April 22, 2011

COMMISSION ON THE STATUS OF WOMEN:

PRELIMINARY RESPONSE TO THE PRELIMINARY REPORT

OF THE TASK FORCE ON FRINGE BENEFITS

Preliminary Report of the Task Force on Fringe Benefits

Because fringe expenditures are an important component of the climate for women at any university, the Commission on the Status of Women devoted a number of meetings this year to getting up to speed on issues that might affect women. In particular, we met with Jessica Kandel, chair of the Fringe Task Force Retirement Committee (and a member of CSW), on October 13, 2010; Sharyn O'Halloran, chair of the Fringe Task Force Medical Committee, on November 10th, 2010; and Elizabeth Scott, chair of the Fringe Force Tuition Committee, on February 2, 2011. We're extremely grateful to these super-busy people for meeting with us. Like all members of the Columbia community, we are also grateful to all the members of the Task Force for giving their time and expertise to this important issue. Finally, the CSW met on April 13, 2011 to discuss the Preliminary Report of the Task Force. This preliminary response to the report conveys the substance of that discussion.

At this stage we have six reactions.

1. As will surprise no one, we were truly delighted that, even in these hard times, a benefit was added that we believe to be crucial to the climate for women: a preschool benefit.
2. We also enthusiastically applaud the establishment of a permanent committee to monitor fringe allocations and expenditures going forward.

We have three somewhat different types of suggestions about the Medical benefit. Although only two of these directly address proposed changes, we feel that the third should also be discussed while benefit issues are on the table.

3. The first issue concerns progressivity. Although no real figures could be given at this time, the general principle of progressivity in monthly costs is reaffirmed for future years. We trust that the progressivity will be in some way proportional to the rate of increase of the costs (which apparently will be substantial). Since it seems reasonable to believe that the POS100 plan will either be extremely expensive or enter a death spiral and disappear (or both in that order), we are concerned about the yearly maxima for out-of-pocket expenses for the POS90 plan. If it is necessary to raise those substantially as well, beyond the current $1K per person/$2K per family, we believe it is important to introduce a further progressivity here. We hope, for example, that out-of-pocket expenses aren't so high that a junior staff member doesn't have to consider whether she can medically afford to have a child. The principle for this change is identical to the principle that stands behind progressive monthly fees.

4. The second issue concerns what we assume will be a continuing feature of the Medical insurance plans. It is something that needs to be fixed. Our current infertility treatment has a $5K maximum per annum, with a $15K lifetime cap. As the accompanying graph indicates, this does not appear to be a sensible strategy. Success rates climb quite dramatically through 4 cycles, where they begin to level off. Assuming these data are correct, we recommend that all Columbia health plans adopt a $20K lifetime benefit, with the individual deciding how best to allocate that over the years. That would bring us into line with our peers (see accompanying chart[1]). Although it hardly needs saying, we note anyway that it is difficult to think of an issue that is more central to a person's life experience than the decision of whether or not to become a parent.
5. Our third recommendation may seem to concern only rhetoric, but we believe that the rationale for some changes shows muddled thinking. In particular we object to the following two claims (p. 28): "With a high deductible ...individuals tend to be more judicious in their use of medical services. When medical treatment costs the individual relatively little, people tend to consume more services without questioning their cost and value." These statements are probably true, but they need to be balanced with other obviously true claims, such as, "When medical costs are high, people tend to forego needed tests and treatments." When only one side of the cost/benefit equation is noted, it is too easy to see the virtues of raising costs while the vices are left in the shadows.

Our final reaction concerns an issue that the report mainly postpones: the future of the Columbia School.

6. The proposal (p. 15) is to continue charging the fringe for tuition scholarships given to officers' children who attend the school and to push the school's deficits onto the various schools. This has always been an odd benefit, because it is not one that all eligible administrators and faculty who pay into the fringe pool can benefit from—even when they have an eligible child. Although we have not seen figures, we harbor a strong suspicion that this benefit is largely skewed to male faculty. After all, the rationale for the school was recruitment and most Columbia recruitments involve men. We would urge that the committee that looks into this benefit examine whether it can pass muster in terms of gender equity and equity more generally. We also encourage the committee to consider a cost/benefit comparison of the fringe being committed to pre-school child-care with the cost of The School at Columbia.

Thanks for considering our recommendations.

Cordially,

Patricia Kitcher

Maya Tolstoy, Co-chairs of the CSW

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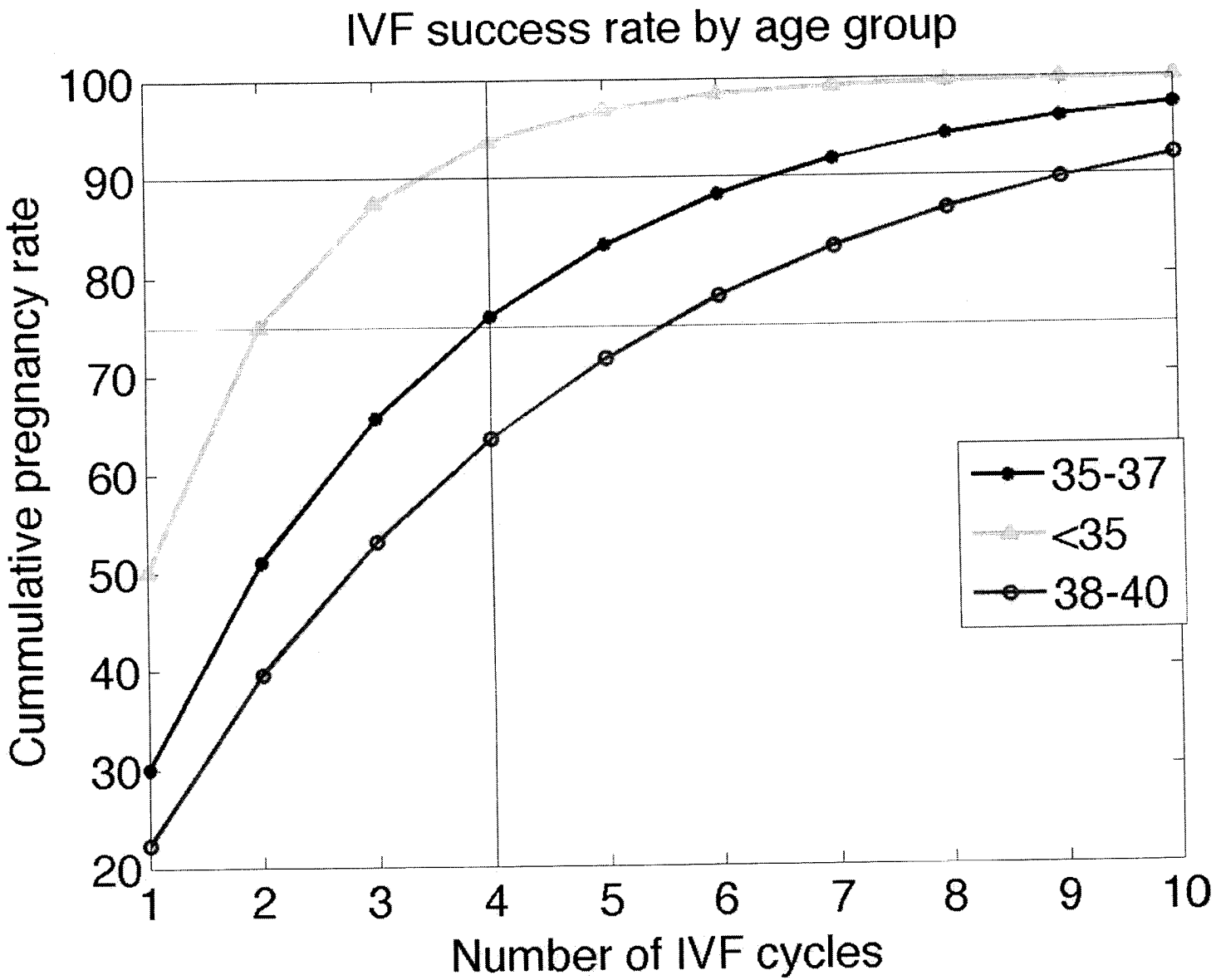
[1] Thanks to Kuheli Dutt for supplying both the graph and the chart.

Assisted Reproduction Technologies – Coverage by medical benefits at universities

University	Limits on Procedures	Limits on Medications
Columbia	5,000 dollars per year	15,000 dollars lifetime
Princeton	20,000 dollars lifetime	20,000 dollar lifetime
Cornell	20,000 dollars lifetime	Not specified
Yale	20,000 dollars lifetime up to 4 cycles lifetime	100% of meds for 4 cycles
MIT	Covered by MA state law	
Harvard	Covered by MA state law	
Brown	Covered by RI state law	
Rutgers	Covered by state law – up to 4 cycles	


IVF success rate by age group
Cummulative pregnancy rate
100
90
80
70
60
50
40
30
20
1
2
3
4
5
6
7
8
9
10
Number of IVF cycles
35-37
<35
38-40

COLUMBIA UNIVERSITY CENTER FOR WOMEN'S REPRODUCTIVE CARE
NEW YORK, NEW YORK

A comparison of clinic success rates may not be meaningful because patient medical characteristics and treatment approaches vary from clinic to clinic. For more details about this, along with information on how to interpret the statistics in this table, see pages 81–90.

2007 ART CYCLE PROFILE

Type of ART[a]

IVF	>99%
GIFT	0%
ZIFT	<1%
Combination	0%

Procedural Factors:	
With ICSI	63%
Unstimulated	0%
Used gestational carrier	0%
Used PGD	<1%

Patient Diagnosis

Tubal factor	4%	Other factor	4%
Ovulatory dysfunction	4%	Unknown factor	7%
Diminished ovarian reserve	39%	*Multiple Factors:*	
Endometriosis	2%	Female factors only	3%
Uterine factor	1%	Female & male factors	16%
Male factor	22%		

2007 PREGNANCY SUCCESS RATES

Data verified by Michael M. Guarnaccia, MD

Type of Cycle

	Age of Woman				
	<35	**35–37**	**38–40**	**41–42**	**43–44[d]**
Fresh Embryos from Nondonor Eggs					
Number of cycles	323	240	346	187	134
Percentage of cycles resulting in pregnancies[b]	51.1	37.5	29.8	24.1	11.9
Percentage of cycles resulting in live births[b,c]	45.2	29.2	22.3	14.4	5.2
(Confidence Interval)	(39.7–50.8)	(23.5–35.4)	(18.0–27.0)	(9.7–20.3)	(2.1–10.5)
Percentage of retrievals resulting in live births[b,c]	50.0	32.6	26.7	19.0	7.4
Percentage of transfers resulting in live births[b,c]	52.3	36.3	30.8	22.3	9.7
Percentage of transfers resulting in singleton live births[b]	31.9	23.3	24.0	21.5	6.9
Percentage of cancellations[b]	9.6	10.4	16.8	24.1	29.1
Average number of embryos transferred	2.3	2.6	3.2	3.5	3.5
Percentage of pregnancies with twins[b]	36.4	28.9	18.4	4.4	2 / 16
Percentage of pregnancies with triplets or more[b]	4.8	5.6	5.8	2.2	0 / 16
Percentage of live births having multiple infants[b,c]	39.0	35.7	22.1	3.7	2 / 7
Frozen Embryos from Nondonor Eggs					
Number of transfers	59	29	28	9	3
Percentage of transfers resulting in live births[b,c]	50.8	34.5	32.1	1 / 9	0 / 3
Average number of embryos transferred	2.6	2.5	2.6	2.4	3.3

	All Ages Combined[e]	
Donor Eggs	**Fresh Embryos**	**Frozen Embryos**
Number of transfers	112	34
Percentage of transfers resulting in live births[b,c]	53.6	29.4
Average number of embryos transferred	2.2	2.0

CURRENT CLINIC SERVICES AND PROFILE

Current Name: Columbia University Center for Women's Reproductive Care

Donor egg?	Yes	Gestational carriers?	Yes	SART member?	Yes
Donor embryo?	Yes	Cryopreservation?	Yes	Verified lab accreditation?	Yes
Single women?	Yes			*(See Appendix C for details.)*	

[a] Reflects patient and treatment characteristics of ART cycles performed in 2007 using fresh nondonor eggs or embryos.
[b] When fewer than 20 cycles are reported in an age category, rates are shown as a fraction and confidence intervals are not given. Calculating percentages from fractions may be misleading and is not encouraged.
[c] A multiple-infant birth is counted as one live birth.
[d] Clinic-specific outcome rates for women older than 44 undergoing ART cycles using fresh or frozen embryos with nondonor eggs are not included because of small numbers. Readers are urged to review national outcomes for these age groups (see page 29).
[e] All ages (including ages >44) are reported together because previous data show that patient age does not materially affect success with donor eggs.