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2010 Contract Bargaining Begins March 9

After many months of preparations, negotiations for the 2010 contract are set to begin on Tuesday, March 9th. We anticipate at least two formal bargaining sessions in the month of March, with the usual “away from the table” work ongoing from this point forward.

Semester conversion, set to begin Fall 2012, has been a point of discussion in the Executive Council for many months now. We believe that it will most likely be in everyone’s best interest to avoid having a contract that spans the quarter system and the semester system. The complications that would ensue in calculating and clearly stating various compensation



formulas in a single contract would be formidable. We are therefore beginning to negotiate with the idea of a 2010-2012 contract in mind, although this could change as the course of negotiations unfold.

In 2007, the Executive Council worked hard to keep faculty informed all throughout the negotiations process, including the release of tentative language (“TA’d” proposals) as they were signed. We plan to do the same this round, and hope you’ll stay engaged over the next few months.

— Steve Howe
President

Trend in Health Care Costs for AAUP Bargaining Unit Faculty, 2002-2008 UC faculty costs well below regional averages

As we head to the bargaining table, the Chapter leadership is analyzing regional and national health care trends, as well as the trend in health care costs for the University of Cincinnati faculty represented by the AAUP. It is no great surprise to see that health care costs continue to rise at an alarming rate, both regionally and nationally. In 2004, physicians from the American Heart Association, the American Cancer Society, and the American Diabetes Association noted:

Collectively, cardiovascular disease (including stroke), cancer, and diabetes account for approximately two-thirds of all deaths in the United States and about \$700 billion in direct and indirect economic costs each year. . . . A concerted effort to increase application of public health and clinical interventions of known efficacy to reduce prevalence of tobacco use, poor diet, and insufficient physical activity—the major risk factors for these diseases—and to increase utilization of screening tests for their early detection could substantially reduce the human and economic cost of these diseases. (Eyre et al, “Preventing Cancer, Cardiovascular Disease, and Diabetes: A Common Agenda for the American Cancer Society, the American Diabetes Association, and the American Heart Association.” *CA Cancer J Clin* 2004; 54:190-207)

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Unfortunately, little has changed since 2004. As a nation, rising health care costs are related in large part to preventable illnesses:

The 2009 Rankings shows the nation’s health care system has become extremely adept at treating certain illnesses and disease, such as cancer and cardiovascular disease. However, Americans are struggling in the battle to modify risk factors, such as smoking, poor eating habits and lack of exercise, which may contribute to chronic diseases in the first place. The United States currently spends more per capita than any other nation on health care, including \$1.8 trillion in medical costs associated with chronic diseases, such as diabetes, heart disease and cancer. These chronic, preventable conditions all have a direct link to smoking and obesity, the nation’s two largest national risk factors. (From *America’s Health Care Rankings*, published jointly by United Health Foundation, the American Public Health Association and Partnership for Prevention; available at <http://www.americashealthrankings.org/2009/highlights.aspx>.)

Costs in the tri-state region are increasing even faster than the national average. As reported in the *Cincinnati Enquirer*, studies by the Mercer Group and by Hewitt Associates have shown that employers’ health care costs in Greater Cincinnati and Northern Kentucky have increased at almost twice the national average rate from 2007 to 2008 (see “Health Care Costs Skyrocketing,” September 24, 2008, and “Think You’re Covered? Just Don’t Get Sick,” August 28, 2009; both articles by Peggy O’Farrell).

The cost of health care for AAUP-represented faculty, however, is a notable exception. The results of our analysis of data provided annually by the U.C. Benefits Office are shown in the table below. Employers’ health-care costs from 2002 to 2008 have increased by 55.4% nationally, 72.4% regionally, and by 29.2% for the AAUP. The consumer price index for Greater Cincinnati increased 18.6% over the same period. So the AAUP health care inflation rate now exceeds the CPI—largely because of a thus-far inexplicable spike in costs from 2007-2008—but not by nearly as much as it does for Greater Cincinnati and the U.S. The 2008-2009 data will soon be available to tell us whether this favorable trend still holds.

As noted in our report in Fall 2008 (*Works* 15.7, October 17, 2008, pp. 1-2), we do not have the data necessary to determine why UC faculty health care costs are so much lower than the average costs in the region and the U.S. Almost certainly the elimination of the expensive, traditional indemnity plan (the “MCMP”) beginning in 2003 contributed substantially to a reduction in costs. In addition, after several years of urging by the Faculty Members on the Benefits Study Committee, in 2007 the University put the HMO on a self-insured basis, as is the PPO. This

resulted in millions of dollars in savings to the University (see the 2006-2007 trend in the table below). We also continue to believe that Faculty Members probably have more information than the average American about how to make good use of health care services, and about the connection between lifestyle and chronic diseases, thus significantly lowering health care costs to the University.

The data clearly shows that UC faculty are doing their part and paying their fair share of health care costs, and have been for the better part of a decade. In this case, health care costs should not be used as a reason for avoiding significant improvements in faculty compensation and other excellence proposals that will ensure the overall health of the University into the future.

— George Bishop (A&S/Political Science)
Daniel Langmeyer (A&S/Psychology)

Trend in Health Care Costs: AAUP vs. Greater Cincinnati and USA: 2002-2008*			
	AAUP Bargaining Unit	Greater Cincinnati	U.S.
2002-2003	-5.3%	15.2%	14.7%
2003-2004	7.3%	14.8%	12.3%
2004-2005	5.5%	18.5%	9.2%
2005-2006	15.6%	7.9%	7.9%
2006-2007	-8.6%	4.9%	5.3%
2007-2008	14.7%	11.1%	6.0%
Total Change:	29.2%	72.4%	55.4%

*Data shown for the AAUP are for total health care costs in each year, 2002-2007. The trend data for 2007-2008 are based on just incurred claims in each year because of a change in the composition of the bargaining unit (clinical faculty) that could not be separated out by the University’s Benefits Office in their database. The consumer price index for Greater Cincinnati increased 18.6% over the period, 2002-2008 (see <http://www.cincinnatiusa.org/pdf/eco/cpi.pdf>).

The authors are members of the joint Benefits Study Committee, along with Robert Cluxton (Pharmacy) and Daisy Quarm (A&S/ Sociology); Daniel Langmeyer is also a member of the 2010 AAUP-UC Chapter Bargaining Team.



HEALTH INSURANCE PREMIUMS: FINAL PHASE-IN OF NEW SYSTEM NOW IN PLACE

You probably noticed that the amount deducted from your end-of-January paycheck for your health insurance premium co-pay was higher than in previous months. This increase was the last step in the phase-in of the new health insurance premium system. Under the provisions of Article 16.2.1 and 16.2.2, the premium co-pays were scheduled to increase to their final phase-in for 2007-2010. The increases, calculated as a percent of base salary, went from the levels set January 1, 2008—0.50% (single), 1.00% (double), and 1.35% (family)—to 1.00% (single), 1.50% (double), and 1.85%

(family). In other words, everyone saw an increase of 0.50% of base salary.

When the method of calculating premium co-pays was changed in 2008 from a flat dollar amount to a percent of salary, many Faculty Members saw a modest increase in the amount they were paying, but many others, especially those with lower salaries, saw a decrease. For 2008 and 2009, the premium co-pay as a percent of salary remained the same; any dollar increase in 2008 and 2009 was very small and was proportionate to the salary increases effective those years. As mentioned earlier, the increase implemented on January 1, 2010 was due to the percent increase (an additional $\frac{1}{2}$ of 1%), negotiated in 2007.

Meanwhile, you received a salary increase of 3.00% effective September 1, 2009 and will receive an additional increase of 1.50% effective mid-year. Since all Faculty Members are now on a 12-month pay schedule, “mid-year” means the halfway point in the academic year (September through August); thus the additional increase will be effective March 1, 2010. You will first see that increase on your end-of-March paycheck.

Prior to January 1, 2008, health insurance premium co-pays were expressed as flat dollar amounts, and those in the PPO/POS paid more than those in the HMO. During the negotiations in 2007 we negotiated a change in the way that health insurance premiums are calculated, from a flat dollar amount to a percent of base salary, with no differentiation between the PPO/POS and the HMO.

There are several reasons why the Chapter Executive Council proposed this new system for dealing with premium co-pays. First, over the years HMO premiums had become “out of sync” with the actual costs of that plan, such that PPO premiums had been in essence subsidizing those in the HMO. Given that the costs in the two plans were similar, this new system makes premium payments more equitable across plans, in line with actual costs.

Second, we believe this new plan is superior to the old method of arguing over how much of the annual increases in health care costs should be borne by Faculty Members. By tying premium costs to salaries rather than to health care cost increases (as was proposed by the Administration), Faculty Members are insulated against sudden rises in health care premiums—much of which are most likely *not* attributable to Faculty Members’ behavior but rather to larger national and regional trends, and to inefficiencies in health care as it is administered in this country. Under this new system, health care premium co-pays increase only when salaries increase (or when there is a contractually mandated increase in the % contribution, as there was effective January 1, 2010). In this way, premium co-pay increases have a proportionate, rather than an absolute relationship to increases in health care costs.

Finally, linking health care premium and salaries allows everyone to more easily see and assess the real impact of health care costs on faculty salaries, thus making the system more transparent.

The current system of calculating health care premium co-pays seems to be reasonable, and fair to both Faculty Members and Administration.

— Dave Rubin, PhD
Director, Contract Administration
Chief Negotiator, 2010

A Few Words about the Tax Implications of DP Benefits

The most recent Collective Bargaining Agreement marked a significant advance for both faculty members and the University as a whole, making accessible to faculty members' domestic partners an array of benefits hitherto available only to spouses, thereby placing the University in the emerging mainstream among academic employers. As a result of this step, faculty members' domestic partners, of the same or opposite sex, now have access to medical and dental benefits, as well as life and personal accident insurance, and tuition remission.

However, the fact that domestic partners have access to these benefits does not mean that these benefits receive the same tax treatment, under IRS rules, as those for spouses and dependents. For example, medical and dental premiums for spouses are treated on a *pre-tax* basis by the IRS; in other words, the value of these premiums is not taxable to the faculty member. However, under IRS rules, the premiums for domestic partners are treated on an *after-tax* basis; the value of these premiums is considered "imputed income," and is thus taxable to the faculty member. The exception to this rule occurs in the uncommon, but not unheard-of, circumstance in which the domestic partner is a qualifying legal dependent of the faculty member, under IRS rules.

The cost of this unequal tax treatment with respect to health benefits can be considerable; couples in domestic partner relationships pay an average of \$1,069 per year more than married, opposite-sex couples in federal taxes. Badgett, M.V. Lee.

(2007) Unequal Taxes on Equal Benefits: The Taxation of Domestic Partner Benefits. UC Los Angeles: The Williams Institute. The Tax Equity for Health Plan Beneficiaries Act of 2009, currently referred to the House Ways and Means Committee would, if passed by Congress and enacted into law, accord the same tax treatment of health benefits for both domestic partners and spouses. However, it is uncertain whether this, or similar, legislation will be enacted any time soon.

If you have a domestic partner who might enroll in a benefits plan at the University, we encourage you to contact your attorney and/or financial advisor for guidance on the applicability and operation of IRS rules with respect to medical, dental or other benefits provided to domestic partners, since this is a highly complex issue.

— Stephanie Spanja, J.D.
Director, Contract Administration

Wellness Program Available from Humana

Announcement from the UC Benefits Office



The Humana Health Assessment is a brief online questionnaire that can help you improve or maintain your health. After taking the Health Assessment, you will be able to access a variety of Humana resources and tools including:

- **Condition Centers** for back pain, exercise, nutrition, stress management, tobacco cessation and more
- **Library of Health Topics** on diseases, conditions, tests, and medications
- **Video and Audio Health Library** on wellness topics
- **Complementary and Alternative Medicine Program** with discounts on massages, acupuncturists, and chiropractic services
- **Discounts and Coupons** for health-related products and programs

Employees who take the Health Assessment before **March 15, 2010** will have their names entered to win various prizes including Dick's Sporting Goods gift certificates, hand weights, pedometers or health/wellness guides. (Humana will share with us the names of those employees who take the Health Assessment for purposes of identifying winners; they are not permitted by law to share any other information.)

Wellness Website

http://www.uc.edu/hr/wellness_programs

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