



UCLA
Faculty Association
Newsletter

An Independent Membership Organization of Faculty at the University of California, Los Angeles
 P.O. Box 33336 Granada Hills, CA 91394-3336 Phone and FAX 818 341-8664 ucfa@msn.com
 For more information, see the FA at UCLA Website at <http://www.uclafaculty.org>

Nonprofit
 US Postage Paid
 Granada Hills, CA
 PERMIT No. 138




HEALTHCARE RATIONING AT UC?

NEW HOOPS & LONGER QUEUES

The FA at UCLA sponsored a town hall meeting on UC healthcare on Feb. 15, 2002. About 75 faculty came to hear the Directors of the UCLA Medical Group, Michael Karpf and J. Thomas Rosenthal, speak and answer questions about current developments with UC Care and other UC health plans. This session was so successful in offering a forum for the exchange of ideas about healthcare at UCLA that the speakers have offered to come again, on Friday, May 17, noon, Math Dept. Lounge, 6th fl, 6620, and continue the discussion and answer any more questions. Please join us for this second Town Hall meeting about healthcare at UC.

Although individual cases and topics varied widely on Feb. 15, one theme emerged: the apparent need for more rationing of medical care at UC. There are two major forms of healthcare rationing: price and queues. The British system features queues, the American price and queues. Faculty heard that tier 1 at UC Care did not do such a good job of rationing: Primary Care Providers (PCPs) helped eliminate waste and therefore reduced medical costs, but they found it hard to be effective gatekeepers. Patients either got the referrals from their PCP within tier 1 or they accessed tier 2. End result? The number of doctor visits did not change much over the last 5 years or so of Managed Care at UC. Employees learned to slip through the HMO hoops and queue up for physicians in tier 2, checkbook in hand. Some even learned to master the medical billing mazes and mistakes of network and non-network. Others remain frustrated and confused every time they make an appointment or pay a medical bill. The University will likely accept a bid for UC Care in 2003 with lower coverage, higher premiums, new hoops, longer queues and with more effective rationing techniques. The UCLA provider groups will be forced to optimize their resources even further to live within their UC Care contract. As Directors Karpf and Rosenthal put it, no one is happy.

The medical landscape is now shifting once again: the costs of medical care are going up despite Managed Care. Advertisements for prescription medications every night on primetime TV are driving up prices and demand. High technology escalates the cost of hospital care, and an aging population increases demand. At UC, rising medical costs plus the construction of two new hospitals at UCLA fuel the drive for more

Continued, page 2 

FA at UCLA UPDATE

2nd TOWN HALL MEETING
on HEALTHCARE with
 UCLA Healthcare Dirs. Michael Karpf and J. Thomas Rosenthal,
 Fri. May 17, MSB 6620, noon
 Please RSVP at ucfa@msn.com
Come and ask Questions!
 Refreshments

STOP COLA DELAY, p. 7

ARE YOU AN FA MEMBER?
 Do you see "Member" on your mailing label? If not, then this FA newsletter is being mailed to you courtesy of your colleagues. Please join them and support us all. An application is on p. 8.

FA at UCLA EXECUTIVE BOARD OPENINGS: Please let us know if you would like to serve in 02-03 (ucfa@msn.com)

FA FAQs:

MEDICAL SAVINGS ACCOUNTS AT UC

What are MSAs?

Medical Savings Accounts combine familiar elements—deductibles, coinsurance, out-of-pocket max, tax deductible savings—in an unfamiliar way and add a brand new element: full payment for the full cost of medical care under the deductible limit. MSAs reward careful selection of medical care with year-end savings balances and place an upper limit on the total cost for those who need extended care.

Continued, page 3



Hoops and Queues at UC Contd. from page 1

effective rationing. According to Karpf and Rosenthal, part of optimizing UCLA resources consists of moving routine care to Santa Monica and making the path to the UCLA Med Center an extremely arduous one for anyone except the very sick who need high-tech, high-acuity healthcare. Even a PCP still on campus will likely make referrals to “subspecialists” at UCLA-SM who will assess patients’ medical needs and refer only extremely serious and complex cases back to WW, like organ transplants or brain tumors, and treat other, more routine care at SM.


The steep increase in UC Care premiums in 2002 will probably be repeated in 2003 along with higher copays (the amount you pay at the time of the visit) and maybe even higher coinsurance (the percentage of the eligible medical bill that you pay at tier 3). CalPERS, the 2nd largest health insurance provider in the nation and the largest in CA will raise premiums 25% and some out-of-pocket expenses up to 50% and drop PacifiCare and HealthNet as HMO options (*LATimes*4/17/02, C1). The premium increases at UC over the last 8 years plus an ominous future are strong indicators that the current UC Care plan is in a death spiral, much like its predecessor Prudential High Option. The speakers at the Town Hall meeting made several references to a future at UC without UC Care and to high deductible medical plans where users need to cover all payments out-of-pocket within the high deductible limit before they can access medical insurance.

This new concept is called Defined Contribution medical care and is based on tax-free 401k retirement accounts in which employers contribute a defined amount to the employee’s 401k, and employees can also contribute up to a max amount tax free. In healthcare, the theory is that the premiums for high deductible insurance plans are significantly lower than for standard, low deductible plans like UC Care. Employers could take the savings from purchasing a high deductible plan for employees and make a deposit in an employee’s medical savings account that could be used to pay for routine medical expenses. If the employee is prudent in the care s/he seeks, there will be a surplus in the account at the end of the year, which can grow tax-free and be used in later years for medical expenses or ultimately for those over 65 for retirement. If s/he needs more care, catastrophic insurance kicks in.

MSAs not only shift some of the healthcare risk from the employer to the employee, they also shift bureaucratic or third-party rationing of healthcare to self-rationing. The incentive not to waste and not to seek only marginally beneficial medical services is rewarded by MSA balances. But in return for self-rationing, employees must take responsibility for paying the full cost of routine medical, dental, vision, and prescription costs out of these accounts up to the deductible limit. Most of us have no idea what healthcare actually costs; we are used to writing checks for copays of \$10 or \$20 for an office visit. Beyond that is a blank—some kind of seemingly endless shell game with each party passing on the cost or part of it to another party. The current medical insurance system disassociates consumer demand for care from cost of care. Only the uninsured know what a typical office visit or lab test costs.

Those in favor of MSAs believe that reconnecting demand and cost during the deductible phase will result in more effective rationing of medical care than hoops and queues and allow more people to maintain their health insurance when they are unemployed, because they own MSA balances and can therefore afford to purchase their own high deductible plans. Others fear that MSAs favor the young, affluent and healthy at the expense of the poor, old, and infirm. Another concern is the bridge amount between the deductible and 100% coverage. Once out on that Out-of-Pocket (OoP) bridge there would be no way back to a PCP in an all-inclusive HMO. Still others worry that the incentive to save may outweigh good judgment in seeking needed medical care, which could lead to even higher medical costs. A few may simply find consumer-driven health plans too complex in design to manage.

The advantages and disadvantages of MSAs are currently being debated in the Senate and House of Reps. HR 3103 now allows only small employers (under 50 employees) and the self-employed to purchase MSAs and only until Dec. 31, 2002. Legislation now in committee would allow wider use of MSAs. Medical insurers are impatient to test the market and several are beginning to offer Defined Contribution hybrids without tax savings or with more limited tax advantages. Aetna has come out with “HealthFund” designed for mid-sized, self-insured employers that blends a high deductible, preferred provider health plan and the payment methods of a health savings account that can be rolled over at the end of the year with any remaining funds going toward covered services in future years. Once the deductible is met, “HealthFund” would pay 10%/90% for PPOs and 30%/70% for nonPPOs up to the OoP max. Aetna includes access to the Navigator, a comprehensive online resource to manage health and track expenditures. As a first step toward defined contrib. health care, UC plans to offer Flexible Savings Accounts (FSAs) in 2003, which can be used to pay healthcare costs, including copays but not premiums. (For more on FSAs, see p. 6.)

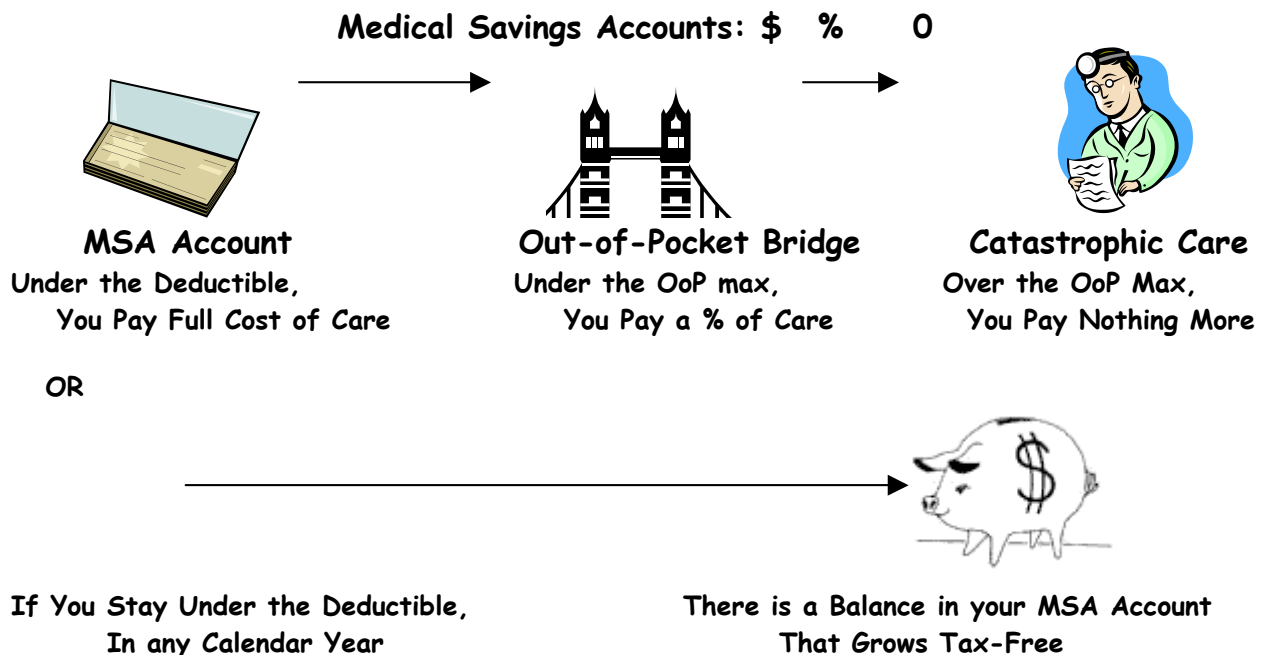
UC faculty should not be surprised to see UC Care spiral up in costs and out of the affordable range very soon. State funds cover a 6.7% increase in UC’s costs of providing healthcare, not the 10% requested to keep premiums low. The FA at UCLA will continue to lobby the Legislature and UC to prevent the effective lowering of faculty compensation UC is proposing by shifting more medical costs to employees. Raising the cost of healthcare has especially serious implications in years in which there are also no COLA and PARITY increases. 



MSAs, Continued from page 1

MSAs are tax deductible savings accounts combined with a high deductible health insurance plan. Employers can customize MSAs for their employees by coming to an agreement with medical insurers on the amount of the deductible, the out-of-pocket (OoP) limit, and the level of coinsurance (like 20%/80%). These figures must fall within government-set parameters for qualified MSA plans. In 2002 for an individual, the minimum deductible is \$1,650 and the maximum \$2,500; for a family, \$3,300 and \$4,950 respectively. The maximum OoP limit for an individual is \$3,300 and \$6,050 for a family. There are also limits on the amount that individuals or employers on behalf of employees can contribute to an MSA tax-free. Current legislation allows a tax-deductible contribution of 65% of the deductible for an individual and 75% for a family.

Once MSA accounts are established, people use the accumulated funds to pay the full cost for routine medical care like physician visits, dental, vision, and prescription costs that fall within the calendar year deductible limit. After reaching the deductible, they pay coinsurance (for example 20%/80% or 40%/60%) out of pocket until the OoP limit is reached, and finally the catastrophic insurance would cover anything over the OoP limit at 100% for long hospital stays, accidents, or major illnesses. Any year-end surplus in the MSA could be saved and used for future medical expenses. And MSA balances would grow tax-free.



Contributions for MSAs:

Who pays the high deductible premiums and who contributes to the MSA?

At present, it is usual for the employer to pay the entire premium for high deductible insurance and make a contribution toward the MSA deductible limit. Federal restrictions do not allow both the employer and the employee to make contributions to the MSA in the same calendar year; therefore, the usual practice is for the employer to make a taxable contribution to the gross compensation of the employee, and then the employee makes either monthly or yearly contributions to the MSA and takes those amounts, including any employer contribution, as a tax deduction on his/her W-2 form.

The current limits on the amount that can be put into a tax free MSA are set by the federal government: 65% of the deductible for an individual and 75% for families. Current legislation is urging a 100% of the deductible contribution for both individuals and families. The higher the deductible, the higher is the level of benefits to the employee. On the one hand, poorer employees, many of the self-employed who qualify for MSAs and the unemployed, desire the lowest deductible catastrophic plan available in order to make the MSA combination of high deductible insurance and MSA savings account less expensive. On the other hand, higher paid employees desire the

highest deductible health plans because it means that both employer and employee can contribute more money into the tax-free MSA accounts. Some tax savvy individuals actually use other accounts to pay for routine medical care and save as much as they can in the tax-advantaged MSAs for retirement.

Experience with MSAs since 1996 when HR 3103 allowed a 4-year testing period has shown that all groups of people, employed and unemployed, sick and healthy, young and old can benefit from MSAs. Regardless of these variables, including whether the enrollees were single or had families, people who signed up for MSAs appear to have exercised more judgment in the routine care they sought because they paid the entire medical bill and avoided unnecessary or only marginally beneficial care and saved the amount of that care in their MSA accounts against future medical care, premium payment for long-term care insurance, or retirement. Test cases of those people in MSAs have shown that most do not reach the deductible and even fewer reach the out-of-pocket maximum and most have a positive year-end balance in their accounts. In a study of MSA accounts between 1997 and 2000 at the Cato Institute in Washington DC, a small employer with fewer than 50 employees, over 85% of the employees opted for the MSA plan. On average, an employee saved \$1,143 in his/her MSA and families saved \$1,181 each year (www.cato.org/pubs/pas/pa411.pdf, Aug. 8, 2001, page 26).

UC Employer Contributions:

Would UC be lowering its level of health benefits for those who choose MSAs?

That would depend on several variables:

- **Size of the deductible:** the higher the deductible, the more generous the benefit level because the amount in the MSA savings portion is higher.
- **Out of pocket (OoP) maximum:** the lower the level of the OoP, the more generous the benefit level. Put another way, the longer the distance from the high deductible maximum to the OoP limit, sometimes called the OoP bridge, the more the individual has to pay in order to reach the 100% level of insurance.
- **Choices among providers:** most employers will offer some kind of preferred provider plan PPO-nonPPO as part of the high deductible insurance in order to control costs during both the deductible phase of medical care (what counts toward the deductible) and the OoP bridge (what counts toward the OoP limit).

It is important to remember that not all medical care is eligible for insurance reimbursement whether under an MSA or any plan; each person must inquire about what is or what is not covered and if covered, the rate of coverage. For PPO use, the key term is “eligible expense” and for non PPO access it is “usual, customary, and reasonable” (UCR) rates for medical services in a particular geographical area (currently Aetna would tell you the UCR for a given medical service in the Los Angeles area). During the high deductible phase of the MSA, the patient is responsible for 100% of all medical costs but only eligible costs will count toward the deductible. Eligible in this sense means both eligible for a tax deduction from a government qualified MSA and eligible according to medical insurance guidelines. While on the OoP bridge to the out of pocket limit, visiting a PPO provider might result in cost sharing of eligible expenses at 20%/80% ratio and cost sharing of UCR expenses for a non PPO provider at 40%/60% ratio.

MSAs may help people understand the true cost of medical care, but there is still a medical insurance system infrastructure that sets the rules of use. MSAs are not a return to fee-for-service type medical care where individuals can visit any physician they wish and pay the bill out of the MSA account. People must still understand that only certain services are covered and the rate of coverage depends on whether those services rendered by a physician or medical service are within the network of the medical insurer or outside. With this fundamental level of understanding, individuals can use MSAs to pay for the medical care they need when they need it with the physician they want without the frustrations of access and billing that go with the territory of managed care plans. MSAs also reduce the cost of purchasing qualified long-term care insurance because it qualifies as a tax-free medical expense.

Employee and Employer Cost Sharing:

What would an MSA cost?

At UC, employers and employees now share the cost of the premiums for UC Care. In 2002, individuals pay \$489 per year in premiums and the employer pays \$2,501 to equal \$2,990 total. Families pay \$1,320 and UC pays \$6,762 to equal \$8,082 total. If we stepped back about ten years to 1993, the University contribution to UC Care was about

the same: \$2,496 for individuals and \$6,060 for families. There were no premiums for the employee in 1993 (see www.uclafaculty.org/Newsletters/UCCare10yr.htm) for a chart of UC Care expenses over a ten year period).

One guideline for MSAs at UC (high deductible premiums plus contributions to MSA accounts) in 2003 or 2004, depending on enabling federal legislation, might be a combined high deductible insurance premium and employer contribution to the MSA plan of not less than \$2,500 for individuals and \$6,000 for families in addition to maintaining the current level of employer coverage for vision and dental insurance. Then experience with MSA accounts could lead to further savings as it did for the Cato Institute over the period between 1998-2000. Cato's health care costs per employee stabilized, and MSA experience allowed Cato to purchase higher levels of high deductible insurance at lower premiums. (See www.cato.org/pubs/pas/pa411.pdf, Aug. 8, 2001, for a useful study on how MSAs save money for both individuals and employers).

Best Case and Worst Case Scenarios:

How can I compare the costs of an MSA with a standard insurance plan?

The table below compares the costs of a standard, low deductible family health plan of \$250/\$750 and out of pocket maximum of \$3,750 and an MSA with a deductible of \$4,950 and out of pocket maximum of \$6,050 under a worst case scenario—with claims up to the out of pocket limit-- and under a best case scenario—with no claims at all. The average family would fall somewhere between these extremes.

Family Coverage	Worst Case Scenario		Family Coverage	Best Case Scenario	
	Standard Trad., plan	High Ded MSA plan		Standard Trad., plan	High Ded MSA plan
Deductible/pers	\$250	\$4,950	Deductible/pers	\$250	\$4,950
Out of pocket max	\$3,750	\$6,050	Out of pocket max	\$3,750	\$6,050
Annual Premium (est)	\$6,000	\$3,900	Annual Premium (est)	\$6,000	\$3,900
MSA Acct (75%ded)		\$3,713	MSA Acct (75% ded)		\$3,713
Cost of Coverage	\$6,000	\$7,613	Cost of Coverage	\$6,000	\$7,613
Max Claims			No Claims		
Deductibles/ fam	\$750	\$4,950	Deductibles/fam	\$0	\$0
Co-insurance*	\$3,000	\$1,100	Co-insurance*	\$0	\$0
Total expenses	\$3,750	\$6,050	Total expenses	\$0	\$0
Less MSA		\$3,713	Less MSA	\$0	\$0
Cost of Claims	\$3,750	\$2,337	Cost of Claims	\$0	\$0
Cost of Coverage	\$6,000	\$7,613	Cost of Coverage	\$6,000	\$7,613
Total costs	\$9,750	\$9,950	Total costs	\$6,000	\$7,613
Less Tax Savings**		\$1,014	Less Tax Savings**		\$1,014
Net Costs	\$9,750	\$8,937	Net Costs	\$6,000	\$6,600
			Less MSA assets		\$3,713
			Actual costs	\$6,000	\$2,886
Savings w/MSA***		\$814	Savings w/MSA****		\$3,114

(See <http://www.lipman.com/insurance/msafamily.htm>)

*difference between OoP and the deductible

** 30% of MSA contribution

***difference between net costs

**** difference between actual costs

Disbursements

How would someone pay a bill using an MSA?

The patient might use a special MSA credit card or special checking account set up by a bank or insurance company. Money from this account could only be spent on medical care, long-term care insurance, prescriptions, vision, and dental expenses allowed by the IRS as medical deductions. MSA money used for non-medical expenses would be taxable and carry a 15% penalty. Surpluses in MSA accounts would be rolled over to the next year for use

in paying medical expenses or for retirement expenses in the future when one is over 65. MSA administrators would offer different investment options for the higher balances in MSA accounts (e.g. in excess of \$3,500 might be transferred to MSA brokerage sub-accounts for higher interest earnings). There would be administrative fees for a bank or insurance company to set up and monitor MSAs.

Advantages of MSAs:

Why is there so much interest in MSAs?

MSAs may be an effective way to manage escalating medical costs in the future. Healthcare costs are rising faster than inflation and faster than the GDP (healthcare costs were up 7.2% in 2000, while the GDP as a whole was up 5.6% and in 2001 healthcare costs were up 7.7% with the GDP at 3.7% (Percent change is annual change per capita; see the Feb. 2002 UCFWC document "Health Care Costs: Trends and Relationship to Insurance Premiums," by Kirk and Ettner at www.ucop.edu/senate/hccosts.pdf). There's also a new wave of discontent or backlash in Managed Care plans. Many in HMOs are resisting the restrictions on access to care and members choosing between network and non-network providers are frustrated at the attempts of third parties (employers, insurance companies) to set up more and more roadblocks to care and charge higher and higher copayments and premiums for less care.

Administrative costs (including medical billing) are taking up a larger percentage of the healthcare dollar especially for minor, routine visits. Some estimate administrative costs as much as 50% of the healthcare dollar. According to the government's Bureau of Labor Statistics, in 1999, the average person spent nearly \$2,000 on healthcare coverage, with 48% going to health insurers, 29% to medical services, and 24% to drugs and medical supplies. In 2000 healthcare costs jumped by 5.5% (www.bls.gov/news.release/cesan.nr0.htm and the BLS Annual Consumer Expend. Survey for 1999, Table No. 163).

Theoretically MSAs are a way for patients to regain control by paying bills directly to the doctor at the time of service. Doctors can charge patients the true cost for routine office visits and lab tests without having to add on the cost of insurance intermediaries and inevitable billing confusion and collection. They can also make known the costs of visits to their patients and even offer a discount for full payment at the time of service thus avoiding the nightmare of medical billing. Physicians have powerful incentives to lower the cost of working through third party payers in favor of direct payments from patients. Many feel that they would have more time to spend with patients and could recommend appropriate tests or further medical care that now require authorization or insurance approval under Managed Care.

Disadvantages of MSAs:

Who is against MSAs?

There is concern that MSAs are an alternative to single payer health care, and those in favor of nationalized healthcare oppose MSAs. However, some medical economists believe that the high deductible portion of the MSA plan will eventually be funded by the govt as part of a universal, basic health plan, with individual and employer plans accounting for the savings portion and perhaps the bridge coverage between the high deductible limit and the OoP maximum. MSAs generally return control of medical care to patients and doctors and take some control and income away from third parties (like employers and insurance companies).

MSAs encourage participants to control their demand for care knowing that they will pay the bill; managed care health plans control the supply of care so that patients have to overcome the barriers if they want care (for a full discussion of MSA theory and practice based on claims experience of several companies between 1996 and 2001, see the Cato Institute Health Policy Analysis of MSAs (www.cato.org/pubs/pas/pa411.pdf, Aug. 8, 2001). Squeezing supply and demand can result in savings, but many medical economists argue that MSAs put that savings in the pockets of patients and physicians and out of the pockets of third parties.

Eligibility:

Could UC offer MSAs to its employees?

Not at present because UC has over 50 employees, and tax-qualified MSAs are currently available only to small employers with fewer than 50 employees and the self employed. However, there is considerable legislative pressure right now to relax the federal restrictions on MSAs to enable any taxpayer—employed or not in any sized firm-- to choose one. UC will offer FSAs during Open Enrollment 2002.

Flexible Spending Accounts (FSAs) may sound like MSAs, but in fact they are quite different. FSAs are extremely valuable to the person or families who can estimate carefully the costs of medical care (co-insurance, copayments, premiums, even child care), put that amount into an FSA, and take a tax deduction at the end of the year. The medical care dollar in this scenario is stretched by the income tax bracket of the saver. The catch with FSAs is the forfeiture rule or "use it or lose it": under IRC (internal revenue code) regulations these funds cannot roll over from year to year and will be forfeited to the employer. Until that restriction is removed, FSAs have limited appeal to all but those who can carefully estimate their eligible costs. MSAs are more like medical IRAs; FSAs like annual calculated investment risks.



FA at UCLA SEEKS AN END TO THE COLA DELAY
CPEC calculates a 7.7% increase for UC faculty to achieve parity with Comp 8

With state budget deficits now estimated at \$20B, no one is optimistic that UC faculty salaries will increase in 2002-03. Merits will likely be covered but not COLAs or faculty PARITY increases. Last year UC faculty received a 0.5% COLA, whereas nationwide, faculty salaries increased 3.8% on average, a rise of 2.2% after adjusting for inflation in consumer prices (AAUP's *Academe*, March-April 2002). With no salary increases projected for next year, UC faculty will fall even further behind the Comparison 8 Universities (Harvard, Stanford, Yale, MIT and U.VA, U.Mich., NYSU at Buffalo, U.Ill at Champagne-Urbana). CPEC (California Post Secondary Education Commission) calculated that UC would need a 7.7% salary increase in 2002-03 to achieve Parity. May state budget revisions may lead to more budget cuts, but the only positive side of the current financial crisis is the opportunity to remove the COLA delay and restore the PARITY and COLA to July 1 in 2003. The FA at UCLA has sent the following letter to Chancellor Carnesale with copies to Senate leaders, systemwide committees, and the Regents.

April 19, 2002

Dear Chancellor Carnesale,

Last spring several members of the Faculty Association at UCLA met with you to discuss the effect of the COLA delay on faculty salaries. We would like to follow up on that meeting. The state budget crisis offers an opportunity for the University to right this wrong: with no salary increases in sight for 2002-3, it is a good time to move the full value of the COLA and faculty PARITY increases back to July 1 for the coming academic year.

The COLA and PARITY delay result in lower salaries for faculty. Although it might seem that faculty receive the same total amount in the end regardless of when each year the COLA and PARITY begin, the Faculty Association's calculations indicate this is not correct. A comparison of salary figures between 1994 and 2001 with and without the delay for a faculty member who earned \$100,000 in 1994 shows the delay causes an average loss of about \$1,000 in salary each year (see www.uclafaculty.org/News-letters/Feb2001.htm).

In addition to loss of regular income, delaying the COLA and PARITY adjustments to October 1 results in lower summer grants because many of these grants are based on July 1 salary levels. It also divides budget requests into two time-frames, an Oct.-June budget allotment for the new year and then a July-Oct. continuation cost from the past year; and it interferes with calculating optimal retirement dates.

The Faculty Association at UCLA respectfully asks that you support us in this matter by urging President Atkinson to discontinue a one-time emergency measure in a year when merit increases were themselves in danger but which since then has become a regular practice. We ask that UC resume paying full salary, including COLA and faculty PARITY, on the first day of the new academic year, July 1, as was the practice prior to 1994, and not on October 1. Thank you very much.

Sincerely,

Karen Orren,
Chair, Faculty Association at UCLA

Cc
The Regents
President Atkinson
John Edmond, UCLA Senate Chair
UCLA Faculty Welfare Committee
UC Faculty Welfare Committee

FA at UCLA Executive Board
Joyce Appleby, history
Stephen Cederbaum, psychia
Susan Downey, art history
Sheila Greibach, computer sci
Gordon Kipling, English
Thomas Liggett, math

John Merriam, biology
Amos Norman, emeritus rep.
Richard Olsen, medl pharma
Karen Orren, poli sci
Carole Pateman, poli sci
Dwight Read, anthro

Olga Yokoyama, Slavic Lit. & Lang.