NEGOTIATIONS BULLETIN

Contract negotiations took a brief pause over the holidays, but we had five productive days of bargaining in mid-December (12/8-9, and 12/14-16) and have upcoming scheduled dates in late January (1/26-27) and early February (2/3). The December sessions saw preliminary bargaining on a range of important issues, including leaves, telecommuting, grievance and discipline procedures, the abuse of temp appointments, delayed permanency decisions, librarian issues, and bullying/workplace civility. The primary topic of bargaining, however, and the one on which we have made the most progress, is Health Benefits and changes to the Empire Plan (which, as a reminder, is the only plan we negotiate, and the plan in which over 80% of our benefits-eligible employees enroll; HMOs establish their plan designs independently). We anticipate that our next sessions will begin serious bargaining on compensation and job security, among the most important issues for our members. Likewise, we will return to the range of issues discussed in December once we get more substantial responses from the State. However, because access to affordable, quality health care is so important to our members and so complex in its details, we have decided to devote this Negotiations Bulletin to an extended discussion of the negotiations surrounding health benefits.

As a rule, health benefits bargaining tends to be difficult and contentious. As we know all too well, health care costs continue to rise, often at alarming rates. The State generally comes into bargaining hoping to make changes to the Empire Plan that will save it money, usually by shifting costs to employees. In some respects, this round is no different. The State has proposed Plan changes that it believes will reduce its overall expenses. However, in other respects the specific nature of those cost-saving changes along with several potential gains in benefits access and coverage make this round more favorable.

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First the good news. We anticipate no increases in the employee share of premiums or in the co-payments, prescription drug co-payments, annual deductibles, or co-insurance maximums that our members who access care must pay. We also are optimistic that we will achieve our proposal that employees pay a single co-pay for all services such as the office visit, office surgery, radiology, diagnostic or lab work provided by the same medical provider on the same visit. Taken together, this stands in stark contrast to the State's proposals in the last round, which looked to significantly increase the cost of health care utilization by members.

Additionally, we anticipate no changes to benefits-eligibility that would strip members of their ability to access health care. We are optimistic that we will be able to remove the 42-day waiting period for graduate students who enter the UUP bargaining unit with no breaks in service from their employment in titles represented by GSEU. In other words, graduate students who enter UUP as part-time Lecturers, Adjuncts or in professional titles, but who were GAs or TAs immediately before, will no longer have a long delay before they can access their health benefits. Again, taken collectively, this is a notable shift from last round where the State sought to achieve cost savings by making eligibility standards more restrictive, and hence reducing our members' access to health care.

More good news: The Empire Plan will be working with the Betty Ford Hazelton Clinic to establish a Center of Excellence (COE) for Substance Use Treatment. The current COEs for Cancer treatment and Infertility treatment have demonstrably improved outcomes for patients. As with all COEs, Empire Plan enrollees who use the new Substance Use Treatment facilities will be entitled to significantly reduced costs, travel subsidies, and a range of other paid benefits. Using our Joint Committee on Health Benefits, we will be discussing implementation of an additional COEs to treat musculoskeletal disorders (primarily to treat back, knee, hip, and other joint conditions) and a telemedicine program for sleep disorders. A more narrowly targeted, but still important gain: we anticipate will be that physician-prescribed mastectomy bras will now be covered in full, with no deductible or copay.

Not surprisingly, however, the State is seeking changes to reduce Empire Plan costs. The cornerstone of the State's proposal would shift the ways in which Out of Network (OON) care is reimbursed. Currently, the Empire Plan reimburses providers for OON services based on a "Reasonable and Customary" rate, which is calculated based on the lower of a) the medical provider's actual charge, b) the provider's usual charge for same or similar service, or c) the usual charge of other providers in the same or similar geographic area using FAIR health benchmarks. State Comptroller Tom Dinapoli's office analyzed this method of reimbursement in a 2020 report (https://www.osc.state.ny.us/files/state-agencies/audits/pdf/sga-2020-18d2.pdf) that raised concerns about rapidly escalating OON costs. The report also raises concerns about dramatic differences across geographical regions for the same procedures (with no evidence that these differences were the result of predictable factors such as increased claims or higher medical care cost-of-living). Some of the disparities are quite egregious. The report cites examples of common conditions being charged at rates 17 times the cost of In-Network (IN) care. In one example, the same spinal procedure was billed at $167 in one area and $38,000 in another. A different spinal procedure was billed at rates twice as expensive in Long Island as it was in Queens. In reviewing the various disparities, the report's conclusions focus on the latitude that individual providers are afforded to set their billing rates independently, knowing that the Empire Plan will reimburse them at very high rates. The report looked at health plans for government employees in 14 other states and found New York's Empire plan to be a notable outlier in its OON reimbursement methodology. To contain costs and level out significant

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geographical disparities across the state, the report recommends that OON reimbursement be pegged to a percentage of the Federal Medicare Rate. The State, closely mirroring the rationale and recommendations laid out in the Comptroller's report, has ***proposed that our contractually established OON reimbursement be changed from the current Reasonable and Customary rate to a rate no greater than 275% of Medicare's rate.***

This proposal has downsides for our members who use OON care, but it also brings some potential benefits. On the one hand, some members who rely on OON services may see their individual bills from providers go up if the Empire Plan reimbursement to providers goes down. This, however, is difficult to determine in advance. OON providers vary considerably in the amount of so-called "balance billing" that they charge patients beyond what will be reimbursed by the Empire Plan, so there is no simple way to determine what the net effect will be for individual members who use OON care. On the other hand, by controlling rapidly escalating OON costs, the plan as a whole saves money, which in turn will be shared with UUP members in reduced employee premium costs.

As we move towards an agreement on Health Benefits, UUP's primary concern is working to ensure that there is adequate In-Network coverage so that our members can reliably find high quality In-Network providers who are geographically convenient, rather than rely on more costly OON providers. We are particularly concerned about access to In-Network Mental Health care, which our members have repeatedly flagged as inadequate. The State has provided credible evidence to suggest that the shift to 275% Medicare reimbursement may help drive some OON providers into the network, since they will no longer be reimbursed based on their independent billing rates. We are looking to establish clear geographical network standards that ensure In-Network rates to members who cannot find a provider close by. We have a joint commitment to publicize Empire Plan resources, such as referral services that authorize In-Network rates to members who are unable to find providers in their area.

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There are several remaining important UUP proposals in Health Benefits where no agreement has been reached. UUP proposed a series of provisions that would expand benefits eligibility for part-time academic contingents by counting teaching done over summer and winter sessions, overloads (i.e., more than 6 credits) taught in the fall, and courses taught at more than one state-operated SUNY campus. As part of our broader efforts to make gains for contingent faculty, we hope that there may still be opportunities to reach agreement on some or all of these proposals.

UUP has also proposed to establish a two-person (employee plus one) health benefits tier. Our members who currently pay family plan rates but have only have a spouse or single dependent covered have repeatedly asked for this benefit. As in past rounds where UUP has also made this

proposal, the two-person tier has proven to be very difficult to achieve. Because NYS is self-insured, it pays all claims made by Empire Plan enrollees. Changing the tier structure would shift how costs are distributed, but would not affect the total costs to the plan. It is a zero-sum game.Adding a new two-person tier would reduce bi-weekly expenses for 18% of the unit by about $100 per paycheck. But it would raise rates by about $100 for 39% of our unit who would remain on the family plan with three or more enrollees. Because the Empire Plan is statewide and is uniformly administered across all bargaining units, the State is very reluctant to make changes that would only affect one unit, and thereby set up different administrative requirements for different unions. They do not believe that a contract which significantly raises employee premium equivalents for such a large portion of the unit would be easily ratified. But even if UUP were to agree to this change, the State is hesitant because they don't believe that other unions will follow suit, thereby creating a different administrative structure only for UUP. We have attempted to find creative ways to solve this problem, but over many rounds of bargaining we have thus far found no way to reach agreement with the State on this proposal.

While there are additional details that have been part of our bargaining—health benefits is an extremely complex area—and there are some important items on which we we have thus far been unable to reach agreement, the detailed overview above should give UUP members a relatively complete sense of what they can expect to see in the final Agreement on health benefits.

Moreover, I know that most of you are eagerly awaiting updates on other priority issues, most notably compensation, job security, telecommuting, and leaves. We have yet to receive a formal compensation proposal from the State, nor have they responded to our detailed job security proposals. We anticipate that we will begin to get those details starting with our bargaining sessions on January 26 and 27. Expect a new negotiations bulletin shortly thereafter with more details. We also anticipate that we may get more details on many of our other priority proposals in the weeks ahead, and we will post updates promptly as we have additional information.