

HEALTH INSURANCE, HEALTH CARE, AND P-FAC: PROBLEMS AND POSSIBILITIES

Report by Christine Pfeiffer
As of December 21, 2005

Introduction

The lack of affordable, adequate health insurance and health care is a constantly cited concern among part-time higher education faculty in the United States. P-fac members are no exception. Of 142 respondents to a December 2003 P-fac survey, 104 said they would be interested in obtaining insurance through the union, and 50 of the 142 said they had no insurance coverage.

Providing health coverage for P-fac, or for any part-time faculty group, is not easy in a country whose health care system is based on employer-provided policies for full-time employees, and where insurance is provided by profit-motivated corporations for all but a few restricted groups (the elderly, disabled, and extremely poor) covered by government programs. Furthermore, the very nature of a group of part-time employees works against obtaining insurance coverage. P-fac members come and go, teach at a variety of other colleges and hold other jobs (in Columbia faculty's case, often as independent contractors in media and the arts, another "uninsurable" category). Worse yet, many part-time faculty cannot afford the rapidly rising premiums and deductibles of traditional health insurance policies. And as a group of 800-1000 people, some of whom would opt out because they are covered by spouses or other jobs, P-fac is a very small pool for the purposes of getting the group discounts which make employer-based health coverage a "better deal" than individual coverage.

Improving health care benefits for P-fac is not impossible. At the outset of my research in spring 2004, looking toward contract negotiations coming up in summer 2005, several alternatives seemed worth exploring. With research, additional possibilities emerged, while others proved unpromising. Illinois' adoption of the Health Care Justice Act also adds some optimism. But the unfortunate truth is that a "perfect" solution that fully protects all P-fac members who need health coverage is unlikely at this time. A more realistic expectation is to make progress; to gain *something* that will be a step or two in the right direction. That can be done.

This report will present an assortment of options, discuss how Columbia College's current benefits program for full-time employees operates and may relate to us, and explore some of the major obstacles, challenges, and factors that affect our situation. Precedents of how other college and university faculty groups have made progress are included, as is information on the Illinois Health Care Justice Act. And, because it is impossible to understand our situation otherwise, there is background information on the current state of health care in the United States, and how the system's complexities and spiraling costs cause difficulties.

Note: This report was prepared before contract negotiations were completed. As of December 21, 2005, I have added a few "latest news" updates which are in italics. As this document is intended to be a "living" document, useful for future reference and

subject to further discussion and updating, all the possibilities we considered and that may be applicable in the future are included.

HEALTH COVERAGE: WHAT ARE OUR OPTIONS?

All options considered during the research and discussed in the report are summarized here. “Likelihood” is as of November 2005 unless otherwise indicated. “Good” and “Bad” refer to potential advantages and disadvantages of each possibility.

I.. Columbia’s own health plan.

- ❑ Good: Theoretically could be easily extended.
- ❑ Bad: College is unlikely to want to extend this self-insured policy, since they assume the insurance risk, and extending the policy would cost them more. Affordability might be a problem for P-fac members even if it were offered, unless the college is willing to provide financial subsidies similar to those it includes in full-timers’ benefit packages. Colleges are seldom willing to subsidize part-time employees’ health coverage to the degree that full-timers are subsidized.
- ❑ Likelihood: low, since it would be very expensive for CC because they assume all costs. *The College was not interested.*

II. Via Columbia: HMO Illinois.

- ❑ Good: easily extended. Good deal? \$99/month for an individual, \$260 per family for full-timers (but they are subsidized partially by the College).
- ❑ Bad: Affordability might be a problem for P-fac members even if it were offered, unless the college is willing to provide financial subsidies similar to those it includes in full-timers’ benefit packages. Cost has been a problem at the few other institutions which have extended HMO eligibility to part-time faculty, because the part-timers have been required to pay the HMOs’ full fees. Also, the preferred providers list limits choice.
- ❑ Likelihood: Possible, especially since there are precedents we can cite (City Colleges, some in other states). *The College was not interested.*

III. Extension of Student Health Service to us.

- ❑ Good: easily extended? Inexpensive: Students pay only \$10 or \$25 a semester. Would provide basics for minor illnesses and injuries, referrals for more serious cases, a 24-hour hotline.
- ❑ Bad: Limited services offered by providers, Sage Medical Group. Costs for P-fac members could be considerably higher because we are older than the students.
- ❑ Likelihood: Although this seemed like an easy idea at first, neither Columbia College nor Sage Medical group was willing to consider it. The riskier demographics of an older group was cited as a main reason.

IV. Our own nurse-practitioner, clinic, or other on-campus service.

- ❑ Good: straightforward; similar services as III; probably not expensive per person.

- ❑ Bad: limited services, possibly administrative costs/bureaucracy/liability the college wouldn't want.
- ❑ Likelihood: Possible, if the college is willing to provide space. In theory, either the College or P-fac could pay the nurse practitioner's salary.

V. An on-campus "health care day" with services provided by a hospital or other health care provider.

- ❑ Good: Hospitals often do these as public relations efforts with little or no cost involved to the sponsors. Routine exams (cardiovascular, diabetes, mammograms) are often offered at low prices, which would be helpful to uninsured faculty.
- ❑ Bad: Very limited in scope.
- ❑ Likelihood: Possible. The college would merely have to give permission and provide space.

VI. Group membership in a union-sponsored clinic such as Sidney Hillman Health Centre.

- ❑ Good: union-oriented, direct services, probably not too expensive (preliminary estimate was approximately \$100 per person, but exact figure would be negotiated with SHHC); any size group is accepted so there would be no need for universal or majority membership.
- ❑ Bad: Off-site services and hospitalization still would not be covered.
- ❑ Likelihood: SHCC administrator has shown interest in working with P-fac. Sponsorship could be by the College or by P-fac itself. A group of interested members would need to be organized, and a contract arranged with SHCC.

VII. A regular health insurance policy from a company.

- ❑ Good: standard deal most people expect, usually includes hospitalization, etc.
- ❑ Bad: past inquiries have proved unaffordable for our members or insufficient in coverage; the changeable nature of our group is also highly unappealing to insurers; quality benefits are not guaranteed just by paying high premiums for a policy.
 - ❑ Likelihood: unlikely, unless something new and exceptional can be found. *The College was not interested in sponsorship, and only one provider was even willing to provide a bid--which was later withdrawn.*

VIII. A "menu" or "cafeteria plan" arranged by a broker or management company, which combines a choice of programs from several insurance providers. (Note: Ellen Shapiro, a Marketing Communications P-fac member, has done excellent research on this option.)

- ❑ Good: Flexibility to suit differing needs, which is clearly in demand by P-fac members. Members would choose only those benefits they preferred. The outside management company would handle the process of selecting and administering the programs; the College would need only to arrange payroll deductions and provide some office support. Program could be paid for in full or in part by the College, or offered without a financial contribution from the College to members who would then pay the entire cost of the programs they select.

- ❑ Bad: Costs could be unaffordable for some. Also, group size, required enrollment percentages, underwriting, and other factors could raise costs or cause prospective providers to withdraw their offers.
 - ❑ Likelihood: Possible. *The College was not interested in sponsorship, but was willing to consider a side letter outlining benefits that P-fac members would pay in full; the College would administer payroll deductions. As of Dec. 21, 2005, this possibility is under discussion.*

IX. Insurance statewide through the IEA (or possibly nationwide through the NEA?).

- ❑ Good: large organization would be sponsoring; possibility of achieving standard benefits and group discounts. College would not need to consent. Some IEA administrators have expressed interest.
- ❑ Bad: part-time higher education faculty would presumably need a separate deal-- could there be a statewide “school district” for us? IEA has been approached with this idea in the past, and may still be reluctant to do all that just for us (we pay ¼ dues); current IEA financial status is shaky and they’d be unlikely to want a new expense now; even if successful, it still could be too expensive for many of us to afford.
- ❑ Likelihood: worth pursuing; eventual plans for a Chicago-area group of higher ed faculty may prove fruitful. This is a future possibility, not an immediate one.

X. Flexible Spending Accounts.

- ❑ Good: full-timers already have them so program could be easily extended; individual determines how much of pretax salary to set aside for own anticipated needs.
- ❑ Bad: We don’t make much money, so benefit would be modest (employer doesn’t put anything into these--it just administers them); unused amounts are lost at the end of the year.
- ❑ Likelihood: possible. *These may be on a menu.*

XI. Health Savings Accounts, Health Reimbursement Accounts, and other set-aside plans, some of which include both employer and employee dollars.

- ❑ Good: could be more savings with tax break from pre-tax withholding, or even more money from mostly-employer funding, depending on the type of account.
- ❑ Bad: some require purchase of high-deductible policies, or expire at the end of the year (causing you to lose the money you put in).
- ❑ Likelihood: possible.

XII. Illinois State single-payer or other universal health care plan via the Health Care Justice Act (HCJA).

- ❑ Good: the bill calls for a plan to implement universal health care for Illinoisans by January 1, 2007, which may well be our best hope of getting more than token improvements. Public hearings began in October, 2005.
- ❑ Bad: The bill creates a panel to come up with a plan, rather than requiring universal coverage right away-- so the plan could be delayed, inadequate, underfunded, etc.

- ❑ Likelihood: better than most other options, but not an immediate solution.
- ❑ Note: IPACE funds could be used to support the project, and P-fac could support progress as an organization and through individual members' participation.

COLUMBIA COLLEGE HEALTH COVERAGE FOR FULL-TIMERS (AND STUDENTS)

Understanding what Columbia College offers its other “populations,” full-time faculty and staff and students, gives us a basic understanding of what the College considers reasonable benefits.

Columbia College offers its full-time employees a choice between its own self-funded insurance plan and HMO Illinois. (Employees have the option to switch plans each December.) The College also pays for disability insurance after 90 days of employment and provides basic life insurance for full-timers.

The **Columbia College Health Plan** is a complete medical plan that, *after* the employee pays the deductible, pays 90% of most expenses if the employee uses a network of preferred providers, but 70% if the employee uses providers outside the network. The deductible is \$250 for an individual, \$750 per family, per calendar year, if network providers are used (if not, the deductibles are \$400 and \$1200). The plan also charges a monthly fee of \$25 for an individual, and \$50 for a family. Prescription drugs are reimbursed at 80%. There is a lifetime limit of \$1,000,000, and hospitalizations must be “pre-certified” within 48 hours. Dental (but not orthodontic) benefits are included, and vision care (glasses or contacts) is partially reimbursed. Limited outpatient mental health visits are covered at 50%.

HMO Illinois charges a fixed monthly fee (\$99 individual and \$260 family for medical, plus \$7 individual and \$18 family for dental which does include orthodontia), and members must use approved medical providers. There are no deductibles or maximum benefit limits. Most hospital services are covered in full, although there are \$50 co-pays in some cases. Prescription drugs are \$5 (generic), \$10, or \$23 depending on brand. Visual exams are covered, and there is a \$75 benefit for glasses or contacts every two years. Twenty inpatient and 20 outpatient mental health days are also included.

In addition to this choice of basic plans, full-timers with dependent children under 18 or dependent elder relatives in their households can get up to \$5000 to pay for daycare or a babysitter or nurse, if the dependent care is necessary to enable the employee to work.

To help with deductibles and co-payments, a full-time employee can set aside up to \$5000 of salary before taxes in a **Flexible Spending Plan**. The employee chooses the amount, and installments are deducted from each paycheck. The employee must pre-fund the account by one month before submitting a claim.

The college website gives basic information about benefits, and more details are provided in the Faculty and Staff Benefits handbook which fulltime employees receive when hired.

The Columbia College Health Plan is self-funded, which means that Columbia College money is used to pay claims, and Columbia itself takes the risk that claims may

exceed income. This differs from employer policies where the insurance company does the gambling on its assortment of clients, and individual companies negotiate deals with the insurer. Because the total client pool is extremely large and rates are largely controlled by the insurance company, this usually results in profits for the insurer. By self-insuring, Columbia assumes all the costs and all the risks. Because this is expensive, chances are that the College would be reluctant to extend this benefit to part-timers—although it is theoretically possible that they could.

As there is precedent (at City Colleges of Chicago, for example) the chances of extending HMO Illinois coverage to part-timers is probably more realistic. Fees for part-timers will be higher, however, than for full-timers if the College is unwilling to subsidize part-timers to the same degree. This has been a problem at some other colleges (including City Colleges of Chicago) that have extended their HMO coverage.

Flexible Spending accounts are another possibility, although the dollar amount of benefits to P-fac members would probably be modest. After all, the \$5000 maximum would be most of a semester's earnings for someone teaching two classes! But participants could save something by using untaxed income to pay for some of their health costs. The precedent of the College at least doing something for us administratively (no employer dollars are contributed to these accounts) would be progress.

Columbia also operates a **student health service**, which provides very basic care (common upper respiratory and urinary infections, minor skin and eye conditions, and sprains not requiring X-rays are mentioned on the College website) plus some basic tests (mono, pregnancy, etc.), mental health counseling, and a 24-hour physician answering service. Students pay \$25 (full-time) and \$10 (part-time) in their semester fees. It is conducted by Sage Medical Group, an independent group of eight physicians and two nurse practitioners. Allowing part-time faculty to use this service might be an easy way for the College to provide at least some health care to P-fac members. (Or at least, it seemed so at the beginning of my research.) This would be more health care than some uninsured faculty are getting now, even though it would not solve problems of severe illness or hospitalization.

Another possibility is having the College pay for a **nurse practitioner** to serve P-fac members (or perhaps even all part-time faculty and staff if P-fac and US of CC eventually cooperate).

An **on-site health day** offering low-cost screenings, tests, and basic services is another possibility, one used by companies and school districts (and occasionally provided for Columbia students). Hospitals and other providers often see these as good public relations, so costs to the College would be low.

Now that the "Super-Dorm" is open, extending its **fitness center** privileges to part-time faculty would be another small but welcome health-promoting benefit that would cost the College nothing.

THE BIG PICTURE: HEALTH CARE IN THE UNITED STATES

As uninsured or underinsured employees who are neglected by the U.S. health care and insurance system, we are far from alone. In Illinois, 1.8 million people were uninsured in 2003, 14.3 percent of the state's population, according to a U.S. Census bureau study released in August 2004. The national total was a record 45 million people, 15.6 of the U.S. population. The total was higher for the third consecutive year, and was the highest in a decade.

The number of uninsured would be even higher without public programs like Medicaid and the State Children's Health Insurance Program, according to a study by the nonpartisan Center for Studying Health System Change (HSC), also released in August 2004. From 2001-2003, nearly 5 million children were added to these programs.

In 2003, 81.4 percent of the U.S. population under 65 belonged to a family with at least one worker, the HSC found, a decline from 84.2 percent in 2001. The proportion with employer health coverage fell from 67% in 2001 to 63% in 2003. However, employer health coverage varied considerably by ethnic demographics, with 46.7% of Latinos having employer coverage, 51.3% of blacks, and 71.3% of whites. Both Latinos and whites lost employer coverage and increased in public coverage during the three-year period covered by the study. (Proportions did not change for blacks.) Public coverage for the three groups in 2003 was 22.1% for Latinos, 21.5% for blacks, and 7.9% for whites.

The recession and rising unemployment account for part of the problem, according to the HSC. But rapidly increasing costs—28% increases from 2001-2003—were another important factor, leading to reduced coverage for fulltime employees as well.

In Illinois, the Families USA report for 2002-2003 found that nearly 1 in 3 people under 65 went without health insurance for all or part of the two years studied (this figure is higher than the Census Bureau's because the Census report counted only those without insurance for an entire calendar year). People at or below 200% of the poverty level were most likely to be uninsured. Working for a small business also increases the chances of being uninsured: two thirds of workers at firms with fewer than 10 employees have no insurance, largely because insurance companies quote very small businesses extremely high rates for inadequate coverage.

Health Cost Escalators: Going Up!

Health care premiums have risen by nearly 50% since 2000, and in 2003 they grew three times faster than wages. A family that paid \$1620 in annual premiums in 2000 paid \$2,412 in 2003. Deductibles are also up 50%, and co-payments, especially for prescriptions, are also increasing (figures from Kaiser/HRET Health Benefits survey, 2003). This means that even people who remain employed, with employer coverage, are feeling the pinch.

Consequences for the uninsured are grim: 18,000 uninsured adults die each year because they did not get proper care, the risk of death for uninsured people with cancer is 50% higher, and up to 51% of uninsured people who were sick in 2003 did not see a doctor (source: Jeanne Lambrew presentation to NEA conference, July 3, 2004).

Health care is the largest sector of the U.S. economy, accounting for 14.8% of Gross Domestic Product (GDP) in 2003. For comparison, housing was 10.3%, food 9.9%,

national defense 4.3%, and the auto industry 3.6% (figures are from the Bureau of Economic Analysis, cited in the June 2003 Medical Cost Reference Guide, an annual publication of the Blue Cross Blue Shield Association, BCBSA, an association of 42 BC/BS plans).

The BCBSA report predicts that health care expenditures will double by 2012, and will account for 18% of the domestic economy.

The health care dollar (2001) divides as 31 cents hospital care, 30 cents physician services, 14 cents prescription drugs, 11 cents administrative costs, 10 cents other medical services, 3 cents nursing home and home health care costs, and 1 cent durable medical products.

Hospital outpatient care and prescription drugs have been the fastest-growing components of privately funded healthcare costs for the past decade, with physician services and inpatient hospital costs also rising. Rates of total growth vary substantially by state: from a low 0.8% in New York to a high 12.9% in neighboring New Jersey (1998- 2001). The Illinois rate was 6.7%. (BCBSA).

What's behind these costs? The BCBSA report, produced by insurers, cites an assortment of factors:

Hospital Inpatient Costs: increased use of more expensive technology, higher labor costs driven by the growing nursing shortage, hospital consolidation, high fixed costs of underutilized beds

Hospital Outpatient Costs: growing number of outpatient visits, increasing use of outpatient instead of inpatient procedures (in 2001, 63% of surgeries were outpatient), competition between hospitals and outpatient facilities

Physician Services: increased proportion of physicians in specialties (specialists charge average fees twice as high as primary care physicians charge), increased use of specialists especially by the growing senior population, higher fees charged by physicians because of their own increasing medical malpractice insurance costs

Prescription Drugs: increased use of prescription drugs (1.9 billion prescriptions issued in 1993 rising to 10.9 billion in 2003), shift to use of higher-cost drugs, price increases, research and development costs (\$8.4 billion in 1990, \$26 billion in 2000), advertising costs (especially direct-to-consumer advertising, which was \$0.8 billion in 1996 but \$2.5 billion in 2000)

Technology also has accounted for 10%-40% of health care cost increases, depending on the year, and also accounts for about 18% of variations in costs (BCBSA). New equipment for diagnostic tests and medical procedures is itself expensive, but also increases total costs indirectly by broadening the potential group of patients eligible for procedures because of reduced risk and lower per-patient cost. Improved cardiovascular procedures and in vitro diagnostic tests are good examples, and each accounted for nearly \$40 billion in health care costs in 2000. Diagnostic imaging, the number one growth technology, cost nearly \$75 billion (statistics: Booz Allen Hamilton, 2003, BCBSA).

Uninsured people's health care is another expensive item, according to BCBSA: about \$36 billion in 2001. About \$24 billion was for hospital costs, \$7 billion for clinics, and \$5 billion for physicians (statistics from Hadley and Holahan, 2003, include Veterans Administration, Indian Health Service hospitals, and "other community health providers"). Nearly 1.9 million uninsured patients accounted for 5.6% of all hospital discharges in the U.S. in 2001/2002, at a cost of \$9.7-\$11.6 billion, about 5.1% of all inpatient costs. "Ambulatory care sensitive" outpatient admissions for conditions like asthma and diabetes ("many of which," the BCBSA report notes, "can be prevented through good outpatient care") cost \$1.2 billion to \$1.4 billion in 2001 (Siegrist, 2003, projected from 10 states).

Reform advocates would add another factor missing from the BCBSA report: the role of insurance companies and HMOs. After all, some of the \$100 billion growth per year of the health care economy is profits for them, as well as pharmaceutical companies, health equipment producers, and health care providers. Large companies control the marketplace with effects much like those of Wal-Mart on retail sales. The trend is economically in favor of fewer, larger for-profit providers, and against not-for-profit hospitals and smaller private physician practices.

"What the HMOs want the public to forget is that 12 percent to 33 percent of every premium dollar they collect is eaten by their increasing profits and overhead. Who is responsible for runaway costs if not the companies charging them? Analysts say that less of the premium dollar is going to patient care than ever before because of added levels of administration and profiteering. In addition to the HMOs, there are large physician-run medical groups, hospital chains with the power to demand higher profits and profit-hungry pharmaceutical markets and managers," stated researchers for the Foundation for Taxpayer and Consumer Rights, reported in the Los Angeles Times on March 18, 2003, (cited in *Bushwhacked*, by Molly Ivins and Lou Dubose, p. 285).

In the fourth quarter of 2002, when the Standard and Poors index was down 21%, the profits of Wellpoint, the parent company of Blue Cross, were up 64% from the previous year, and HMO stocks were up 23% (*ibid*, p. 284).

Insurers have the further advantage that they are large and well-coordinated, while their market is fragmented: individual employers, each arranging policies for its own employees. While a large organization that can offer an insurance "pool" over 200,000 people can get good rate breaks, the situation is very different for small employers—not to mention individuals, who may easily find that a health insurance policy costs more than renting an apartment. (What's more, individual insurance isn't even regulated in 10 states.)

"Fragmentation is a leading explanation for the high prices being difficult to negotiate down," said Lee Johansen, Negotiations Specialist for Education Minnesota, in a healthcare presentation at the July, 2004 NEA convention. Unless an organization is large enough to have some bargaining power (at least 200,000 people in the insurance pool) there will be a "Catch 22" choice of raising premiums—which will probably cause some people to drop out, further reducing the pool and thus its bargaining power—or cutting benefits.

The power insurance companies wield is reflected even on their own statistical graphs: per capita hospital inpatient spending growth actually declined from 1994-1998, before

rising again (Milliman USA Cost index, BCBSA p. 8). A Cigna/Hewitt chart from Johansen's presentation shows that insurance prices increased 10% in 1992—but only .01% to 2.5% between 1994 and 1998, before a quick rise to 6%, and eventually to the 2003 figure of 15%. This dip is “The Hillary Effect,” said Johansen—during the years Hillary Rodham Clinton's committee was planning health care reform, rates “coincidentally” stayed down.

The U.S. System in Perspective

“The American health care delivery system is in need of fundamental change. The current care systems cannot do the job. Trying harder will not work. Changing systems of care will.” (Report of the Institute Of Medicine's Committee on Quality Health Care in America, cited in presentation of Reed V. Tuckson, M.D., Senior Vice President, Consumer Health & Medical Care Advancement, NEA convention).

Americans are used to their health care system as it has evolved, with private for-profit insurance companies, Health Maintenance Organizations (HMOs) and Preferred Service Providers; premiums and co-pays and high deductibles; and the loss of health coverage accompanying the pink slip. Medicare helps if you're old enough, Medicaid if you're poor enough, Social Security Supplemental Insurance (SSI) if you're disabled enough. Otherwise, you're dependent on your employer and its insurance provider—or you're uninsured, hoping you won't get cancer or a heart attack or be hit by a truck before you make it to 65.

However, it's worth remembering something that U.S. insurance and pharmaceutical companies, as well as many politicians, hope we won't notice:

The United States of America is the only industrialized nation that does not have a national health care system.

“Americans spend much more per person on health care than people in other countries,” states the BCBSA report, above a useful comparison chart from the Organization for Economic Cooperation and Development (OECD). That's all it has to say about the fact that the U.S. per capita spending for 1999 was \$4,358 while the next-highest spender, Switzerland, spent \$2,853, only about 65.4% as much. Canada spent \$2,463 (about 56.5% of the U.S. figure), with Norway, Germany, and the Netherlands close behind. Japan spent \$1,796, and the U.K. spent \$1,569, only 36% as much as its former colony.

Perhaps presenting these figures without comment implies that Americans should feel lucky to be so far “above” other countries who are still striving for our high economic standards. Or perhaps we're supposed to feel guilty because we can't keep our personal costs under control. But what these figures really show is the dismal inefficiency and unfairness of our system.

In the United States, a national health insurance program could save up to \$2 billion a year in administration, marketing, and other industry expenses, according to Physicians

for a National Health Program in an August 12, 2003 article in the *Journal of the American Medical Association*. This would be “more than enough to provide care to the 41 million Americans who now lack coverage” and would also reduce paperwork for doctors. They suggest a single-payer system that would operate much like Medicare, but be available to people of all ages, and include both prescription drugs and long-term care.

HOPEFUL POSSIBILITIES

The Illinois Health Care Justice Act

After three years of effort by the Campaign for Better Health Care, 325 allied organizations, and Illinois state legislative sponsors, The Health Care Justice Act (HCJA) became law in Illinois on August 21, 2004, with Gov. Rod Blagojevich’s signature. This establishes a bipartisan task force that will make a report to the Illinois General Assembly in March, 2006, recommending improvements to increase affordability and accessibility of health care for all Illinois residents. The law instructs the legislature to vote on a solution (or multiple solutions) no later than December 31, 2006 for implementation beginning July 1, 2007. Illinois is only the second state in the U.S. to pass such legislation, making it an innovator in health care reform.

The HCJA establishes health care reform as a policy *goal*, not a policy, of the state. There are also no specific provisions for funding, although estimates have been made of \$2.6 billion to \$4 billion per year—an amount Illinois would have difficulty affording alone, without federal help, which may not be forthcoming in an era when federal funding to states is declining overall, and Illinois is already struggling with budget cuts.

Still, the task force is required to analyze, evaluate, and debate proposals, and this process includes opportunities for public participation. (Public hearings began in October 2005 and will take place in every Congressional district.) Supporting statewide universal health care may well be the most realistic of all the possibilities for P-fac members to improve their health care coverage (however discouraging some readers may find this idea). Supporters of HCJA are already working toward this goal, and a survey of Illinois small business owners showed that they, too, preferred universal coverage to any other solution, even to tax credits for employers.

It is unrealistic to expect working families to have enough disposable income to afford policies on their own, according to the Campaign for Better Health Care newsletter. It cited the Families USA report: for \$1,000 (the amount of a proposed federal tax credit), “NO insurance policy was available to a 55-year-old woman in Illinois or most other states even if she was healthy” and a healthy 25-year-old woman would be able to get only a high deductible policy with high out-of-pocket costs and substandard coverage. A more acceptable standard policy would cost at least \$1500 for the 25-year-old and \$3400 for the 55-year-old (in other words, more than many of us earn teaching one entire 16-week class).

The Campaign for Better Health Care site, www.cbhconline.org, is a good source of information about health care in Illinois and progress on reform. It also helps uninsured individuals find lower-cost medical services through its Online Help link and by phone at 1-888-544-8272.

Precedents

In her article “Second Class Citizens,” AFT President Sandra Feldman said that only 17% of part-time faculty nationwide have health insurance (AFT Higher Education News, Oct. 29, 2001) So some part-time unions and other faculty organizations have successfully negotiated improvements in their health care situation, proving it can be done—although there is no indication it was easy. Also, high costs can be a problem even when a plan is achieved.

Here are some examples of success:

- The City Colleges of Chicago set an Illinois precedent when its contract (January 1, 2004-June 30, 2005) included “Part-time faculty shall be permitted to participate in the Board’s Group Health Maintenance Organization plan offered to full-time faculty at the part-time member’s sole expense and at the rate charged to the Board by the insurer.” Unfortunately, that cost is so high (\$265 individual, \$734 family, per month) that only 18 of 400 eligible people have signed up for the plan, according to IEA Higher Education Consultant B.Diane Davis.
- In its most recent contract, the NEA-affiliated union at University of Massachusetts-Boston representing both full and part-time faculty added part-timers to the college health care plan.
- In Michigan, The Lansing Community College Faculty Association created a Voluntary Employee Benefits Association to provide some health insurance benefits for adjunct faculty.
- The California State University contract extended health insurance eligibility to half-time lecturers (gradually adding them according to seniority).
- At University of Michigan, half-time employees get health benefits. An employee must have worked half time for two terms and be signed up with half-time teaching for the subsequent term. Until recently, half-timers had to sign up for COBRA each summer, but the newest contract extends benefits through the summer.
- The Long Island University Faculty Federation (AFT) contract of 2003 requires the university to contribute to a benefit trust fund to help adjunct faculty pay for health insurance.

An important note: private and state employees often have different rights. In some states, such as California, Washington, and Massachusetts, state employees who work half-time are entitled to partial or even full medical and/or retirement benefits. Those rights don’t necessarily extend to private employees, although they can set a useful precedent for negotiations. Also, employers are not above making sure that employees never quite get to that half-time mark. At University of Massachusetts-Boston (cited above for its subsequent success), for example, part-timers were classified as teaching 2/5

of a fulltime load even though most taught two classes while full-timers taught three! The rather specious argument was that “part-timers don’t do research or service” so they actually had far less “load” than full-timers.

Adjunct life has built-in disadvantages with regard to traditional health care. At one extreme is the multi-school teacher. One San Diego man, who taught French part-time at four different colleges simultaneously (*American Teacher*, Feb. 2000) obviously wasn’t going to be offered health insurance by any of the four schools, and individual health coverage would “eat up too much of my monthly salary.” California eventually passed legislation that would have entitled him to join an HMO—but not before he contracted appendicitis and was presented with a \$12,000 bill, about half of his total annual earnings.

On the other hand, successfully gaining hours at a single school may not help, either. At Southwest Illinois College, where part-timers outnumber full-timers 6 to 1, most part-timers teach 6 to 9 hours per semester. This course load means “most are not able to find other jobs that would provide health insurance” (*Higher Education News*, Oct. 3, 2003). Note the assumption that only another job, not college teaching, could be realistically expected to provide health insurance!

Perhaps an idea from other professions should give us food for thought. (About 30% of U.S. workers are in “nontraditional” employment arrangements, by the way, according to the Economic Policy Institute.) In unionized building trades, and in film, TV, and radio, employees gather benefits that accumulate from the different jobs they have. Working Today, an independent advocacy group, advocates wider use of this idea—which may well be familiar to some media professionals teaching at Columbia College.

MORE ALTERNATIVES

Traditional (or maybe not-so-traditional) insurance policies

P-fac is far from the only organization of non-standard employees that has searched in vain for an affordable group insurance policy with reasonable benefits. The National Writers Union has a cautionary tale. It searched nationwide, found what looked like a good option, and attracted many new members partly because it offered group health insurance to freelance writers, a group even more devoid of health insurance options than adjunct faculty are. Unfortunately, the insurance company proved to be both fraudulent and financially ruined, despite its superficially appealing credentials and client recommendations. It had fooled colleagues in the insurance industry as well as its clients by operating through recognized agencies that also handled prestigious companies’ policies. The NWU-- which lost many members and suffered embarrassment in its process of becoming sadder-but-wiser-- now offers only limited coverage to writers in New York.

Naturally, the existence of one fraudulent company doesn’t preclude the possibility of finding an appropriate policy somewhere else. But every source I’ve encountered points out that unless you are a very large group, with members who can afford the premiums and deductibles, an insurance company will not give you much of a break. Either high prices (which may be unaffordable to members) or limited benefits (which may be of little use), or both, are likely.

One sample proposal with limited benefits—no hospital coverage, for example—would have cost more in premiums than I spend on direct medical expenses in most years—and I am a middle-aged woman with seven pre-existing conditions. If I am not getting hospital or major medical coverage (the parts I really worry about), why would I want to use up \$2500 or so paying premiums every year when just saving the money would make it more likely I can afford what I actually need, when I need it? For many of us, the problems of initial cost are compounded by policies' long lists of exclusions. If we become ill from a pre-existing condition or an exclusion, we could find ourselves in the unenviable position of having spent thousands of dollars on insurance that won't cover the cost when an actual health problem arises. We'll still have to spend additional money (that we probably now don't have) on out-of-pocket health costs.

As a union, we have members with a wide range of circumstances and needs, and a given available policy may serve some people, but not all. Probably that is better than not helping anyone. But my research tells me the *system* is set up against us, so an exceptional *policy* will be hard to find.

William Lannin, who is working on insurance issues for Roosevelt's adjunct union, RAFO, says:

“The problem we have as part-time employees is that conventional insurers don't like our risk profile as a group and that our employers do not have much clout or are unwilling to risk their experience rating for the full-time group. Insurers always have to be concerned with the risk of anti-selection in groups, which basically means that the participants need to represent a cross section of the employee population, actively at work (requiring a certain degree of good health), preferably with a high rate of enrollment. The lower the participation rate, the greater the risk that the unhealthy will participate in disproportionate numbers. Part-time employee groups traditionally have very low participation rates, partly because of affordability, partly because employer subsidies tend to be smaller or non-existent.”

A Menu of Options

A promising alternative to the traditional “one policy, one employer” form of health insurance is a menu or “cafeteria” plan, in which employees can select from a list of options. John Jones and Sarah Smith might have benefit packages that cost the same, but may include different elements: perhaps John has dental and visual coverage, but Sally has a Flexible Spending account and eldercare coverage. In most cases, employers provide full or partial funding of menus, but it is also possible to offer menus that are paid in full by the employees (“voluntary benefits plans”), with premiums based on the menu items they select, and only minor administrative costs borne by the employer.

There are management companies that specialize in formulating menus. They survey varied insurance providers, conduct an information census of the employee group, and put together a menu package, usually including multiple providers, and administer the program. These companies receive a percentage of each enrollee's premium as payment. One such company, Better Business Planning, Inc. with headquarters in Itasca, IL, has proposed some possibilities for Columbia College P-fac.

Possible health-related components of menus include:

- ❑ A standard health insurance policy that covers both standard day-to-day health costs (such as doctor visits, laboratory work, etc.) and hospitalization.
- ❑ A “mini-medical” policy that covers day-to-day costs but provides very limited hospitalization benefits.
- ❑ A prescription discount card.
- ❑ A health services discount card (i.e. whether or not a person is insured, he or she can get discounted fees when paying directly for medical services from providers included in the discount agreement).
- ❑ A Critical Illness policy that pays a one-time lump sum (for example, \$5000-\$50,000 depending on the level of coverage selected).
- ❑ Dental Insurance.
- ❑ Vision Insurance.
- ❑ Short and/or long-term disability insurance.
- ❑ Life and accidental death insurance.
- ❑ Long term care insurance.
- ❑ Flexible Spending Accounts.

Menus also may include other benefits such as public transportation and parking paid for with pre-tax dollars, prepaid legal services, home and/or rental insurance, auto insurance, pet health insurance, and retirement plans.

Ideally, an employer covers at least part of the cost of employee benefits. However, even if there were no financial contribution from Columbia College, offering a fee-based menu would give many P-fac members access to benefits that they have not had before. This would also set the precedent of treating part-time faculty more like “real” employees, by officially acknowledging that they have needs similar to those of full-timers, and that the College has some responsibility to help them.

A menu offers considerable advantages. Rates even for a small group are lower than individual rates, and employees could select and pay for only those benefits they needed and could afford. Options using pre-tax dollars also save money for participants.

The main potential disadvantage is, as always, the costs of benefits. Fees may be “reasonable” for the industry, but still out of reach for some people. Also, there may be a difference between the proposed, estimated rates employees consider when they decide to sign up, and the actual rates if underwriting (examination of the health conditions of participants) is required; underwriting requirements vary by policy and provider. Actual rates would also rise if the group that actually signs up is smaller than the group on which the estimate is based.

Menu plans also require non-participants to sign waivers indicating whether they are declining because of previous coverage, or for other reasons (for example, not being able to afford the policy, or deciding its coverage is insufficient considering its cost and the individual’s needs). Those with alternative coverage are not counted in the pool of applicants. However, an insurance provider determines the size of the eligibility pool and generally requires a minimum percentage (often 50% or 75%, but sometimes higher or lower) of those it considers eligible to sign up. If it considers the enrollment inadequate, the insurance provider may withdraw the offer entirely.

As of December, 2005, there is already an example: Only one insurer (of more than 20 surveyed) was willing to provide a bid for comprehensive health insurance as part of Better Business Planning's menu proposal. When a company representative met with BBP and P-fac and learned more exact demographics, the insurer withdrew the offer.

Insurance via a larger group: IEA, NEA, or possibly COCAL or another coalition

This interesting possibility is sometimes suggested at meetings or asked about in “why don't we have health insurance?” conversations. However, it seems unlikely for now, although it is a possibility to work towards in the future. Several years ago, IEA was approached with this idea, but said no. At least one other state has attempted unsuccessfully to start a program for adjunct faculty members statewide. IEA/NEA,, which is heavily dominated by K-12 educators, would have to be persuaded that health coverage for its lower-dues-paying part-time higher education faculty should be a priority.

A favorable sign for cooperative health care of some kind in the future is the current movement towards more inter-group action among Chicago-area part-time faculty unions. IEA member unions in downtown Chicago and in the greater Chicago area are meeting to discuss common concerns. COCAL (Coalition of Contingent Academic Labor), which has traditionally held conferences of educators from Canada, the U.S., and Mexico every two years, has also been a recent vehicle for cross-group discussions among Chicago-area adjunct faculty unions and associations (including those affiliated with AFT, AAUP, and other sponsoring organizations and unions besides IEA/NEA). The member organizations all are interested in improved health coverage for adjuncts, so creative measures may evolve.

Union Health Service

Some large unions operate health clinics for members, and may include members of other unions through contractual arrangements. The sponsoring union is paid by the employer, the member union, individuals, or some combination thereof. I have had extensive conversation with Dr. Geralynn Kahn, the director of the Sidney Hillman Health Centre, who has expressed interest in working with P-fac if a group of our members is interested. There is no minimum requirement for number of members in the group, although (as with all health coverage) a larger group would get a better deal (fees are negotiated for each group's contract. Per-person costs average \$100 or below in most cases). SHHC provides primary care, specialist care, dental and eye care, and some laboratory services on-site. It also maintains a 24-hour answering service. SHCC is located near Columbia College in the UNITE HERE building, 333 S. Ashland Blvd.

Off-site services, including hospitalization, are not included. However, the Centre does help members find and negotiate prices for outside medical services.

Set-aside accounts

Flexible Spending Account (FSA): Employees contribute pre-tax dollars, somewhat like a 401K. In effect, the employer reduces taxable pay by the amount the employee selects, and agrees to reimburse employee expenses by the same amount. Under current law, it is on a “use it or lose it” basis annually. For example, suppose Tom Jones decides to contribute \$1000. He won’t pay taxes on that \$1000 and also won’t receive it as potential cash in his paycheck. Instead, if he has, say, \$600 in medical expenses that year, the college will pay them. However, at the end of the year, the unused \$400 would disappear (at least, from Tom’s perspective). Columbia College offers FSAs to full-timers.

This could be a feasible idea for P-fac members. However, a problem does arise if an FSA holder works part-time: what if the person doesn’t work all 12 months or doesn’t have income in some months? Usually a full-timer would have a monthly deduction. While it would be possible to deduct the money up front, that might make an FSA a lot less appealing.

Health Reimbursement Account (HRA): This account is the opposite of an FSA in one sense: it is entirely contributed by the employer, with no employee salary reduction or contribution. If Columbia established an HRA for Sally Smith, the College might put \$1000 into the account, but Sally wouldn’t need to pay or lose anything. If she had \$600 in medical expenses in 2004, the College would reimburse her. The remaining money would carry over into subsequent years, too.

The challenge in this case is that the College would have to be willing to make the contributions, and if it were, they might not be very large. Still, this seems worth trying for. Possibly a fixed contribution per course or credit hour taught would be a good idea.

Health Savings Account (HSA): An HSA is like an IRA for medical expenses. It is owned by the individual and is portable (not tied to a specific employer). This is a very new type of account, and will not be generally available until 2006. The HSA may or may not also have an employer contribution. Like an IRA, the HSA reduces taxable income.

The “catch” is that this account must be tied to a high-deductible insurance policy (HDHP for High Deductible Health Plan); it is not available on its own. The deductible would be at least \$1000 for an individual, but no higher than \$5000, with higher limits for family coverage. The HSA holder can contribute the amount of the deductible to the account—more if he or she is ages 55-64. Whatever is not used is saved.

Suppose Terry Brown buys an HDHP with a \$2000 deductible for \$150 a month, and contributes \$167.66 per month to the accompanying HSA (total \$2000 a year). Terry is paying \$317.66 per month for health care (\$3811.92 per year). However, if there are zero claims, the \$2000 stays in the HSA, available for future use, whereas in a conventional policy nothing would be left. If there is a large claim, the HSA would pay the first \$2000 and the HDHP would cover the rest.

As with an HRA, it might be possible to negotiate a fixed or per-course employer contribution. However, for many P-fac members, the expenses involved in this alternative would be prohibitive.

Conclusion and Recommendations

Although a perfect, complete solution to health care coverage for all P-fac members is unlikely, some sort of progress for the next contract period is feasible. Because P-fac members' needs and abilities to pay vary widely, a multi-level approach has the best chance of providing useful benefits to as many members as possible. These goals seem reasonable:

1. Extension of HMO coverage to part-timers
2. Provision of some sort of protected account to part-timers, either Flexible Spending or (more desirable because employer dollars are contributed and funds carry over) a Health Reimbursement Account.
3. Provision of some on-campus health care: a health fair day each semester at minimum; extension of clinic services similar to those for students for more long-term benefit; opening existing campus facilities (such as the fitness center) to part-time faculty.

Since P-fac members have widely differing needs, funds contributed by the College that could be used flexibly by individuals is desirable. (A person might want to use funds for direct payment of medical costs, membership in a union clinic, or for a group or individual health insurance premium.) This would be much more useful than providing only one option, useful only to those who could afford it, that would merely give the appearance of an improvement.

Another possibility, with precedents at other colleges and universities, would be for the College to contribute money to a benefits fund. A committee including both P-fac members and College administrators could be formed to study, establish, and administer the fund.

In addition, P-fac should support the Health Care Justice Act and the Campaign for Better Health Care, and work toward strengthening Chicago-wide coalitions of part-time faculty, to build toward stronger bargaining positions and fuller coverage for the future.

December 2005 addendum (after contract negotiations were complete)

Benefits, including health care, were not covered in the contract per se. However, Columbia College did agree to the use of side letters for proposed benefits that were under discussion during the contract negotiations. These letters could allow more flexibility during the four-year period (2006-2010) the contract covers.

The College refused to agree to sponsorship of any benefits; i.e. it refused to take liability as an employer generally does for its full-time employees. It did agree to procedural and administrative support, such as allowing payroll deduction processing.

As of Dec. 21, 2005 the exact possibilities that may be offered are still under discussion. They will not, however, include a standard health insurance policy, because (as

mentioned earlier) no insurance provider of the 20-plus surveyed on P-fac's behalf was willing to offer one.

The struggle to attain better health care for P-fac members, and adjunct faculty generally, continues to be extremely challenging. Many economic and social factors are beyond our control--but the problems are not beyond our influence. We can use our collective intelligence and organizing powers to keep working for improvements.