprofit world. With continually escalating costs, and a lack of significant cost-of-living wage adjustments for several years now, to pile on the additional higher costs of this health insurance plan is really an egregious breach of professional care for the workforce.

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(35) "Senate reported that the perception among those on the Benefits Committee and WKU Higher Administration is that the new health plans are fine and acceptable to faculty and staff, because apparently no one has complained to them directly or there were no overt expressions of concern."

I would like to point out that **a)** people were so confused by the options and changes, that they were too busy trying to figure out the complexities of the new plans to voice their concerns; and **b)** often, non-tenured faculty and staff are just too afraid to complain or protest for fear of retribution or retaliation.

That's pretty much a well-known secret, in any case: Don't rock the boat, or you risk "falling" overboard."

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(36) Some of the issues I have with the health care options.

1 – if a person is already doing preventative activities (colonoscopy or mammogram) they cannot count that toward a healthy activity in the 2 tiered approach.

Also if someone is not a smoker then they do not have the option of quitting smoking as a possibility.

Both of these seem to be penalizing to people who are (or have already) tried to make their life healthier.

When the session for other health options like Weight watchers are scheduled whoever put the schedule together for the time slots has totally disqualified anyone who is teaching a Tuesday and Thursday class from 11:15-12:25 time slot. This then restricts the options to Wednesday mornings which backs right up to an 8am class start time or Wednesday afternoon. What about some evening times for these sessions that would possibly be more open to people who cannot make the other time slots.

It appears that we (the university should look into other possibilities for insurance, that is possibly go away from the self-insured. I would suggest that it is a conflict of interest that the only people who are making the decisions are the people who's jobs

are dependent upon the University being self-insured. For the amount of money that is being "spent' Per participant there should be some alternatives available for the employees.

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(37) Have faxed my MD assessment 3 times as of Monday. Obtained proof of fax this last time and sent to Wade Pinkard who was frustrated with company. Wade asked me to provide the documentation of it being faxed.

The first time I called the company to ask about my fax (a month later) the person didn't record my call in their system (according to the 2nd person who took my call—she seemed genuinely shocked at that misbehavior).

Don't understand if Tier Two is 1, 2, or 3 things to do. I thought you did either 1 or 2 but someone else interpreted as doing both.

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(38) I just wanted to give my feedback about the new health plans. As someone who has a chronic, long-term illness […] it is really difficult for me to be able to afford my medications with the current structure of our health coverage. One medication alone is $4000 a month, but I was only paying $50 for a 3 month supply on our previous insurance. With things set up the way that they currently are, I have to meet my deductible before the co-pay structure kicks in and it makes it […] harder for me to afford my medication even though I'm using my health benefits.

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(39) While I don't have any feedback right now, I know that the new plans will be a hit for us financially. Just this week, my [spouse] had to do a CT Scan and that, combined with several office visits and a potential GI scope to be performed in the not too distant future would certainly be a burden for us. From my perspective, the new health plans are no different than a pay cut. The [last] time we had a pay cut ($600.00) was when WKU no longer provided enough support to be covered on the high plan and that those who still wanted to be on the plan had to pay 50 a month.

This time it is much more serious. Any serious event (and my family has had several of those in the past year) would mean serious medical payments which we cannot afford. Perhaps the worst part of the new plans is that it penalizes preventive care in some ways. Just the other day my daughter expressed how ill she felt. My response was simply wait it out. While I am not the person to see a doctor for every tiny issue, my fear is that the new plans punish people for seeing doctors (outside of routine exams) and, thus, could lead to minor issues (tumors, etc) become major ones.

Finally, I might note that I had issues with both Wageworks (my card didn't work for 10 days) and with Livehealthier (it took them two months to get my [spouse]'s biometric up and running). Lowest bidders, I guess!

Well that is my 2 cents. Now, between you and me (if you want to share this, please keep my name out of the following comment): why should I put my heart into my job here at WKU anymore. For the past years we have had little to no raises and this year we have taken a serious pay cut (unless the gods shine bright and everyone is healthy). Why should I be invested in an institution that doesn't support its employees and faculty. I have now cut my office hours to the bare minimum and have little interest in going beyond what I am obliged to do. Before this I applied for a number of outside grants (and was quite successful) and was involved in a number of committees. No longer. We have a beautiful campus with a real shitty morale! Is that Ransdell's vision of a leading american university?

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(40) The new insurance has increased the cost (mine has gone from $75 to $224 for one person) and lowered the benefits. If you have regular doctor appointments for an internalist and specialists, you may have to make decisions to not go to the doctor when needed because you cannot afford the expense. The hospital costs will be out of the world. Our old insurance was better and even if the cost had been increased you had benefits.

I heard there has been no complaints about the new health plan. Well, I am finding it really hard to actually tell what my expenses are going to be. I expect I will have a much better idea after a couple months in the plan. I won't have to purchase medications until the end of January so I will know then what the cost difference will be. Since I have a couple chronic health issues, I will know what my costs for monthly doctor's visits will be.

I expect there are other's like me who are watching and waiting. I also expect there are others who will be in for a big surprise when they make their first doctor's visits or order their first medications for the year.

I don't expect the costs to be the same as last year, I expect them to be higher. I expect my FSA will be used up faster. On the other hand, we could be forced into private insurance or using the Affordable Health Care Act.

The plan changes will affect the lowest wage earners the most. Measuring by percentage of income it is always the lower wage earners who take the biggest hit – top wage earners will have little effect on their overall disposable income. Perhaps there needs to be a cost containment plan for those on campus who earn under a given amount (50 thousand or some other number).

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(41) I have just finished my income tax so I am very aware of my health care costs for the last year. Based on medical costs to date this year and projecting for the rest of the year I believe I will pay approximately one thousand dollars more this year for health care than last. On the other hand I will have met the out of pocket max this year, which I have not done in previous years. Perhaps it will balance.

Costs are really hard to predict because there are so many factors. It does look like the service discounts from Anthem are the same as last year.

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(42) The new health insurance plan is certainly several steps downgraded from our previous coverage. Deductibles and copays are markedly higher and the new policy is best compared to a catastrophic care policy. Additionally, keeping up with the receipts to justify the debit card expenditures is cumbersome and time consuming. I hope that the university will consider better options for future years of coverage.

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(43) I [have] worked at WKU for 10 years […] I have 3 small children. My [spouse is self-employed so] must be insured by my policy. I have a few chronic health issues which I do work hard to manage through diet and lifestyle. My kids are kids and get sick like all kids and occasionally have accidents such as last year a broken arm. My [spouse] is extremely healthy.

I came to WKU 10 years ago because "the pay is not great but the benefits are great". This was true for quite some time. Now, the pay is terrible and the benefits- well can we even call them that anymore?

Just to take my daughter to the pediatrician for a high fever/chest congestion (to make sure she wasn't getting pneumonia) was $120 (due to having to pay the full cost until meeting the deductible! I have 2 other children who then both came down with what she had. Am I supposed to be able to afford another $240 all in one week. This doesn't even include the prescriptions. The money that is "put into our HRA" from WKU I will estimate will not even last my family 6 months. My own regular doctor visits will be in the hundreds of dollars per visit and for the first time in my life I am literally choosing not to go to my specialists (neurologist and hepatologist). So yes, I am putting my own health at risk.

So this great, modern University is putting me in a position that I am not paid enough to support my family (no raise in 6 years), pay the now $420 insurance premium and somehow still pay for the doctors visits at 100% until the deductible is reached!

I realize that we are in this position partly or mostly because WKU wants to stay "self insured" so that if there is any money left at the end of the year (as Ransdell just confirmed by email), then the University gets to keep that money (in his email he states we had $4 million left for 2014). So basically the University is making money and my family is struggling to get by and I am essentially giving up my own health care because I simply cannot pay the out of pocket costs. I seriously dread any accidents coming up such as another broken bone which could cost thousands out of pocket. One x-ray alone is about $500 and for my daughter's last broken bone she had to have 4 x-rays!

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(44) I am worried about the new package. I've already gone through most of my deductible, which means coming up with an extra 1000 in January for unexpected medical bills. Real eye opener. It was extremely difficult to get the Dr's office to give me a quote, so I would know what was coming... I think when they 'pre-cert' you that a quote should be included. They gave lots of excuses about every insurance being different, but they really don't know what things cost. The quote I received was only for their office, and I still have radiology bills of unknown amounts coming (mammogram screen was covered, but when they found a lump, none of those subsequent tests were covered - sounds backwards to me). It's always a horrendous surprise that comes in the mail in pieces over the next couple months... for each procedure.

I don't feel [HR] explained the use of the credit card for the flex account well. I don't have any idea what is covered and what isn't, and the Dr's office doesn't either. The website said nothing. Walmart seems to know what can and can't go on the card (be part of the deductible versus covered versus co-pay), but for some reason Robert's antibiotics were listed as 'not covered'. Way too complicated for most people to figure it out. I have a good sense of how these things work, since I work in healthcare and my father is a healthcare consultant. I expect others will be really overwhelmed with all the new 'rules'.

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(45) Well for one thing, this idea they have presented that if we all a) lose weight and b) stop smoking that all our health problems will go away is ridiculous. That's what irks me the most. It doesn't matter how much weight I lose, my [illness] won't go away. I have no other health problems BUT that.

And basically I feel like I am being punished for being "sick" (which I hate that word). My meds are exponentially higher but my salary has not increased in a long time. And I'm the carrier of my family's plan.

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(46) I have not had any issues with our new insurance plan per se – my [spouse] and I have claims in progress, and we have used our Wageworks card for some prescriptions with no problem. But I am very concerned that the Wellness Portal, which is supposed to be documenting our activities toward fulfilling the TopLife Pledge, does not appear to be very reliable. My [spouse] and I have done our part to complete the Tier 1 activities - we completed the online health assessment and biometric screening in mid-January - but [my spouse's] biometric screening results appear to be lost. So the Wellness Portal displays that [my spouse] has not fulfilled [the] Tier 1 activities and I am afraid that it will remain unresolved while the Feb. 15th deadline passes and then someone is going to expect us to pay the penalty. I cannot describe to you how furious I will be if that happens.

I don't know if this Wellness Portal website is administered by the same company as in 2014, but I also had issues with it in 2014. My height was entered incorrectly and never corrected, and so it has carried over to the current website showing a grossly inaccurate BMI for 2014. I also had an issue with the fulfillment of my wellness activities being recorded on the site in 2014 and it took nearly three months of repeated emailing to finally get the information entered and points awarded.

So my impression of this Wellness Portal is that it is poorly run, and it is causing me a great deal of stress.

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(47) The new WKU Health Plan constitutes a significant **pay cut** for many employees. At least it does for me (my plan is the $1,000 deductible). The high deductibles are a killer (I've been paying $200 - $400 for single 30-day prescriptions since January 1, not to mention other exorbitant medical costs for doctors' visits and procedures). I can't understand how people who earn low wages here on campus, like BSAs etc., or folks who live check to check (like my household) can possibly come up with such piles of cash to keep them ensured. As for me, I've been forced to borrow from my TIAA-CREF retirement account to survive the upfront costs required to meet the deductible. Without that option, I don't know what I would have done for my [spouse] and me. I expect these high costs for medication and treatment will continue for us probably through March, when we will finally hit the $1,000 deductible for each of us. Ironically, it's because we are recovering from life-threatening illnesses that makes our medical expenses high (and now higher still under the new WKU health plan, including higher premiums, higher deductibles, and less coverage than before). I am recovering from […] cancer (and I continue to undergo maintenance chemotherapy) and my [spouse] is recovering from [major] surgery. Luckily [the] surgery occurred last September under the old plan, which between Anthem and Medicare covered every cent of […] treatment at Vanderbilt. If we are hit with another life-threatening disease in our household (and we are both well advanced into our sixties), I am seriously worried -- and I've lost a good deal of sleep over this -- that such a situation would leave us bankrupt. Even if the current costs stay the same next year (they said in the briefing that next year's costs would be lower, but HR has become adept at lies of commission *and* omission), I will still need to withdraw money from my retirement funds in order to meet the deductible in the first few months of 2016.

In many respects, I consider the new health plan an outright obscenity. This has been imposed on the WKU faculty and staff without allowing the employees to have a say in any of the crucial decisions. Instead, the health options were presented to us a fait accompli. Supposedly, HR consulted our comparable institutions of higher learning to determine what the norm is for health care -- something that probably should have been done a decade ago. At the same, though, WKU faculty earn dramatically **less** than faculty at our comp institutions. The obscenity comes from the fact that the WKU administration forced this salary cut on us without even a whisper of any impending salary increase to make up the difference (which, by the way, would still keep the faculty underpaid, an indication of how terribly the faculty at this institution is regarded and treated). Salary increases have been so rare and so miniscule in my 8 years here that I think the faculty has become inured to never seeing another increase--ever. That's why there was so little outcry when this new health plan was introduced and implemented. Faculty are resigned to the fact that nothing can be done to stop the administration, especially when we are told we have no choice anyway. Like most things in this world, it will be practically impossible to change the now existing health plan. The administration will resist it and will come up with all kinds of explanations, real and imagined, as to why it can't be changed. It's the old rule of the inability to put the toothpaste back in the tube.

So I write this with a feeling of complete futility. If I were a young faculty member without tenure I would be looking to jump this ship as quickly as possible. But professors are a complacent lot and aren't prone to activism. Nor is the job market good -- something the administration repeatedly counts on. As a senior professor, I truly wish I could find a different job elsewhere (I'd leave in a split second), but no place advertizes for Full Professors with Tenure. Most campuses, wherever you go, are badly administered, and faculties are *always* taken advantage of. But this place is the worst I've experienced in my more than 20 years in academia.

But at least there is not a stray leaf to be found on the campus, the Alumni Temple is almost big enough to block out the sun, and the stadium lights remain turned on no matter what. In my […] years [here], there is no doubt in my mind as to WKU's real priorities. And they have nothing to do with rewarding faculty or, for that matter, with higher education. Most of my friends who are not

from south central Kentucky get a pretty big laugh over: "A leading American university, with international reach." But, then again, most people I know think UK stands for the United Kingdom.

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(48)

1) Faculty agree that it is too soon to offer detailed feedback about the new insurance/benefits plan. Faculty have only been exposed to the Tier 1 activity requirements as of late.

a. One faculty member experienced difficulty with transferring personal doctor documentation to the Graves-Gilbert Clinic.

b. Wade Pinkart was helpful, but a method to prevent similar difficulty has not been determined.

2) Need clarification on number of activities required to complete Tier 2. Must faculty complete a total of 2 activities, or choose only 1 of the provided activities?

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(49) I predict many people won't be going to the doctor because of the cost. Instead of a co-pay, there is an unknown percentage that could devastate a monthly budget. I tried calling my doctor to find out how much an office visit would be so I could figure out my share, and was told they couldn't give me that information.

We have a wellness program that stresses prevention but health insurance that makes going to the doctor a luxury? Sounds like WKU logic.

The thing that bothers me most is that we seem to have created a rift between the people who are healthy, for whom the change isn't significant, and those who have medical need. **One of my co-workers made a comment about how sick people have drained the insurance fund, and we should get rid of them.** There seems to be no compassion for people who are sick or have chronic conditions and disabilities. I wish Dr. Ransdell would put an end to that and lead by example.

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(50) My co-pays have [gone] up $10.

2. My new flex card would not work the first time I went to the chiropractor

3. I have to make an appointment by Feb 15 AND pay for it, and fill out a bunch of paperwork about how much I exercise and drink alcohol - to demonstrate that I am healthy - when I have been a functioning, healthy individual for my entire life. But now, I have to prove that to someone just to get health care.

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(51) Basically pay more for lower benefits and a "big brother is watching" approach.

WKU insurance trust must be in serious financial trouble. I hope other ways to maintain benefits that prioritize the treatment of the folks who work here will be considered in the future.

A bogus pay raise could have been better used to undergird the health benefits. This is a shell game. "Look we can give you a pay raise means we are screwing you on your benefits to pay for crappy health care."

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(52) The new benefits HRA 2600 seemed better to me because I didn't have to pay for it and don't have significant costs so I would have gotten a lot of cash to pay for many of my out of pocket expenses like chiropractic copays, massage, etc… that the old health plan didn't cover. I felt I came out ahead with the new plan but I found out that I couldn't purchase the HRA because I already had VA coverage. I could have purchased one of the other plans but they cost me and didn't make it worth it so we are just sticking with the VA care and taking the cash payment to cover the out of pocket health care expenses. I am hoping they can just put it in an FSA but that is in question yet so I still haven't received my FSA card. Thankfully we finally got assigned a primary care provider at the VA in Bowling Green after 5 months so at least we have coverage if we need it.

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(53) My eye drops went from $12 copay to $800. Then after it was finally approved I still had to pay $300. There are no other choices I can have for my eyes.

My [spouse] and I are employees here at WKU. In the long run, we have more out of pocket expenses and pay more for less coverage.

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(54) This is my feedback: I find it quite an invasion of my privacy to have the health insurance company tell me how I have to spend my free time or be punished by less money.

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(55) I am a new employee and I haven't had insurance in 2 years. I was excited about working not only in my position, but also excited about receiving benefits (insurance, retirement etc..). I just recently went to my doctors office where I am normally a self-pay patient. I have to pay $70 for self-pay, so I was excited to present my medical insurance card in hopes of decreasing those out of pocket costs I have been paying for 2 years. Unfortunately...I had to pay $68 WITH INSURANCE! This is very frustrating. Not only do I have to pay for insurance to come out of my paycheck, but I still have to pay the same amount for my doctors visits. So why have insurance at all!? I have the WageWorks card, but $500 is NOT going to cover anything. If I look at the break down, I will have to pay nearly $1700 to have the insurance itself, plus deductibles and percentage amounts after the deductible is met. I thought one of the benefits for working for a university was to receive great benefits. This is very saddening to me and it is actually deterring me from going to see doctors that I truly HAVE to see.

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(56) I get injections in my neck 4 times a year, in order to prevent a major spinal surgery. Last year I paid a very affordable $40 copy for these injections. My portion of the injection is now $1,325 for each injection! How am I supposed to pay for this? At this point I feel like I am forced to not get the injections and just end up with surgery in the next 2 years. I am so frustrated.

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(57) First, I think it was extremely unfortunate and unethical for HR to roll out such a different plan without giving faculty and staff the particulars of the plan. I don't mean the particulars that they did provide; I mean the changes that we were not informed about. The example that affects me personally is allergy shots. Allergy shots, to my knowledge, were covered 100% on last year's and the year before's plans. No copay, not subject to deductible. Now they're subject to deductible, which, for me, means $22.00 per visit 1-3 times per week/4-12 times per month, so $88 - $264 per month depending on how frequently I go. On top of the visits, the charge for producing the allergy serum is $230, which means that on top of the $88-$264 per month, there's a $230 charge every time I finish a round of shots.

Result: I have stopped my allergy shots. Even with the deposit in the HSA plan, I cannot afford to continue allergy shots. Possible future result: Return to allergy spells that keep me away from work for 1-2 days in August, October, and periodically throughout the year.

Second, even with the HSA deposit, I am reluctant to go to the doctor now because I know I'll be paying 100%. There's no way I will go to the doctor enough to meet my deductible unless something tragic happens to me, so I'll be at 100% for the entire year. I would describe myself as a typical male when it comes to visiting the doctor. I don't go until something's wrong (unless I'm "encouraged" to go by something like a wellness program), and now my estimate of when something's "wrong" will be colored by the anxiety of having to pay 100% of the visit.

So, now that I've said that, I'll give you some context: My [toddler] was hospitalized last spring for a condition that's only recently been diagnosed. It's an extremely rare genetic mutation [and has required] three hospitalizations over the past year, totaling 12 weeks at two different hospitals. Needless to say, we met [the] out of pocket max last year and have already met it this year. The entire $2300 WKU deposited in the HSA along with the additional $200 per month I'm deducting from my check will meet [my child's] individual out of pocket this year (I planned it this way), but that leaves $0 for me, my [spouse], and my [other child's] health care needs. So my allergy shots will be 100% before deductible and 100% out of pocket for me, and I simply cannot afford them. Any doctor's visit outside a wellness visit will be 100% for me and my family, excluding my son. We won't meet the family deductible unless something tragic happens.

On the other hand, I think the Wellness program is a good idea, but using the stick rather than the carrot is a terrible idea. Incentives for wellness participation are good; reduction of benefits for opting out is not.

In a nutshell, I think this plan works well for faculty and staff who are healthy and who have healthy families. For faculty and staff who are or who have family members who have health problems, the plan does not work.

And finally, one thing to share around with others if you have the opportunity: It is my understanding that the deductible is reduced by the amount of the claim that a provider files with Anthem. The amount the employee actually ends up paying does not affect the amount that counts toward deductible. Take this scenario: I have a one-day hospitalization with some tests and an emergency room visit. The hospital submits a claim to Anthem for $4800; Anthem's contracted amount for all the services and the ER visit reduce it to $2350. Since I haven't met my $2600 deductible yet, I receive a bill for $2350 (100% before deductible is met). I negotiate a 20% discount with the hospital and end up paying $1880 (80% of the billed/claim amount). Despite the discounted amount that I actually pay, the deductible is reduced by $2350, which is the amount filed with Anthem. I now have only $250 left before I meet my $2600 deductible. In short, I've made my HSA dollars last longer.

… I haven't tested this out yet, but we will soon since my [child's] hospital bill will be coming soon, I'm sure. If you'd like, I'll let you know what happens.

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(58) Faculty, I am writing to request you add your voice to mine to demand a change in insurance coverage for the next year. The Benefits Committee will shortly be convening to recommend insurance changes for the next year. I do not know how to reach the impacted population but I believe this is an issue of concern for our entire community. You will be surprised to know that WKU has excluded coverage for treatment of a specific chronic disease, that of morbid obesity with bariatric surgical intervention. Morbid obesity has been recognized by the AMA and NIH for several years as a chronic disease requiring, for a small population, intervention through surgery and other methods. Anthem has provided coverage for bariatric surgical intervention for several years and has in place a procedure for requesting approval. It is a lengthy process requiring persistence and work by the individual and health care team. Anthem representatives tell me that WKU has specifically chosen exclusion of coverage for this treatment so they, Anthem, are removed from the process of helping individuals. Human Resources may tell you that this exclusion is cost related, however there is no validation for this exclusion at WKU due to cost, rather the cost of not covering it is greater due to complications from diabetes, heart disease and joint disease. The emotional cost is not measurable. Currently Vanderbilt Medical Center quotes cost for this surgery is $500 for evaluation and up to $30,000 for bariatric surgery. This is a small percentage of the cost of coronary artery bypass ($75,000 - $200,000 according to the American Heart Association), or joint replacement (total knee replacement $50,000-$100,000 according to keeReplacementcost.com). These are all covered treatments at WKU as is appropriate. I believe WKU's exclusion shows prejudice to a specific faculty/staff population. I find no other chronic illness specifically excluded.

I want to be very clear that this may only impact a small population of your peers and co-workers with the diagnosis of morbid obesity, but it has tremendous impact on their quality of life, productivity, and future. Deciding to seek treatment through bariatric surgery requires months to a year since the individual must first pass through evaluation and treatment by a nutritionist, an exercise physiologist, and a psychologist prior to gaining surgical approval.

I have had discussions with Mr. Glisson and his staff which have been unfruitful. I suggest that this isn't an appropriate or just exclusion. The policy **must** be changed.

I have been informed by my physician at Vanderbilt that individuals can in fact seek resolution of this problem through ADA since in some instances this is a chronic disease resulting in a disability. It is a mystery to me why individuals should have to seek ADA assistance due to an inappropriate insurance exclusion, however some may need to consider this option.

I would be glad to share with you Anthem's policy which can be followed by WKU, and other research studies, AMA statement's etc. explaining this chronic disease with recommendations for when bariatric surgery is suggested**. Please lend your support by demanding this policy and the exclusion change.** Contact the Benefits Committee, Tony Glisson and HR representatives. If you have encountered a similar situation I also encourage you to send an email to Margaret Crowder, Chair of the Senate as soon as possible as she is collecting individual information on problems you have encountered related to our insurance coverage. Please share this with your staff colleagues. Thank you.

Responses to above:

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(59) I am in support of this resolution - it could save some lives.

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(60) If you have read up on these procedures and the longer-term results, having such an exclusion makes no financial sense at all. That's why the vast majority of insurance companies do cover the procedures as long as the patient goes through the extensive vetting process.

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(61) I support you in this. It does not affect me but I do not understand the "pick and choose" approach to excluding covered procedures.

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(62) I did not realize this was a change this year, and I advocate WKU re-including the coverage for treatment of morbid obesity with bariatric surgical intervention under our insurance.

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(63) We do have many tools and support systems available with the Health Saver insurance that can provide guidance to our colleagues who fall into this category, including myself.

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(64) I am using these support systems, and although I would not consider the surgery for myself, I believe it should be an option and covered by our insurance for those who need it (especially at the prices we are now paying!).

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(65) For some, surgery is necessary for a myriad of reasons and should be left to the discretion of the person and his or her doctor.

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(66) I fought this battle December 2013. Was diabetic with associated high blood pressure and other things. I was told that the WKU health insurance would pick up counseling with a nutritionist, but nothing else. I had been through every type of weight loss program and could probably write a book on nutrition. So I took money from my retirement account,(and yes, the tax hits are a bit painful) paid $15,000 for gastric sleeve (yes they charge the insurance companies considerably more) and have lost 140 pounds. I got

my life back, no more diabetes, more energy, and because they remove the part of the stomach that contributes to cravings, no more feeling deprived from the "diet" syndrome. I did not go to Vanderbilt but had it done here at the Medical Center. Do not wait for insurance! Obesity is one of the major illnesses that is discriminated against. Makes no sense!

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(67) I want to add my voice to these—seems to make a lot more sense to lower weight than pay for the heart, etc.

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(68) Thank you for this message. I had no idea that our insurance excluded this surgery. I fear retaliation from doing an all-faculty reply so I am emailing you directly. If you use my words please do not use my name. There is such a prejudice against overweight people on campus that I fear your message will prompt more voices saying that fat people got that way themselves and it is their own fault – too bad. As a morbidly obese person I have been the victim of prejudice at WKU in many ways over the years – and it is without apology – and almost daring me to look offended. My guess is that most people would support us having this surgery covered, but won't dare say it where others can see/hear because it is a very unpopular stance.

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(69) Latent diabetes is prevalent in my family – I was diagnosed about two years ago. It is controlled with meds but makes regular dieting nearly impossible. I have rheumatoid arthritis as well. So exercise is important, rare, and painful. It is ironic that years ago I decided to teach because my [spouse] owns an independent pharmacy and we needed health insurance. I work for health insurance — that is still our situation today. Only now the "benefit" of having the insurance diminishes every year. This is just another huge blow. I think administration/powers that be at WKU are fine with their obese employees just dying and I believe we will come to a time when overweight people cannot get hired due because of some sort of "screening" that is done prior to employment.

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(70) I need the surgery as doctors have tried for years to come up with some combination of food and medication to trigger weight loss to no avail. If I lose, I gain back plus 10. Every single time. So, enough of my personal struggles — the whole "wellness" push is a farce in my opinion. I jumped through the "consult with a dietitian" hoop – huge waste of time. Finally, on our 5th email she actually copied and pasted a URL into the message – it was to a site that sold diet books. If buying diet books caused weight loss I would a size 8.

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(71) I am sorry to be the voice of doom but I just think WKU hates that we are even seen on campus. Maybe if enough fatties get tired of the abuse and discrimination on campus we will leave to find better insurance elsewhere (just about any where else). Their mission accomplished.

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(72) I want to add my support … for the policy and exclusion change.

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(73) I must say I am very disappointed to learn that WKU specifically discriminates against people who are obese when it comes to the medical treatment they need, as certified by a licensed health care provider. Perhaps you and your staff are not aware of the current research on this subject. I am sending you a link to help you get up to speed on this topic. Most insurance companies are well aware that the cost of not treating this disease in an appropriate manner is much higher than the cost of treating it, and even more so when the person is relatively young, as they have a much longer life span to develop secondary conditions. So WKU really needs to think about how to avoid the costs of chronic obesity, and as the article will show, diet and exercise is not a long term solution for the people who are over a particular BMI for a number of years. No study has ever found that diet and exercise works for these people, not on a long term basis. You have a higher chance of being cured of cancer than you do of chronic obesity, unless you consider surgical options.

http://www.eurekalert.org/pub_releases/2015-02/tl-tld021015.php

http://www.medscape.com/viewarticle/839759

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(74) I agree totally with…[this] assessment. I have also had this discussion with [HR]. I have had three doctors, my internist, my heart doctor, and knee doctor all recommend bariatric surgery. This has been recommended for over three years. My sleep apnea doctor is also in favor of it. The cost that I have been quoted is about $15,000. My medication for type 2 diabetes, atrial fibrillation, sleep apnea, and knee disfiguration probably cost well over $1000 a month. And that does not include the costs of seeing the doctors on a regular basis for monitoring my health issues. My knee doctor has said that knee replacement (most likely both knees) is the only thing that will correct the situation As [...] said, while this may only affect a small portion of the population (probably more than people realize), it dramatically impacts the quality of life, as well as the quality of instruction I can provide for my students.

The other aspect of our insurance which I find hard to believe and swallow, which I have also discussed with multiple people in HR people […], is that we do not cover **hearing aids.** We have insurance for vision (which was covered as part of our regular insurance before this year), but not for hearing issues. I guess not being able to hear is not as important as not being able to see clearly. This is total BS. This also has a major impact on my teaching, as I frequently have to ask students to speak up and repeat themselves or I misunderstand what they say. It also happens in meetings, discussions with others, and presentations. It gets to the point where I give up and just do not hear what is being said. I also suspect I am not the only faculty member whom this impacts. I have bought

my own hearing aids in the past. The last pair, which I bought about 10 years ago, cost me $3500. Unfortunately, I do not have the money to spend $6 or $7000 again, so I just have to go without. I feel this should also be covered by our insurance.

I hope you will address these issues with the insurance decision makers. While self-insurance may seem like a good thing to some, including administration (obviously), faculty and staff are being shafted and left out in the cold by WKU. After 25 years of service, I HATE than I feel this way about my employer, but I feel like they do not care about us as people.

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(75) I am [an employee at WKU]. I also share [the] concern about not including the weight loss surgery as a covered benefit. I am [part-time] but have insurance through my [spouse at WKU].

My physicians have asked me more than once why I choose not to have the weight loss surgery. I explain to them why I can't have the surgery due to WKU's insurance constraints. I had one of my physicians tell me he would write Mr. Glisson in HR a letter to try and reach out to him to see if there was anything that could be done to fund the surgery. [My doctor] stated to me, "Does he not know that the surgery is as common as getting your gallbladder out? The problems they had many years ago with the old gastric bypass surgery isn't the reality today." I asked him to send the letter to Mr. Glisson in HR I believe [several] years ago. I spoke with [my doctor's] nurse and she said the letter was being sent in [date deleted]. I never heard back from HR regarding the issue....not even an email.

My [spouse] called to […] speak with Tony about the weight loss surgery restriction. Tony told [my spouse that] he didn't believe the surgery was safe and many people die from the surgery or have complications from the surgery. He said we could personally pay for the surgery ourselves but if I had complications from the procedure even years later that WKU would not be held liable and would not pay for any of the care received from the complications.

No one on the committee knows what it is like to need to lose massive amounts of weight and have endured the yo-yo effect of constant dieting down through the years. I have been to the nutritionist for counseling…. I am currently in Weight Watchers and once again hopeful to get at least some of the weight off of me. I have very many weight related health problems. No one can know how this impedes the quality of life unless you are trying to live through it. I don't understand why insurance can pay for many, many things that don't have as huge an impact on a person's health but not the weight loss surgery. One of my co workers just had weight loss surgery through [a spouse's] insurance even though [the coworker] has WKU insurance coverage. [The coworker] has already lost more than 80 pounds and has…chronic health problems under full control. I want that for the WKU employees. If getting my story to you will help educate the committee on the personal side of the obesity epidemic, then I will gladly tell it. It isn't like you can just get the surgery without jumping through many hoops to get it approved medically. I can't even get started with the process due to the restrictions from our insurance. It does seem discriminatory to me to refuse to cover a surgery that can actually save someone's life and give them a healthier, higher quality of life by getting it. Please ask the insurance committee to research the procedure for possible inclusion in the future. I'm sure the bariatric physicians at The Medical Center would be glad to provide information. The committee can ask them questions and get information on the newer techniques that are now being used. They can educate the committee on the success rate of the surgery and the possible complications (and their probability). I feel confident the committee will see things are much different today using the newer procedures available.

I respectfully send you this email in hopes of making a difference for the WKU family.

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(76) I'm not sure if this insurance problem is the sort of thing you are looking for, but let me tell you about a hidden provision that no one thinks about until it penalizes them:

I turned 65 last [year] and was automatically transferred from the KTRS Humana health insurance to Humana Medicare. OK, so I'm still insured, just a new set of rules to learn. BUT, I had to start all over toward meeting my deductible! So I had to pay my deductible twice in 2014 and start again in January 2015. This provision basically screws anyone who is not born on January 1 or December 31.

My [spouse], who has been on my policy since the day I was hired at WKU , also had to switch to a different Humana policy even though [a few years younger than me].. Guess what? [My spouse also] had to start all over on [the] deductible also. After <u>many many</u> calls to every agency and office affiliated with Humana or KTRS we found out that [my spouse] IS eligible to transfer the deductible from the old policy to the new one, BUT ONLY IF [BY] REQUEST[]. Who is not going to request it? The insurance companies have known that this day was coming for the 40 years that I have been insured through my employment at WKU, but they do nothing to make this automatic or even to inform us of their requirements. I wonder how many thousands or millions of dollars they save with this trick? When we "requested" to roll the deductible over to the new policy, they told us it would take about 30 days for this to go into effect and we would just have to pay out of pocket until then. **When my [spouse threatened to lodge a complaint with] the Kentucky Insurance Commissioner if they didn't take care of this before the phone call ended, they figured out how to do it!**

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(77) I had my [child] got some vaccine required by [] age which usually should be covered by any health insurance. When the clinic sent the bill to the health insurance, they rejected to pay it. So the clinic sent the bill to my [child, who lives with my ex in another state]

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(78) One of my biggest issues is that when you go to see a doctor or get some other type of medical service, you have no idea what you will be paying. I ended up paying $75 for a five-minute visit so the doctor could confirm what I already thought I had. If I had known that I was going to be charged that much, I would not have gone to the doctor. The same goes for a gynecologist appointment that was a follow up from an abnormal mammogram from last semester. There I was, actually considering cancelling my appointment with him because I didn't know how much I was going to end up paying.

My other problem is with prescriptions. I was prescribed a medicine which costs $247 for a 30-day supply. It is a medicine that I need to keep taking, so it means that every month I would have to spend $247. I cannot pay this amount so I have to go without this medicine, I don't have any other choice. Even the pharmacist asked me why did WKU change insurance, we HAD the best insurance in town!

Isn't it sad that people have to go without seeing a doctor or without buying a prescribed medicine because we don't have the money to pay? I can't even imagine what my fellow instructors or staff members who have families do.

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(79) Well with a new baby and a toddler we've already racked up a few hundred dollars in bills just to take care of minor doctor visits. But my jaw dropped completely when two prescriptions I have had for years went from $50 to over $600 in just a matter of months. I'm not going to be able to afford to keep using my prescription.

So I got ahold of the prescriptions and here was the breakdown:

At Walgreens one has a retail price of $503.99 and with our insurance will be $416.74 (our insurance covers $87.25)

At a doctor friend's suggestion we looked it up on the Epocrates app and the cost was $298.99

The other has a retail cost of $316.99 and with our insurance the cost will be $249.39 (our insurance covers $67.60)

On Epocrates the cost is $57.58

…as our doctor friend pointed out, the price is exorbitant and we are going to need to shop around to other pharmacies to see if we can find a lower price. Now, my problem with this is, hasn't our insurance negotiated to lower the prices and if that's so are they just selling us short? Why haven't they negotiated this to a fair price? Also, I realize I have more resources than some as far as having a friend for a doctor to help us navigate this, but what happens to other staff and faculty who don't? Are other people unknowingly paying sky-high prices because they don't know any better? If we're going to have mediocre insurance, isn't it the responsibility of HR to help educate us to all of our options?

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(80) You may add the following to your list of challenges people are facing with the new insurance program:

1. Some providers are unable to provide appropriate receipts at POS (e.g. podiatrist) because billing is handled by a different group. In other words, you receive a receipt for payment yet the details are inadequate for the new Wageworks health care program. This requires follow up which results in more paperwork and personal expense.

2. Unable to determine upfront costs of medical service until billed - again, this results in additional time by patient and provider in order to pay by the Wageworks debit card.

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(81) I went in to the dentist this past Monday and when it came time to pay, I gave them my WageWorks card, and was denied! When I called WageWorks, they told me that I should have $1300 on my card but the university had not processed anything. I had to pay for all services out of pocket!

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(82) My experience…points out a problem with which I wasn't familiar – and I assume others, too.

My son bought prescribed medication through the insurance. We had told me that he needs to tell his doctor to prescribe generic medication if at all possible – which was done. I only describe what happens with the medication he has to fill each month:

The payment – with insurance coverage was $156.- per month. After he paid that the first time, I did some searching around for a cheaper alternative (since that's supposedly one of the things our new health plan was designed to encourage us to do), and I found one (actually: many) through a webpage called GoodRx. I told him about it and the next time he took a coupon along (no

membership required – just go there and print it) and bought it for $80.- . However, he was told he can either use his insurance and have it added to the deductible or pay cash.

I am not sure what types of agreements there are between drug companies, pharmacies, and insurance companies, but it boggles the mind to think about what systems makes a drug twice as expensive when bought WITH insurance than with a coupon which can be printed by everybody off a website.

P.S. I just pulled up the same information again on that website and it has changed. Now the coupon price is only $10.- less than the insurance price. In their price trend information (http://www.goodrx.com/tetracycline-antibiotics) it shows how the price changed from about $33 to $44 from January to March. My son got them mid-February and paid less than what's listed there as the 'max price'

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(83) I would like to say that I think our new health insurance plan with its emphasis on healthy living habits and on preventive care is a very good thing for the university and the faculty. I am proud of our institution for the care and thoughtfulness that have gone into trying to keep costs down over the long run and to hold individuals responsible for managing their health well. I am sure that more faculty and staff have become aware of potential health issues through the checkups and screenings that have taken place already. I am proud of our institution for being so progressive. I am sure it is uncomfortable for some to be shaken out of their complacency with regards to health issues. I believe our new plan is the right approach.

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(84) I would like to submit a comment pertaining to the exclusion of hearing aid technology from the WKU insurance policy.

For many years, I have experienced progressive hearing loss, and about 12 years ago I was forced to begin wearing hearing aids to accommodate this problem. Imagine my dismay when I learned that hearing aids were NOT covered by my insurance policy -- I was informed by our benefits office that only people under 18 and over 65 were eligible, but got no further explanation.

The exclusion makes no sense to me. I am on my second set of hearing aids (the first eventually proved not effective enough), both of which I have paid for out of pocket. A good set of hearing aids costs roughly $3000-5000, and both times I have had to pay this I've wondered why my insurance policy will not cover it.

I realize this problem (hearing loss) does not affect the majority of employees at the university, but I'm sure it affects some -- I've seen some of my colleagues wearing hearing aids. Please ask the Benefits Committee to bring this issue up and make a case for inclusion of hearing aids for ages 19-64 in our insurance policy. Hearing loss is a serious problem for me, and one that would prevent me from doing some aspects of my job if I did not have the hearing aids. I would be happy to provide testimony or documentation about this issue if that would help.

Also, I would like to go on record as supporting the inclusion of bariatric surgery under the WKU health insurance policy.

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(85) Thank you for collecting comments about the new insurance plans. My concern is that allergy shots (allergen immunotherapy) were previously considered preventative and fully covered, but now they are viewed and billed as treatment. This has increased my personal costs, but I know it has also created difficulties for a number of faculty and staff, some of whom have to make decisions about getting fewer shots per week since we have to pay for the shots in full until the deductible is met. Allergy shots are extremely effective preventative care for allergy sufferers.

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(86) In general, I'm very supportive of WKU's efforts to move towards high-deductible, HSA plans—that is, very likely, the direction the health care needs to move in order to moderate the growth of spending over the long term. However, my issue is how the plan was designed and, most importantly, priced. While maintaining the basic foundation of what an insurance is supposed to be (a backstop for unexpected, catastrophic events), a good plan will also link two things:

1. A properly structured incentive system: there should be clearly identifiable and meaningful incentives to look for lower cost alternatives without sacrificing quality of care. The goal here is to reduce wasteful spending. On this account, I believe our HSA does a good job.

Some meaningful linkage of my out-of-pocket expenses to my health care usage. This is purely anecdotal but in my case (a somewhat low/average usage customer), my health care expenses this year will very likely exceed my last year's expenses by somewhere between 40 – 50% without any additional usage. That is quite significant and is clearly seen by me as a larger than average increase and a penalty that is disproportionately targeted towards 'healthier' individuals and families. On the other hand, the heavy users from last year are likely going to see no increase in the total amount that they are spending this year—and may even see a slight decrease! This is in large part because of the difference in how prescription costs are being treated differently this year compared to last year. Regardless, this appears to me as the exact opposite of what we should be doing. While there may be some need

at the very low end of staff to be subsidized, that subsidy should be given by University, if at all, based on pay scale without messing with the incentive structure of a health plan.

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(87) I hadn't planned on writing to you, but after dealing with "Wageworks" I had just to. WKU keeps changing FSA groups which makes it harder for claims processed from the previous calendar year with Anthem to be approved by our FSA group to accept them. Example: Because we are with a new FSA group any claim processed at the end of 2014 by Anthem that then was billed to me in early 2015 will not qualify for payment by the FSA group because we were not part of that group in 2014. I am now out $160 out of pocket for two bills that I should be able to pay through my FSA/HRA money but cannot because of this ridiculous situation. So I am putting money into my FSA account that I cannot access and now need to lay out more money to pay for these bills.

Additionally with this new insurance program they are not going straight for the deductible and then working out from there. It is an odd mixture of some of the deductible and then some of the percentage. There is never anyway of knowing what to expect. With some doctors' offices wanting their copay upfront this is a REAL mess to deal with as they DON'T like the idea of billing and then getting money from us - like in the "good old days". The couple of times I have spoken with people at Anthem they have been very nice, but their attitude has been "just wait to pay after it has gone through and you get your EOB". Oh and I found out the hard way that they don't send you an EOB if you don't owe anything as it is their SOP. That was an interesting bit of info to find out.

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(88) While I am loathe to have my private health matters shared, I feel that I must share the attached "Wellness Coach" correspondence with you. This service that we are "REQUIRED" to participate in to get a lower health deductible is a time wasting exercise in futility. How demeaning!

Thanks for listening. Please try to find a way to convey this information to the benefits committee in a manner that still protects my health privacy. [Final email in exchange is below, with names and some identifiable information removed.]

[X],

I agree completely, I have not found our interactions very meaningful at all.

In your past responses to me you have admitted that you were not much help.

Quote: "Again, I'd ask your PT (or even the PT supervisor) about that as well as specific exercise bike. There are recumbent bikes which most people find more comfortable than stationery bikes, but it might depend on what range of motion would be best for you.

Rest assured that my PT (a one person practice PT) is quite busy supervising my ACL rehab and his other patients. If the bulk of my questions are referred out, I would have to agree that our interactions are not meaningful and that I should be credited for the good faith effort I made to get substantive advice.

When asked a personal training question, I would think that it would be reasonable to expect: DATA, EVIDENCE, REFERENCES and CONCRETE RECOMMENDATIONS. I asked about the pros/cons of recumbent versus upright bicycles.

As for the range of motion, I am cleared to use an exercise bicycle during week two (I am in week 2).

The primary sport that I train for is…. This sport requires shoulder, hip, and heel alignment with substantial core strength and balance. Weight must be distributed evenly between the seat bones in a neutral position. Which bike will help most with that---again, DATA , EVIDENCE and CONCRETE RECOMMENDATIONS are needed.

My PT order is for…rehab NOT to rebuild my cardio, this is beyond the scope of what my physician ordered. Can the wellness staff write an additional prescription for that since you've referred me back to my PT?

• I also find it insulting that the WKU wellness portal is so half baked that under the "HELPFUL INFORMATION" textbox, the programming "space filler Latin text" is still present: "Lorem ipsum dolor sit amet, consectetur adipiscing elit. Nullam venenatis pellentesque lectus, ac tincidunt dolor suscipit eu. Donec dignissim commodo blandit."

This indicates that no one has even bothered to proofread the webpage. It does not increase my confidence that I am in capable hands.

Please be advised that at WKU, many of us do research for a living. If your responses are not data driven, evidence based and substantive, wouldn't it stand to reason that my time would be better spent researching these things for myself?

Sincerely,

[Y]

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(89) Thanks for this opportunity to add my concerns about the new health insurance plans.

I think overall the biggest problem with the plan is that it discourages participants (especially those on the lower end of the salary ladder) from seeking timely health care and encourages them to hold off on going to the doctor even when they're very sick or when they need preventative attention because you have to pay for the entire visit until you reach your deductible. In the long run, this will lead to not getting preventative care and then needing to treat much worse conditions later on that will be very expensive. Hence, it will lead to higher, not lower, costs in the long run. The deductible also doesn't include dental payments which can add up significantly throughout the year. Requiring participants to get annual blood work to qualify for the extra "health" money is my biggest beef and a real invasion of privacy. In my [spouse]'s case, [who] has difficulty giving blood and because of the very cold weather, it also probably contributed to [my spouse] contracting a temporarily debilitating case of bronchitis/pneumonia because we had to go to the clinic, where there were sick people, to get the blood work done and because [giving blood] left [my spouse] in a weakened state. Finally the number of preventative medications not subject to the deductible is much too limited. In my case, my thyroid medication that is necessary to stabilize my thyroid levels that left untreated can lead to life-threatening condition, is not considered a necessity and is not included on the list.

In short, the plan, even with the University's incentive money, amounts to a pay cut for most participants and requires intrusive requirements, but because it disincentive[iz]es preventative care, will end up costing us more not less money in the long run and is the opposite of promoting "wellness".

Thanks for sharing with other faculty concerns with Benefits Committee, HR, and Administration.

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(90) In previous years, my family and I were on the Standard Plan, with a premium of about $460. Today, we are on the Heathly Saver/$2,600, with a premium of about $360. My [spouse] and I both signed the wellness pledge to get the reduce[d] premium. So each month, my [spouse] and I have an extra $100 per month in my paycheck. Given the fact that [my spouse] is a stay at home [parent] with our two children (4 years old and 9 months old), $100 per month helps.

Having made the wellness commitment – the university placed $2,400 in a health savings account for us to use. Shoveling snow two weeks ago, I pulled a hamstring. That evening (around 10pm), my leg and knee were in extreme pain. Under the previous health plan, I would have gone to Greenview Hospital's ER that night – paid the $125 co-pay, and got relief from my pain and discomfort within an hour or two. While I would have paid the $125 co-pay, the WKU health plan would have received the remainder of the bill (likely an additional $300-$500 for my visit to the ER). Under the new health plan, I knew I would be responsible for the entire cost of that ER visit. Because of this, I stayed up that evening, iced my knee, and took Tylenol and ibuprofen. I made an appointment with my primary care doctor the next morning, saw him that afternoon, and got the treatment and pain medication I needed. I received a bill last week - $75.00 for the doctor's visit – and $15.00 for the prescription drug. Total, I am out $90.00 for that visit – which I paid using [funds from] the $2,400 in our health savings account.

Over the last couple of months my [spouse] has had to fill a couple of [] prescription[s] – which have cost about $150. Thus, we have used about $225 of our health savings account. Under the old health plan, that $225 would have come out of our pocket/paycheck.

From a financial standpoint, my family and I have, so far, benefited from the WKU health plan – with the lower premium and having access to the health savings account. Of course, we have been very fortunate that nothing bad has happened to us this year – and we are, for the most part, healthy. In the last five years [we have had] four children … We are very familiar with the cost of health care ([we have hit the] individual deductible every year since 2010, and two years we hit the family maximum out of pocket expense) – and under the new plans, should we deliver another child, we would have to pay about $1,200 in aggregate costs more for that delivery compared to our previous deliveries. I won't lie – it is in the front of our minds.

The new plan also forced me to make an important choice – go an ER and spent a significant amount of my health savings account, or wait 12 hours to see my primary care physician and spend less.

From a wellness standpoint – the plan has been hugely beneficial. I did the biometric screening and health assessment, discussed that information with my doctor, and together, and he and I have developed a plan to get my weight under control. I am participating in the free weight watchers at work program – and I have done the telephone coaching with a health coach and a nutritionist – again, offered free through the Toplife pledge. For the first time in 5 years, I feel like I am in control of my health and not on a spiral of unhealthy behaviors. The fact the university is paying for these services – and has made them conveniently accessible – has greatly influencing my decision to do this.

I realize a lot of employees – faculty and staff – have experienced some significant hardship under the new health plan with the deductibles on the front end. I have to stress this point – I am very sympathetic to these experiences. I have heard from our colleagues about these experiences, and I do feel badly about them. But, I do know there are a lot of people like my family that have not been mal-effected by the new plans, and in some instances, I think it is important to recognize this flip side as well – and that is

the only reason I am sending this email – just to draw attention to the fact that while some have experienced hardship under the new plans, others have not.

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(91) I've been having issues getting my migraine medicine this year. I have taken the same one for a one as treatment and it's the only one that works. This time when I went to get it filled I was told that I can't fill it because insurance denied it. I haven't found out why yet, but I'm not sure what to do about it. It's actually one that was on a list they sent that I thought was one of their preferred meds---Relpax

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(92) I admittedly have not researched this yet but have just found out the new vision insurance does not pay for the routine dilation procedure. This is a preventative procedure and I cannot imagine why it would not be covered. **The nurse at the eye doctor's office told me Avesis is the only eye insurance they know of not to cover the service.** It is disappointing to learn that such a routine part of an annual eye exam would not be covered.

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(93) **On the "wellness" program**:

1. The "wellness" program was supposed to have a 3-year trial period to assess if it was effective and if it made sense for WKU. Instead WKU has jumped in with both feet; basically we were lied to. "**Wellness" programs are a national FAD with unproven efficacy**. We are paying a lot of money every year to a vendor for delivery of….what? A blood screening and my pledge to exercise. The way our insurance is structured now, I can't afford to make an appointment with my doctor to discuss my blood results. I already exercise. The only effect the "wellness" program has on me is that a substantial amount of my private information is now available to a bunch of additional people. Because of the coercive and punitive nature of the plan this year, I did not feel I could afford to opt out (as I have until now).

***I brought the trial-period issue and cost up at the summer forum and was told "it's not that much money. It's not like it's a million dollars." I would hope not for what we are getting. It does cost $200,000-300,000/year. That is a lot of money and if someone who is spending it doesn't think so, they probably shouldn't be making financial decisions.

If it turns out, after careful, objective assessment that there is real benefit (in the way intended – healthier living to lower costs AND catching problems early before they are as expensive to treat RATHER THAN MAKING HEALTH CARE SO EXPENSIVE THAT PEOPLE ARE CHOOSING NOT TO USE IT EXCEPT IN EMERGENCIES) to "wellness programs", that's great. Let's keep doing it. But spending a large amount of money so we can do what the other cool kids are doing is not okay. BTW, allowing the company/industry in charge of delivering the service to assess its own efficacy is problematic. Of course they're going to skew the data because it's life or death for their created need if they don't. (hello tobacco companies)

And even at that, there is already preliminary evidence out there to suggest that **certain types of wellness programs are more successful than other types**. **Programs that are punitive – such as levying financial fees for not participating in the "wellness" program or fees for certain behaviors (i.e. smoking) - don't work as well**. Well, guess what our wellness program looks like this year? It's the punitive variety. And, people have been dropping hints that it will be more punitive next year (fees for smoking).

2. **Privacy of personal data is a serious concern with the "wellness" program**. The vendor has access to significant amount of private, personal information. You don't have to be a genius to realize that 1) that data is worth money and 2) that data is vulnerable to being hacked and/or used without permission and in unintended ways. The main reason I didn't participate in the "wellness" program until this year is that I don't want my private medical information available to anyone except me and my doctor. When I brought up my concerns at the summer forum, they were dismissed in a rather patronizing manner, "Oh, that's not really a concern." Well, yes it is. There are stories every week about how various kinds of data are misused, mishandled and stolen. Solutions? First, make a solid, unbreachable agreement that personal data (raw and analyzed) will only be available to the relevant insured person; never, ever shared – or sold – for any purpose. Second, if there is so much confidence in the security of that data let's set a penalty fee if there is any kind of misuse of data or breach of security of data.

3. I'll make a prediction – **I bet enrollment in "wellness" is way up at WKU for 2015– not because more people believe in it but because of the financial penalty if they don't**. And I bet that WKU HR and/or the wellness program will take the increased numbers as a type of success and buy in rather than evidence of their coercive, punitive action.

I also predict that our healthcare costs will be down this year. And again, in reality it will be largely due to people feeling too financially insecure because of the cost of care because of how our insurance works (and our stagnating salaries) to seek care in non-emergent situations when they actually should see someone and not because it curbed "unnecessary medical care" or "shopping around" for the cheapest care. And I bet you that WKU HR and "wellness" will take credit for those numbers as well, completing dismissing the real cause. For instance:

My blood test didn't signal any alarm bells (or I would go to the doctor regardless), but there were a couple of borderline numbers that indicate the potential for a future problem. If this was 2014, I would take the results to my doctor and discuss them with her and possible strategies I could undertake to avoid the worsening of 2 borderline numbers. As it is, I won't be doing that. It would

be a gamble because I have no idea what health emergencies I may encounter this year. The reality is that the cost of our health insurance this year is very expensive because of increased deductible and max out-of-pocket coupled with having to pay for care up front. Because of a stagnant salary not keeping pace with basic cost of living increases, I have very little financial cushion anymore month-to-month. I am a mid-career professor and I feel too financially insecure to seek care unless it is something very serious or a true emergency. I can't imagine how desperate and worried staff are. I can't imagine how stressful it is for people who have chronic health issues that require regular care (doctors' visits and prescriptions). **This does not reflect well on WKU and its priorities.**

4. **Why do we need to pay a lot of money to a vendor for what we're getting with the "wellness" program**? We already cover costs for "well visits" to doctors; just include the free annual blood screening. In terms of any of the presentations, health initiatives, exercise pledges, why can't the full-time position currently filled by Wade Pinkard handle that? Isn't that why we created that (extremely controversial) position?

Health insurance

1. Probably the least important point, but I hope with all that has gone on with this shift to a much more expensive form of insurance that **we should never again hear even a murmur from the administration about using the insurance reserve as easy money to make up for budget shortfalls**.
2. Our health insurance is part of our compensation for working at WKU. **Employees must have more of a voice in making decisions about what our insurance looks like** (not just being informed about changes or patted on the head and ignored when they speak up about issues).
3. **The roll-out of 2015 benefits (insurance) was very poorly done**. The available literature was extremely confusing, poorly written, and poorly organized. Considering the substantial changes made to insurance and the fundamental way it works, we should have been notified of changes much sooner. And, to the degree that HR really couldn't be specific (though it seems they were just trying to put off objections until it was too late to do anything about it), they should have been more specific about likely changes.
4. **Get real about the main cause for increasing costs.** The main cause for increasing costs is not from employees making poor or uninformed choices; it is not from over-use by employees; it is not the implementation of the ACA. The main cause for costs is the ridiculous and often arbitrary costs of healthcare. The way WKU has implemented health insurance changes for 2015 it has shifted the burden for increased costs to employees.
5. **HR should create a database of fees for each in-service provider**. It is inefficient and unreasonable to expect each individual employee to call around to health care providers and ask what they charge. The burden for doing this should be shifted to HR who should ask each of the in-service providers to provide a chart of healthcare charges for their various services. It is absolutely inefficient to have hundreds of people calling the same providers for the same information. In addition, assuming that you are likely to be seeking care when you are not feeling well or even have an emergency, you are not going to be calling around first to ask about charges.
6. The upshot of the changes to the way insurance works is that only some employees at WKU will be able to afford to seek basic healthcare in 2015. The **changes to our insurance in 2015 constitute a serious cut in benefits and, because of the increased cost of care, a rather substantial salary cut**. If we are in such dire straits that there is nothing that can be done about that, so be it. But if this was a case of prioritizing, to quote Regent Minter, "wants over needs," I'd like to suggest that the administration re-examine the stuff on the "wants" list and reconsider cutting some of them. And let's not hear threats about substituting cuts to other "needs" instead.