How Can This Continue?

Negotiating health insurance changes

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Health insurance has become the most prevalent issue discussed at the bargaining table today. Recent premium increases for school districts with July renewal dates have focused even more attention on this issue.

Many administrators and board members ask: How can this continue? How do we communicate to our employees, our taxpayers and other interested constituents the effect that our health insurance costs have on our budgets? How do we maintain and, hopefully, expand our educational offerings when our costs for health insurance continue to eat up an ever larger portion of our budget?

There are many factors that have contributed to the high cost of health insurance: utilization of services, demographic trends (such as life expectancy and obesity), healthcare provider consolidation, duplication of services, new products and services, the growing number of uninsured, marketing of prescription drugs, medical malpractice expenses, level of benefits and plan design, among others.

This article will provide insight on how to address items that we can control at the bargaining table: the level of benefits, plan design and consumer behavior. Remember, health insurance is an economic and emotional issue; people don't always make rational decisions when negotiating over this topic.

Why Address the Cost of Health Insurance under a Total Compensation Model?

One of the questions often posed by the union's negotiation committee is the following: If the school board is going to offer us a total compensation settlement why does the board care if we want the money for insurance rather than salary? There are several reasons to address the cost of health insurance. All of these reasons and the data supporting these arguments may be customized based upon your individual school district's situation.

The cost of health insurance benefits in public schools in Wisconsin is dissimilar to those offered in the private sector in Wisconsin and in the public sector nationwide. It is questionable public policy to offer public employees benefits that are dissimilar to those received or accessed by the individuals paying for those public employees.

The information in the table on the top of the next page provides a sample representation of the cost of insurance in the private sector, both nationwide and statewide. The Kaiser Family Foundation and Health Research and Educational Trust 2005 (www.kff.org) conducted a survey of more than 2,000 firms in the United States to assess the amount spent on health insurance based upon plan type and plan design. Charts and tables in this

REPRESENTATIVE 2005 INSURANCE COSTS (PRIVATE SECTOR)										
	Fee for Service		HMO		PPO		POS		ALL Plans	
	SINGLE	FAMILY	SINGLE	FAMILY	SINGLE	FAMILY	SINGLE	FAMILY	SINGLE	FAMILY
Employee contribution	$498	$2,321	$563	$2,604	$603	$2,641	$731	$3,250	$610	$2,713
Employer contribution	$3,284	$7,658	$3,203	$7,852	3,547	$8,449	$3,183	$7,551	$3,413	$8,167
TOTAL PREMIUM	$3,728	$9,979	$3,767	$10,456	$4,150	$11,090	$3,914	$10,801	$4,024	$10,880

SOURCE: Kaiser Family Foundation Health Research and Educational Trust

article break down the information in several ways: varying costs depending on the plan election (single or family), plan type (fee for service, which is also known as indemnity; health maintenance organizations, HMO; preferred provider organization, PPO; or point of service, POS), the cost of the premium paid by the employer, and the cost of the premium paid by the employee.

Similar comprehensive data for Wisconsin are more difficult to obtain. According to the Wisconsin Hospital Association, the average family health insurance premium for calendar year 2005 was $1,054 per month. The average family health insurance premium cost for school districts in calendar year 2005 was $1,230 per month. This means, on average, Wisconsin public school districts' premiums were $2,112 more per year than the average family health insurance premium in the state.

The level of benefits and plan design of public school districts in Wisconsin and private employers in the state is also dissimilar. Few school districts tend to participate in HMOs whereas, according to the State of Wisconsin Office of the Commissioner of Insurance (oci.wi.gov/pub_list.htm), HMOs are the most common form of plan design in Wisconsin as represented in the bar graph to the right.

Generally, when employees have more flexibility to choose providers without any effect on their deductibles, copayments or direct cost sharing — as is often true for non-HMO plans — the premium costs of the plans also increase.

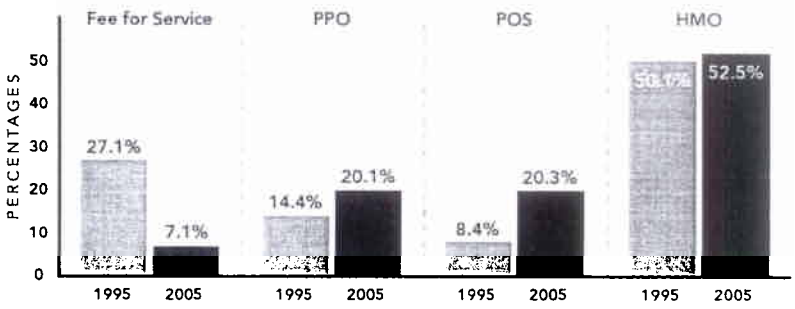
Remember, health insurance is an economic and emotional issue; people don't always make rational decisions when negotiating over this topic.

The cost of benefits has a chilling effect on salary levels and salary increases. All districts presently have a finite amount of money available for employee compensation unless referendum voters approve a taxation proposal that exceeds the revenue limit. The teachers' union's criticism of the level of teacher salaries discounts the value of the benefits received by teachers. When school districts fail to address the benefit side of the compensation equation, the distortion in compensation continues. The truth is that the cost of insurance is depressing all teachers' salaries.

Does Wisconsin spend more on benefits for its school district employees than other states? The answer is yes. Wisconsin ranks fourth highest among the 50 states in staff benefits paid, according to United States Census Bureau data. At the same time, Wisconsin's relative ranking on average teacher salaries among the 50 states has fallen over the last 15 years. According to the American Federation of Teachers, Wisconsin ranked 27th nationally for average teacher salary in 2003-04 and ranked 14th in 1991-92.

The criticism of teacher salaries fails to take into account that,

The trend away from "Fee-for-Service" plans



Overall statewide (public and private sectors combined)

SOURCE: Wisconsin Office of Commissioner of Insurance

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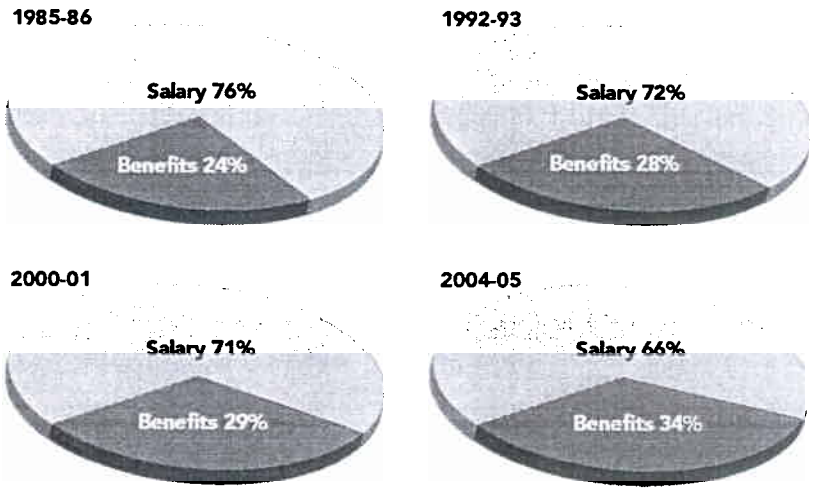
in large measure, the state's problem is not the amount that districts are spending on teacher compensation; rather, the issue is how we are spending that compensation dollar. The pie charts on this page demonstrate the cost of fringe benefits as a percentage of total compensation. These charts can be modified to demonstrate the history in your district. I have found this information to be of great value in making people aware of the connection between benefits and salary levels.

From the charts you can see that in 1985–86 a school district on average spent 76 cents of each compensation dollar on salary and 24 cents on benefits. By 2004–05 a school district on average spent 66 cents of each compensation dollar on salary and 34 cents on benefits.

What would salaries be if the above ratios had been maintained at their 1985-86 level? The average 2004-05 salary would be $7,056 dollars higher (a full 16 percent more) than the actual levels, but the average district's total compensation costs would be the same.

Employees should be made aware of total compensation costs and the impact that benefit costs have on district operations. I recommend that school districts provide to all district employees an annual statement of the employee's total compensation and a delineation of the benefit costs, including items such as pension costs (Wisconsin Retirement System), Social Security, health insurance, dental insurance, long-term disability, life insurance and the

Benefits as a Percentage of Total Compensation



SOURCE: WASB Database

like. For support staff employees you may find it helpful to delineate not only the employee's wage per hour but also the employee's benefit costs per hour and, more specifically, his or her health insurance costs per hour. In many school districts the cost of many support staff employees' benefits per hour is greater than the employee's wage per hour.

Employees should be presented with district budget information that illustrates the cost of benefits has had a negative impact on staffing levels and the types and numbers of employees in varying positions. Districts are creating support staff positions specifically to avoid qualification for insurance, eliminating many positions in their entirety or contracting with outside vendors for services. For example, many districts have found that hiring one teacher will cost less than hiring or maintaining one and one-half full-time teaching assistants due to insurance costs. The cost of health insurance has also resulted in districts looking at assigning employees additional classes or sections, increasing class size and reducing planning time for teachers in lieu of hiring a new teacher.

The increase in health insurance costs is not an isolated or new issue. In the mid 1990s, I created a chart to demonstrate a statewide comparison between the base salaries, the consumer price index and health insurance that has been used by the WASB legislative staff to press for changes at the state level. A condensed version of this chart is below. At the time the chart was first created it predicted that the average statewide base salary for a teacher with a bachelor's degree (BA) would be equal to the average statewide family health insurance premium in 2014-15. Unfortunately, the trend of the chart continues to be eerily accurate. As of 2005-06, it appears that by 2015-16 the average family health insurance premium will exceed the average BA base salary. For individual school districts that time will come even earlier. For the 2006-07 year, Wisconsin will have several school districts with family health insurance premiums over $23,000.

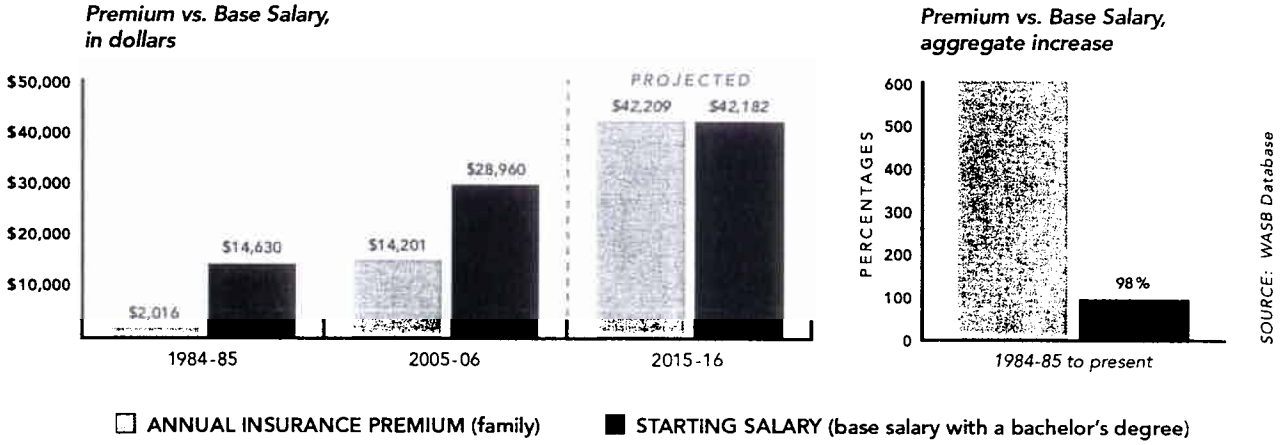
The cost of health insurance has driven up school districts' post-employment benefit costs dramatically. Post-employment costs are not part of the total compensation calculation used for a qualified economic offer (QEO). This has three major implications. First, it constitutes a significant drag on district budgets. Second, it doesn't allow the school district to assess this cost within the parameters of a QEO. Third, it means that money saved on insurance modifications for retirees can be accrued to the district.

Inhibit the Growth in Health Insurance Costs through Collective Bargaining

Education. The first step in inhibiting the growth in health insurance costs through collective bargaining begins with the identification of the problem and educating staff as to its implications, both financially to the employee and to the district. The preceding charts and examples may all be customized to your individual district's circumstances to provide the historical context for the issue in your district.

The discussion of the health-insurance problem can occur within or outside of the realm of the bargaining process. Many districts and unions have found success with a standing insurance committee/task force (please see related article on page 15) that operates outside of the collective bargaining process. This committee should contain representatives from the board, administration and the union(s). The committee may include an insurance consultant. The scope of the authority given to the committee should be clear.

Comparison of Health Insurance Premium vs. Base Salary



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Typically, the committee is given a charge to examine the health insurance issue and bring its findings back to the respective negotiations teams, who may then review the information and bargain over the issue. The committee should review not only health insurance costs, but also examine the potential implementation of a wellness program or heart-risk assessment system (please see related article on page 18). Wellness programs are a mechanism to address the utilization end of the health insurance problem. You may also find that they have a positive impact on your leave usage. The committee may be subject to the open meetings law, so school officials should consult with an attorney to discuss the proper notices for the meetings in advance of the creation of the committee. If you wish to procure an insurance consultant, it is a good idea to have input from the members of committee as to who would be an acceptable consultant. The consultant can serve a valuable role in surveying the staff on providers, plan design and health characteristics. The consultant should be a neutral in the process and be a conduit to other health insurance carriers/health care providers. Many districts have hired the consultant on a group basis to reduce an individual district's costs. You may also want to provide data to the staff that details the costs providers in your area charge for particular services. Information on provider costs by hospital is available at the WHA Information Center, www.whainfocenter.com, and at the Price Point System, www.wipricepoint.org.

Even if you don't create an insurance committee, boards should offer teachers and support staff personnel the opportunity to discuss health insurance cost-control mechanisms in each round of bargaining.

Bargaining. The preliminary step in bargaining health insurance is to determine how your costs compare to other school districts and other employers in your area. In order to make a persuasive argument you should know the lay of the land before you proceed. Health insurance cost data for school districts is available from the WASB and can be customized based upon whichever factors you choose, county, athletic conference, CESA, etc.

The second step is to determine the types of health insurance modifications that you want to propose. All of the health insurance options address the following questions: What types of risk do we want to insure? How, as a collective, are we going to subsidize an individual's utilization of the benefit(s) that we provide?

The WASB Bargaining Goals Committee has recommended numerous items for boards to consider in bargaining health insurance with their employees. The bargaining goals are available at www.wasb.org. Options to consider including in your proposal may be, but are not limited to, the following:

1. *Employer Contribution:* Limit the board's contribution to a fixed dollar amount and/or increase the percentage contributed by the employee.
2. *Deductibles:* Increase up-front deductibles. Presently, the most common deductible is $100/$200, a deductible level that for most districts has not changed in 20 years. An up-front deductible of $1,000 or more changes consumer behavior. However, be careful in your plan design. Contact your insurance carrier/consultant about customizing the deductible to remove preventive care, such as immunizations and routine physicals, from the deductible's application or institute a health reimbursement account. Otherwise you may be discouraging preventive care that, in the long-run, will reduce claims costs.
3. *Three-tiered drug card copayment:* Implement a three-tiered drug card with a percentage based copayment for second- and third-tiered benefits. Copayments that are not percentage based do not have the same effect on consumer behavior. For example, if the copayment was $5 the employee pays $5 regardless of the price of the prescription drug. If the cost of the prescription drug increases the employee does not have any direct financial incentive to switch prescriptions to a lower cost alternative because his/her direct out-of-pocket expenses have remained unchanged.
4. *Provider Changes:* Explore point of service, health maintenance organizations, preferred providers, self-funding and other alternative insurance plans. Consider participation in the state insurance pool. Provide the employee with the choice between fee for service and one of the items listed above with the board's contribution capped at the rate in effect for the PPO, POS or HMO. Also examine group purchasing arrangements with other school districts or employers in your area.
5. *Copayments:* Explore modifications to or implementation of office visit charges and emergency room visit charges. The goal of the copayment is not punitive, but rather to change consumer behavior. For example, a $100 emergency room copayment may encourage an individual to go to urgent care rather than the emergency room if the situation warrants that level of service.
6. *Flexible Spending Accounts/Cafeteria Plans:* Explore an Internal Revenue Service (IRS) Section 125 flexible-benefit plan, which offers tax advantages to both the employer and employee.
7. *HSA/HRA:* Consider health savings accounts (HSA)/health reimbursement accounts (HRA) in combination with high up front deductible plans.

8. *Wellness/Preventive Care:* Explore wellness programs or health-risk assessments as a means of reducing long-term health insurance costs. Insist that insurance carriers offer immediate significant health insurance premium reductions before agreeing to any wellness program.
9. *Alternative Benefit Plans.* School boards offering cash in lieu of insurance benefit should cap the benefit at a fixed dollar amount rather than tying the benefit to the cost of the single health insurance premium. School boards currently offering an alternative benefit plan tied to the cost of the single health insurance premium should cap the cost of that benefit at a fixed dollar amount. School boards should only offer such plans if there is a net savings from implementing the plan.

The third step is to determine the role the QEO will play in bargaining health insurance with teacher bargaining units. For teacher bargaining units that do not want to change health insurance, the QEO is a perverse ally. The QEO statute and rules require that boards maintain existing fringe benefits if a QEO is implemented. A school board cannot force teachers to make insurance concessions without forfeiting its rights under the QEO law. Under the QEO, teachers cannot force school boards to give more than a 3.8 percent total-package cost.

Boards often face the following questions/options in deciding which path to take with their teachers' union:

1. Do we force insurance changes through interest arbitration and relinquish our right to implement a QEO?
2. Do we offer some amount in excess of a QEO, if we can, to purchase a health insurance change?
3. Do we relinquish our goal of making a health insurance change for the certainty of a QEO?

Every district's analysis will be different. For the district with severe revenue limit problems, finding additional money to purchase a health insurance change (option 2) may not be realistic. For the district with a sizeable fund balance, arbitration (option 1) may not be a good idea. For the district with excessive post-employment benefit costs, high health insurance premiums, declining enrollment and a small fund balance, avoiding a discussion of health insurance changes (option 3) may not be advisable.

Fourth, whatever option you select, the employees must be provided with some incentive for reducing benefit costs. You need to determine in advance the "quid pro quo" ("something for something") you are going to offer for a change in insurance. If teachers are willing to reduce insurance benefits to lower costs, school boards should use those savings on the salary schedule or use those savings to offset reductions in staffing levels.

Boards that are seeking an insurance change often face the following question from the recalcitrant union: Why would we trade a pre-tax benefit for post-tax salary? There are several answers to this question. First, there is a salary schedule impact, but there also may be a net salary impact and a positive pension impact. The net salary for employees will increase for those districts that have an employee premium contribution because the employee's premium contribution will be less

Status Quo vs. Health-Plan Change

These charts depict an example of how a health-plan change benefits an employee with an immediate salary increase that will also lead to an increase in the employee's Wisconsin Retirement System (WRS) pension benefit. The top chart shows the reduced premium cost and the net salary gain to the employee. The lower chart shows how the increased salary would factor into the formula-driven calculation of the WRS pension. The pension formula is based on the employee's age, the employee's years of creditable service, the employee's final average earnings (the average monthly earnings during the three years of highest earnings covered by the WRS), and a formula multiplier based upon whether the employee's years of service were before the year 2000 or after the year 1999. If all other factors are held constant, an increase in an employee's final average earnings increases the benefit paid out under the pension benefit formula.

	GROSS SALARY		HEALTH CONTRIBUTION		NET SALARY
Status Quo (3.8%)	$54,489	—	$2,000	=	$52,489
Health-Plan Change	$56,839	—	$1,900	=	$54,939
			NET SALARY GAIN	=	***$ 2,450***

	2006-07 SALARY	2007-08 SALARY	2008-09 SALARY	EST. MONTHLY BENEFIT	LIFETIME BENEFIT
Status Quo (3.8%)	$54,489	$54,489	$54,489	$2,344	$618,816
Health-Plan Change	$56,839	$56,839	$56,839	$2,445	$645,480
			BENEFIT AMOUNT ABOVE STATUS QUO		***$ 26,664***

ASSUMPTIONS: *Person retires on July 1, 2009. Person is at the top of the salary schedule. Person is age 57 at retirement. Person has 30 years of service – 21 years before 2000, 9 years after 2000. Person selects life annuitant option. Payments made for 22 years (264 payments).*

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than if no change occurs. An increase in salary will also have a positive effect on the employee's Wisconsin Retirement System and Social Security benefits. The tables on the previous page, *"Status Quo vs. Health-Plan Change,"* illustrate the salary and pension implications of a change.

The second answer, if applicable, is that you have found similar benefits and coverage at a lower cost. Why pay for services or provider options that are not utilized by the staff? Here is where using an insurance consultant and referring to the survey results can help you in the process.

A powerful anecdotal story is often used at the bargaining table by a teacher or union that doesn't want to change its plan. The common issues are primarily demonstrated in two areas. The first situation is where a particular health care provider who is presently being used by a staff member(s) will be out of the network and, therefore, subject to a higher copayment or not covered at all. Typically this occurs when you are changing insurance companies and/or you are leaving a fee-for-service plan to a point-of-service product or preferred-provider option.

There are at least two ways to respond to this issue. The first is with your district's survey results or health-experience data if that information is available. The information will typically demonstrate the amount of claims from provider A, provider B, provider C, etc. If provider C is not in the new network, but was receiving a small percentage of claims (5-20%) it basically means that the majority of staff is not accessing that provider so a majority of staff is subsidizing the other staff members' utilization of that provider. Second, provider C may not be in the new network because provider C was unwilling or unable to provide the same cost discounts that provider A and B were able to provide to the new carrier. In essence, with expanded choice of providers come higher costs unless you have a very large subscriber base. The second situation is where an employee will now be subject to a higher prescription drug card copayment. The employee discusses how much the additional copayment will cost him or her. The response is that insurance is a collective proposition, and when the copayment increases more of a particular cost will be borne by the individual rather than the group in the group premium. Again, this example illustrates the value of the plan survey and/or experience data.

If you are able to make a health insurance change, don't be tempted to use the savings to buy long-term care insurance or other benefit items. As a state, Wisconsin spends a disproportionate amount on benefits. Why would district officials exchange one benefit for another when the state's salary ranking continues to fall?

Using Arbitration to Address Health Insurance Cost Increases

For the district with excessive post-employment benefit costs, high health insurance premiums, declining enrollment and a small fund balance, interest arbitration may be the path to pursue if the union will not voluntarily agree to insurance modifications. If bargaining with teachers does not result in a voluntary settlement, one or both parties may file an interest arbitration petition.

The Wisconsin Employment Relations Commission (WERC) will assign a staff person to act as an "investigator." The "investigation" is a determination of whether the board and teachers are at impasse. The investigator determines impasse by conducting mediation. If mediation does not result in a settlement, the investigator must either call for an exchange of final offers or declare the parties at deadlock. If the board chooses to implement a QEO, the investigator issues a deadlock letter and the district's fringe benefits will remain unchanged. If the board does not choose to implement a QEO, the investigator calls for the exchange of final offers. The parties exchange final offers until each party, having seen the other's final offer, indicates that it will not change its final offer. At this point the final offers are certified. At any time up to the certification of final offers, the board may revert to the implementation of a QEO. Once final offers are certified, the QEO option is lost. The interest arbitrator schedules a hearing where evidence relating to the board's and union's final offers is presented. A public hearing may also be scheduled where members of the public may comment on the parties' offers. The interest arbitrator will typically set a time for the filing of briefs where written arguments are made. The interest arbitrator must select one or the other final offer in its entirety. The arbitrator bases his or her decision on the statutory criteria. The arbitrator must give a written decision indicating the weight given to each of the statutory criteria.

The process has risks and costs associated with it so it should not be pursued unless careful consideration, including soliciting the advice of legal counsel, has been given to the potential consequences of arbitration if the arbitrator selects the union's final offer.

Conclusion

Negotiating health insurance is a difficult task, but one where positive changes can occur with preparation, information and patience. ■

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