



F O C U S O N ISSUES

Critical

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WINTER
2004

A Perfect Storm

Rising health care costs

The nor'easter that took Captain Billy Tyne by surprise off the coast of Nova Scotia in 1991 was more than a hurricane.

It was a convergence of three weather systems so unexpected, so frightening and rare that scientists called it the "perfect storm."

Tyne and his small crew perished in this collision. Their fishing boat was never found, but the tale lives on in history, a novel and a hit movie.

The health care crisis is like the 100-foot rogue waves that crushed the Andrea Gail and her mariners. The waves seemed to come out of nowhere, relentless . . . like the forces behind the rising costs of health care.

There are so many forces driving up the cost of health care today that we call it the perfect storm, says Seth Garber, M.D., consultant for Kaiser Permanente and Mercer Human Resource Consulting.

We love to blame hospitals, doctors, drug companies, the government, unions, management, unhealthy lifestyles, the news media . . . and yes, insurance companies.

Among the cost drivers: an aging population, medical technology advances, new drugs and our own entitlement culture. We expect the best, we want it right now and from whomever we choose. We don't care what it costs.

If you doubt this concept, ponder these questions: If a beloved family member is battling cancer or a life-threatening disease, what do you do? How far will you go? When you watch a two-pound baby clutching a human finger, don't you want her to thrive? These babies can leave the hospital with a \$700,000 bill and a future of health problems. But they deserve every chance we can give.

Of course you will seek the best care you can find. Most of us can utter the phrase, "thank goodness we have insurance." Some aren't so lucky – which only means the rest of us pay for their health care, too, in the form of higher insurance rates.

"While premiums normally rise with inflation, one of the biggest cost drivers is the double-whammy of cost *and* use," Garber says, noting that when health care *use* increases, the costs go even higher. "For example, you're not just paying for the cost of a heart bypass, but the fact that many, many people, including 80-year-olds, are having them. Add to this the fact that between the ages of 45 and 65, a person's use of

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Perfect storm – from page 1

health care will triple. By the year 2030, we'll have twice as many people over 65. Then, when you hit 80, you use nine times the health care services. And guess what? We're living longer."

Despite the price escalation, consumers are actually paying a smaller share, he says. "Even though we're all paying more, it's still a smaller piece of the overall pie," Garber says. "Consumers have been relatively isolated from the true costs, and employers throughout the country are saying 'enough' and asking employees to share the burden."

School boards in Oregon and nationwide are waking up to realize their sacred cow of fully paid benefits that cover everything from a sniffle to a heart transplant is slipping away – or eating up precious resources we'd rather spend on education programs.

Fact: In Oregon, insurance cost increases have averaged 19.2 percent annually for the last four years. Today, based on OSBA's annual Salary and Benefit Survey, an average of \$8,200 is spent for each teacher's insurance package in the state. That's 82 percent higher than the average 10 years ago.

Another sobering fact: If costs increase as projected, some Oregon school boards could face a price tag for one employee's family health care coverage that equals one new teacher's annual salary.

Wow.

So here we are in Oregon, trying

to survive this storm by doing everything from capping insurance premiums at the bargaining table to exploring the proposed mandate of a government-run statewide insurance pool for school employees.

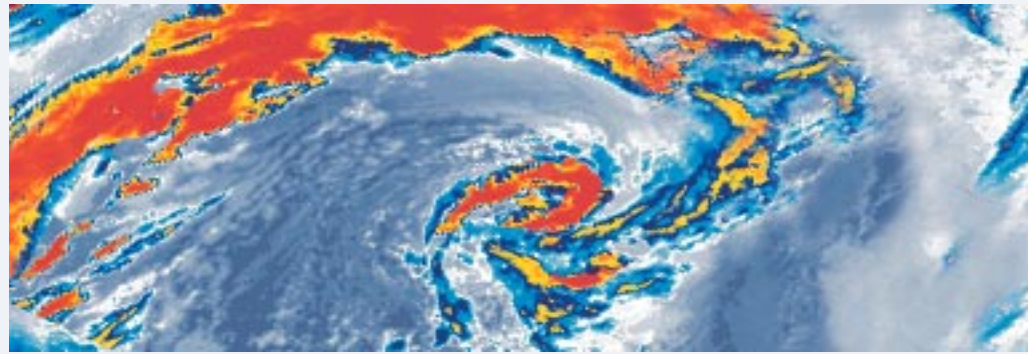
The message every board member, every employee needs to heed is this: There are no single remedies. Now is the time for a new brand of teamwork – the kind you depend on to fight not just one, but several storms.

This edition of *Focus on Critical Issues* explores what goes into this perfect storm, from the real cost drivers to how Oregon school boards

are successfully controlling health costs while offering good benefits.

We interview local and national experts about trends in bargaining health care and cost control. We share preliminary results from a national survey on what's driving up costs. We explore the concept of government-run health insurance pools and how they're working (and not working) in surrounding states.

Lastly, we try to predict the future – what we all must do together to survive with the boat intact and our crew alive and healthy.



Collective bargaining: *Confrontation reigns nationwide*

Across America workers and their bosses are wrestling over the escalating cost of health benefits. Sometimes the workers are fighting the bosses. Sometimes they're on the same tag team, facing the industry in the other corner.

It's been a sweaty business, with no clear winners.

However, the national struggle offers lessons that could help Oregon school boards control health-benefits costs.

Lesson One:
The health-costs debate can get ugly for management and workers.

In the past year, tens of thousands of grocery workers in California, the Midwest and South went on strike

rather than pay more for their insurance. Machinists at Lockheed-Martin, a defense contractor, struck in opposition to higher deductible payments and prescription costs.

Workers at Powell's Books in Portland went months without a contract rather than accept cuts in health benefits and a wage freeze. Electronics and electrical workers struck General Electric because they *expected* difficult negotiations over health benefits.

Labor strife can hammer an organization's bottom line. In California, three supermarket chains faced losses exceeding \$20 million per month in an almost five-month long workers' strike – sparked by a disagreement over health benefits. However, with companies' health insurance bills rising an unsustainable 14 percent a year, management

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<http://www.osba.org>

decided to take a stand.

At the same time, unions worry that if they don't fight back, they will lose hard-won benefits. For example, over the past three decades, employees have paid an ever *decreasing* share of total health costs, says Cynthia Chilton, a health and group benefits consultant in Portland for Mercer Human Resources Consulting. In 1970, workers contributed 35 percent of the cost of care; *now it's down to 15 percent.*

Lesson Two:

Labor-management smackdown doesn't have to be the only approach.

Although unions are working hard to protect health benefits, some are choosing solutions that don't involve going to the mat with management.

Ted Clark, a Chicago attorney who specializes in labor and employment law, reports that to keep health benefits intact, some unions will consider caps on wages or increases in the amount workers pay for their care and medicines. One approach that has passed union scrutiny is to charge workers different co-payments for different types of drugs – lower for generics and higher for name brands, for example.

Clark says unions have sued to force pharmacy benefits managers to lower drug costs, potentially benefiting employer- as well as union-sponsored health plans. Unions in some states are pushing legislatures to sponsor health insurance or prescription drug coverage. The goal is to reduce health costs by creating large groups that can bargain more effectively with providers.

But such activism can only go so far. California adopted a union-backed plan last fall to require many employers to either provide health insurance or pay into a state pool from which workers could buy coverage; however, business opponents have referred the issue to the November ballot. Besides voter anxiety, state-sponsored health plans for workers are likely to be limited by budget shortfalls that already are cutting into Medicaid benefits for the poor.

Lesson Three:

Employers are making changes, but they are tentative and the savings are unclear

- Workers' contributions to their insurance premiums are growing. A 2003 survey by the Kaiser Family Foundation and Health Research and Educational Trust found workers paying an average \$508 per year for single coverage and \$2,412 for a family plan.
- More workers pay more money for physician and prescription services. The Kaiser survey indicates that almost half of workers served by health maintenance organizations had to make co-payments for outpatient physician services, up from 37 percent in 2002. Co-payments for prescriptions reach as high as an average \$29 for "non-preferred drugs," brand name medications with generic substi-

tutes.

- More workers pay for hospitalization. According to the Kaiser study, more employers are requiring workers to pay a deductible or other payment when they are admitted to a hospital. The average payment is \$200 per admission, and more than 40 percent of covered workers now pay it.
- Fewer retirees are covered. Various reports indicate that the share of employers providing health benefits for retirees has fallen below 40 percent, from 66 percent in 1988 and 50 percent in 1993. *The New York Times* reports that many companies which have kept retiree coverage have sharply increased the retirees' premiums.

Despite such changes, the Kaiser study reports that from spring 2002 to spring 2003, premiums for employers marked their third straight year of double-digit increase. In addition, few

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Unions dig in to protect benefits

Negotiating changes in employee health benefits is not for the faint of heart.

A specialist in labor and employment law, Chicago attorney Ted Clark,* says unions nationwide are using worker concern about health benefits as an organizing tool. Once unions get to the negotiating table they are digging in their heels to prevent benefits from being cut.

Still, Clark adds, there are steps employer negotiators can take to boost their chances of success.

- Employers should be willing to share with labor information about how the organization's benefits costs are rising and why action is needed if the organization is to continue to afford them.
- Employers should be willing to listen to employee concerns.
- Employers and workers should be willing to take a methodical approach to change.

"Open the door and gradually get employees to buy in to the proposi-

tion that they need to share in the cost of providing this benefit," Clark says.

Clark says the health-benefits issues confronting public-sector organizations such as school districts are the same as for the private sector. However, school districts have at least one significant advantage over the private sector: equity.

In the typical school district, Clark says, all employees – management and labor alike – are covered by health plans with essentially the same terms and conditions. So in negotiations, the management team can say to the union side, "We're not asking you to do something we're unwilling to do as well."

Clark says that in the private sector, "corporate honchos" frequently have significantly different provisions in their health plans.

"I've got to believe that rankles the unions to no end," Clark says. ■ ■

* Clark is with the National Public Employer Labor Relations Association



Bargaining impacts – Continued from page 3

employers reported actually cutting benefits and few said they planned to take such a step in the coming year.

On balance, the Kaiser study says, employers have made “relatively few changes in their health benefit plans.” The study adds that employers appear reluctant to take away benefits that workers and their families rely on, and that companies “do not have a high level of confidence that current market strategies can reduce premium growth.”

Lesson Four: Labor and management have been through this before, and survived.

Every year from 1988 through 1992, employers’ health-insurance costs rose by more than 10 percent. Firms responded with sweeping changes, and they worked. In 1994, employer costs actually fell, and through 1996, they increased at less than the rate of inflation.

Ted Clark, a labor and employment attorney, says during that time, many employers were able to negotiate their firms away from traditional plans that paid full freight for every service. In their place came health maintenance organizations and other arrangements that con-

trolled costs by controlling the amount or source of the service. Workers also began to share in the cost of their coverage.

Clark says that, like today, the late 80s and early 90s saw tough negotiations over health benefits. However, he says the earlier period could have been even more challenging.

“In some ways, negotiations were more difficult because employers for the first time were asking employees to agree to pick up part of the cost,” Clark says.

This time around, workers are much more savvy about health-care options and much more willing to exercise them (witness the growth in on-line shopping for medicines). Some employers are responding by coupling higher out-of-pocket costs for workers with plans that give them much more control over their own care. Cynthia Chilton, Mercer benefits consultant, calls this a consumer-driven approach, and a handful of local governments, plus the San Diego school board, have already adopted it.

So far, Chilton says, consumer-driven health plans remain “a work in progress.”

But in an economy powered by consumer choice, they just might catch on and bring benefits costs back in line again.

National survey: Turbulent forces drive benefit costs up

Nationally, health benefit costs rose more than 10 percent in 2003, compared to general inflation of about 2 percent. Why the huge difference?

To track trends, national consulting firm Mercer Human Resource Consulting annually surveys American employers. According to Cynthia Chilton, Health and Group Benefits Consultant at Mercer, the 2003 results show a veritable patchwork of factors behind the increases:

- Among the drivers:
 - Consumers feel they are entitled to low-cost, high-technology health care.

Health benefit data on OSBA’s SPOT

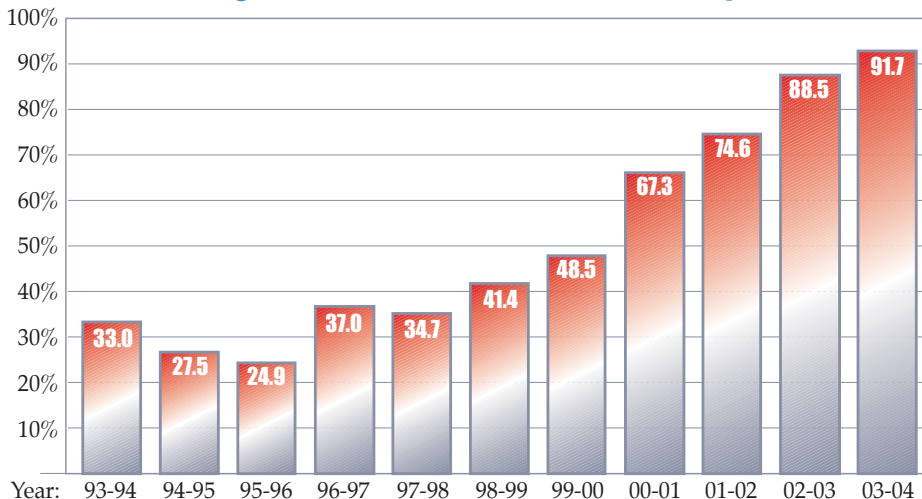
One of the consistent trends emerging in bargaining health insurance in school districts across the state is capping the amount the district will pay. This allows districts to get more control of costs in the face of double-digit premium increases and lean budgets.

More information is online at OSBA’s **School Personnel Online Tools (SPOT)** – a Web-based database available to OSBA member districts – at www.osba.org/spot.

SPOT gives you comparative salary and benefit data on licensed staff in Oregon school districts and ESDs in a format that is easily searched and configured by region, district size, ADM and other parameters.

Usernames and passwords are emailed to district administrators and board members on request.

Oregon K-12 school districts with insurance caps*



* Insurance cap data does not include ESDs. 2003-04 data includes the 121 K-12 districts that provided health benefit information to OSBA as of Feb. 28, 2004.



- Low co-pays and deductibles insulate patients from the high cost of new drugs and cutting-edge procedures – even for the increases in primary care.
 - Drug companies market directly to consumers, building a demand for products that may be no more effective than their generic counterparts.
 - As baby boomers age, they need more health care.
 - Federal and state regulations require more administration and recordkeeping.
 - In Oregon and elsewhere, doctor shortages lead many physicians to push back on discounts demanded by insurers.
 - State Medicaid programs shrink and more people go without insurance. When they do need care, it's usually an emergency room visit and the costs are passed on to those with insurance.
- "Everybody wants to blame the insurance companies," Chilton says. "The truth is, it's a complex situation,

and no one is taking ownership."

Higher costs, reduced benefits

The Mercer survey shows employee costs going up across the board.

- In 2003, the average monthly employee contribution toward family health benefit costs increased \$103 (from \$278 in 2002 to \$381.)
- The median out-of-pocket maximum rose from \$1,500 to \$2,000.
- More than a third of plan sponsors set doctor visit co-pays at \$20 or more.

As "consumer directed" health plans emerge, high deductible PPO (Preferred Provider Organization) options are more commonly part of an employer's offerings. In 2002, 20 percent of PPOs required a deductible of \$1,000 or more. That percentage rose to 34 percent in 2003.

This upward trend will continue, Chilton says. Regence, a major health plan provider in the Northwest, predicts that in 2004 the cost of

medical coverage and prescription drug benefits will go up 16 and 19 percent respectively.

Other examples of increases based on the entire cost of health benefits, nationally, for school employees: If costs increased only seven percent, the cost goes from \$6,000 per school employee in 2004 to \$8,415 by 2009. If costs increased 15 percent, the figure doubles – to more than \$12,000 per year (see chart page 6).

If there is any good news in this story, it is that despite increases in co-pays and deductibles, employees are paying a smaller share of overall health benefit costs than before. On the average, employees now pay about 15 percent of benefit costs, compared to 35 percent in 1970.

Informed choices

To rein in increasing costs, some employers are beginning to introduce consumer-driven health plans. These plans emphasize choice, information and economic incentives. For example, in a consumer-driven plan, you may be able to choose from a large number of providers and treatment options. Your choices will be based on detailed information about the quality, service and outcomes these providers deliver. Your costs will be determined by your choices: you control the amount you spend by choosing less expensive options. But a consumer-driven health plan is not a silver bullet, Chilton says.

"We used to think HMOs would control costs, but we've gotten all the savings we can out of those plans, and we still have double-digit inflation," she says. "There is no single strategy that will solve this situation."

The answer may come down to individual health management choices. "The more proactive we are at making good health choices, following a healthy life style and managing chronic conditions, the less expensive care we'll need," Chilton says. "That may be the most effective way of slowing cost increases."

How do schools compare?

Benefit plans offered by the nation's school boards, including Oregon's, are more generous than those provided by other employers Mercer Human Resources Consulting surveyed.*

For example:

- Districts pay an average annual cost per employee of \$6,000 vs. \$5,646 paid by all employers. Those surveyed expect this amount to go up 14 percent for schools and 13 percent for all employers this year.
- 21 percent of school districts offer traditional indemnity or fee-for-service plans, the most expensive type, as one of their offerings compared to 8 percent of employers nationwide.
- 96 percent of districts offer dental coverage vs. 66 percent of American employers.
- 57 percent of school retirees have access to health benefit plans; only

6 percent of employees generally have access to such benefits.

School districts are playing "catch up" with the rest of the country in sharing costs with employees. Forty-two percent of school boards plan to increase employee cost sharing compared to 25 percent of all employers.

"Education offers some of the richest benefit packages around today," says Cynthia Chilton, Health and Group Benefits Consultant at Mercer Human Resources Consulting. "With the crisis in school funding, it's not surprising school boards are asking employees to pay a greater share."

* Mercer Human Resources Consulting conducts an annual survey of American employers' health plans. In 2003, nearly 3,000 organizations took part. The results are accurate within a range of plus or minus 3 percent, and represent more than 90 million full- and part-time employees. Full survey results will be released this May; preliminary results are posted under OSBA's Health Care Crisis Web resource page at www.osba.org.



Drug costs: A major stormfront

There's a lot about prescription drugs that Americans find hard to swallow.

U.S. drug companies, despite developing miracle cures, have adopted an international pricing strategy that appears to give foreigners bargains at Americans' expense.

Congress has provided the first prescription-drug benefit in Medicare history but at a cost of more than \$500 billion and with no way for the government to bargain with insurance companies for lower prices.

Workers are seeing their own health costs rise as employers ask them to pay more for their prescriptions. That has left many employees angry without appearing to ease employers' lot: drug spending is still cited by employers as the leading factor in rising overall health costs.

Clearly, anyone claiming to have a remedy for prescription drug problems should check his hands for scissors before patting himself on the back.

Drug spending in the U.S. has grown by double digits for much of the past decade and is forecast to continue growing in the 9 to 12 percent range through 2010. The factors driving up drug spending are powerful:

- Doctors are writing more prescriptions. One study says this accounts for half of the increase in U.S. spending on drugs. An aging population and the substitution of drugs for other therapies such as surgery play a role here.
- The unit cost of drugs is going up, in part because billions of dollars have been spent on advertising since the government's 1997 decision to allow more drug promotion. Higher unit costs may account for one-quarter of increased drug spending.
- More new drugs, with higher price tags, are reaching the market, aided by a faster government approval process.

Still, there are causes for optimism about drug-cost control.

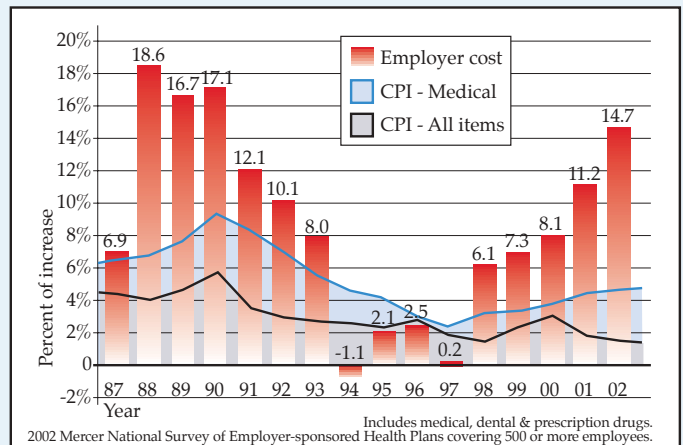
First, although drug spending is growing rapidly, it constitutes only about 11 percent of overall spending on health care.

Next, employers aren't giving up on cost-control measures. A study by the Kaiser Family Foundation indicates that companies big and small plan to increase the amount employees have to pay for prescriptions this year. That should create more consumer pressure on drug companies to bring down prices.

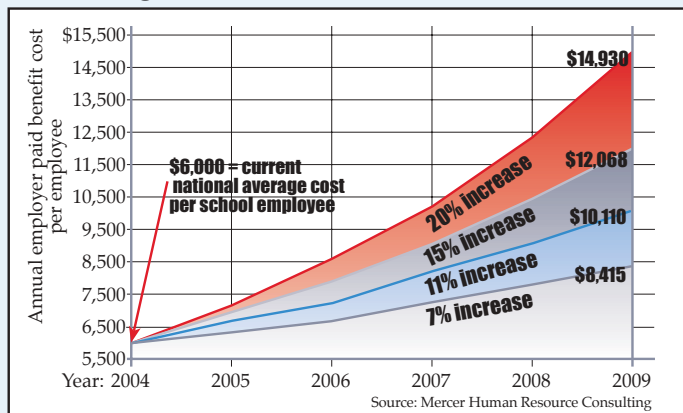
Cynthia Chilton, a health and group benefits consultant in Portland for Mercer Human Resources Consulting, says employers can accelerate this process by switching from drug plans that require employees to pay a set dollar amount for each prescription to plans that require them to pay a percentage of each prescription's cost. Such changes can make consumers "a lot more motivated" to look for cheaper alternative drugs, Chilton says.

There also are signs of increasing government activism on drug costs. Maine has implemented and Hawaii is implementing plans that use state buying power to make drugs avail-

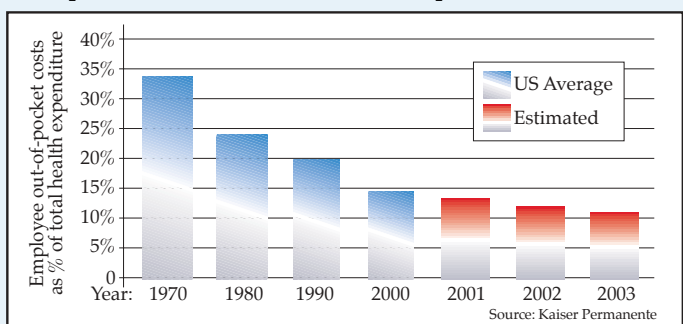
Nationally, employer health cost increases outpace CPI (consumer price index) indicators



What happens to employer costs if double-digit rate hikes continue



Employee cost-sharing has steadily declined compared to total health care expenditures



able at as much as a 60 percent discount to low-income residents.

And at the federal level, pressure is building to study reimportation of lower-priced drugs from countries such as Canada and to revise the new Medicare law to allow government negotiation for price discounts from drug makers.



Oregon success stories:

The 'Four C's' of controlling insurance costs

Choices, Caps, Cost-sharing and Communication

Like the “converging storms” causing health care’s perfect storm, these “four C’s” have a combined strength to get a handle on costs. Board members and district staff are using these approaches successfully around Oregon.

The factors pushing up health care costs are as complex as cutting-edge medical technology and government regulations, and as simple as that old joke, “If I’d known I was going to live this long, I’d have taken better care of myself.”

Whatever the reasons, many of the factors driving costs skyward are out of our immediate control. As OSBA Executive Director Chris Dudley puts it, “The challenge is, how can we get control of an uncontrollable situation?”

Choices, caps, cost-sharing and communication (the Four C’s) are major remedies to ‘control the uncontrollable’ – especially when it appears we’re entering the fifth consecutive year of double-digit premium increases.

Below are a few success stories showing how several Oregon districts use three approaches to insurance: OSBA’s Trust, self-insurance and direct-write. We note monthly premium contributions compared to the state average of \$683. This average was calculated from the 133 school districts and ESDs that responded to OSBA’s annual salary and benefits survey (as of Feb. 28, 2004).

Using OSBA Trust plans

Small districts, big insurance issues

Most of Oregon’s school districts serve 3,000-4,000 students in small

communities with a limited number of health-care providers. OSBA’s Health Insurance Trust offers employees in those areas a variety of insurance choices that prove to be the “best buy” for most districts.

“We’re trying to offer reasonable alternatives for insurance so that every district – no matter the size – can access affordable health insurance for employees,” says Chris Dudley. “One plan fits all” doesn’t work for Oregon schools, but about 40 percent of the number of district employees covered in this state use OSBA plans, Dudley says. In all, Trust plans cover more than 91,000 school employees and family members.

Here are how three Oregon districts use Trust offerings to keep costs down:

Seaside School District

Duane Johnson has spent lots of time in negotiations during his 20 years of service on the Seaside School Board. Those negotiations have driven home one universal fact:

“Employees hate losing benefits,” he says. “In the past, our employees nearly always chose benefits over salary increases. But this year, the board had to get a handle on insurance costs.” By offering employees a choice between two OSBA-sponsored insurance plans, the board found the “handle” it needed.

Both Johnson and Seaside Superintendent Doug Dougherty agree that communication was key in the district’s negotiations.

“Our first hurdle was to help the bargaining team understand that costs were going up close to 20 percent each year and the only way we could continue was to implement a 5 percent cost-sharing or an insurance plan with a higher deductible,”

Dougherty says. (Seaside employees now can choose either a 95-5 split with OSBA Plan A100 or the 100 percent Plan B300.)

Opening up negotiations to the public for the first time enabled employees to hear both sides of the issues as they were discussed at the bargaining table, Dougherty says. Open meetings, which included the press, allowed more people to become involved and understand the implications of skyrocketing health-care costs.

“When we put together the total compensation package, it included insurance and a salary increase,” Dougherty says. With employees contributing to the cost of their insurance for the first time, the Seaside district could offer a 1.5 percent salary increase in the first year. The second year salary increase will be equal to the CPI for next year, according to Dougherty.

“My advice to other board members is to have an open meeting when benefits issues are discussed,” Johnson says. “It really makes a difference when the press is there, reporting the issues to the community.”

Seaside’s maximum monthly premium contribution: \$714

State Average: \$683 (Based on 133 responses to OSBA salary survey.)

South Umpqua School District

Angie Peterman has a broad perspective on health-care costs in the South Umpqua School District and other districts around the state.

As her district’s business manager, Peterman sees first-hand the critical importance of a cap on the district’s liability for insurance costs. As the newest member of OSBA’s Health Insurance Trust Committee, she also is learning the importance of educating employees about wise insurance usage.

The South Umpqua district

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OSBA Health Insurance Trust: A statewide benefit pool for school employees

For 35 years the Oregon School Boards Association Health Insurance Trust has offered its members comprehensive, predictable and cost-effective health care insurance.

Today more than 91,000 school employees and their family members are covered under plans from the OSBA Insurance Trust.

It's competition that keeps the Trust premium rates low and competitors' rates in line, according to Lee Baggett, chair of the Insurance Trust Committee and member of the Umatilla-Morrow Education Service District Board. The Trust has gained the business of 84 percent of our member districts by providing a proven, valuable product at a competitive price, Baggett adds.

"For 35 years the Trust has competed in the open market," he says. "OSBA members can select one of the Trust's plans – or if they can save even more, they can choose another insurance carrier."

OSBA opposes government-run health insurance proposal

During the 2003 Legislative Session OSBA along with Associated Oregon Industries and several private insurance carriers and their agents opposed the Governor's proposal to create a government-run health insurance pool for school employees. Although the proposal was defeated, the Governor has indicated he is still interested in creating such a pool.

Why? The Governor says that such a pool will save school districts significant costs in lower health insurance premium rates.

OSBA is not convinced.

Our concerns include:

- The proposal does not address the real cost drivers that are causing

health care premium rates to skyrocket.

The real cost drivers are:

- Soaring cost and increased use of prescription drugs.
- Use of expensive "high tech" medical procedures.
- Aging employees.
- OSBA's pooling efforts already provide the economies of scale available for a large pool that offers a limited variety of plan offerings.
- Further pooling of a larger group does not affect the most important factors currently influencing the OSBA Trust plan costs and other health insurance programs. Those factors are:
 - The pool's "experience rating" (how much the group uses health services and what kind of illnesses or injuries are treated).
 - The plan's participation rules (who is in the plan).
 - The plan design (what benefits are included).
- The Governor's proposal creates a government-run monopoly with a governing board that is weighted toward employees rather than employers (much like the former Public Employees Retirement System's board of directors).
- A government-run monopoly

eliminates the ability of local carriers to offer cost-effective plans to local districts. Local carriers would be deprived of local business.

- Assuming the new program is fashioned after the Public Employees Benefits Board (PEBB) rate structure, all indications are that health insurance premium rates for the government-run pool would be higher than what most members of the OSBA Insurance Trust pay now.
- An Oregon law that requires school districts to keep retirees in the same plan with the same premiums as current employees. (Based on claims last year in the OSBA Insurance Trust, the cost per retiree family unit was 39 percent higher than the cost per active employee family unit.)

Trust endorsement fee subsidizes OSBA member services

The endorsement fee generated by the Insurance Trust allows OSBA, a non-profit organization, to **subsidize** all of its services offered to members.

Those services include: Leadership training, legislative advocacy, board policy services, employee

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OSBA Health Insurance Trustees

Lee Baggett, OSBA Trust Chair; Umatilla-Morrow Education Service District Board

Angie Peterman, Business Manager, South Umpqua School District

Craig Prewitt, Phoenix-Talent School Board

Craig Roessler, Superintendent, Silver Falls School District

Renee Sessler, Reynolds School Board

OSBA Trust – Continued from page 8

contract negotiation assistance, human resource development assistance, communications services, budget and public contracting assistance and executive search assistance.

In addition, the endorsement fee supports the association's most important role – representing the interests of locally elected board members before the Oregon legislature. The fee also helps subsidize a variety of professional development workshops OSBA offers to board members.

In 2003 the OSBA Health Insurance Trustees, a five-member board that governs the Trust, lowered the endorsement fee the OSBA receives from the insurance programs from 1.025 percent to 0.8 percent of premiums paid to the Trust. The 0.8 percent will provide OSBA \$2.5 million in 2003-04, which amounts to 60 percent of the association's annual revenue.

How the Trust operates

The OSBA Health Insurance Trust is governed by a five-member board appointed by the OSBA Board of Directors. The Trustees operate the Trust independently from OSBA and have sole control over the endorsement fee paid to OSBA. The Trustees maintain policy control and authority over plan design and participating rules. (See list of Trustee members on page 8.)

Every year the Trustees review health plan designs, how members have used health care services, new offerings in the insurance industry and local needs before making decisions on plan design and offerings.

In past years the Trustees have "bought down" premium rate increases ranging from 2 to 5 percent annually. In 2002 the Trustees provided the largest premium relief in the history of the OSBA Trust when it committed \$10 million to a refund of

premium costs paid directly to participating members. In 2003 the Trustees restructured offerings to eliminate high-cost options, create more effective and more economical options and reduced the endorsement fee OSBA receives.

The rising cost of health care is an issue we know weighs heavily on our members.

"It's not just school boards facing the dilemma of soaring costs of health insurance," Baggett says. "We know we must work together – employees and employers – and the health insurance industry to find a way to control costs." (See "The 'Four C's' of controlling insurance costs," page 7.)

To that end, the Trustees are working with Regence BlueCross BlueShield to create plan options to encourage wise use of insurance benefits.

ALTERNATIVES to a government-run monopoly

As alternatives to creating another government bureaucracy, OSBA suggests the Governor and Oregon legislature explore:

Option A:

Establishing a statewide cap on health insurance premium rates – comparable to the rate paid under the government-run Public Employees Benefit Board (PEBB) – that school districts and ESDs can pay for health insurance.

Oregon districts may be better served if funding for their benefits is tied to the actual cost of a comparable set of benefits. Funding adjustments then would be more reflective of the actual costs associated with health care and the market that serves it. It would create the need to manage health care premium costs against a known benchmark such as the state employee plans while

allowing the positive elements of marketplace competition and collective bargaining to continue.

A cap would contain costs and allow local collective bargaining to focus discussion on the most cost effective benefit plans. At the same time, it preserves local control over collective bargaining by allowing local boards and their union chapters to negotiate benefits within the financial framework established by the Oregon legislature.

Option B:

Designating an explicit portion of the school funding formula for benefits only. The amount could be directly tied to the amount being spent on state employee plans. The legislature could restrict the use of district funds of any kind above the budgeted threshold. Funding for retiree subsidies should also be considered in this arrangement.

It's competition that keeps OSBA Trust premium rates low and competitors' rates in line.

Under this proposal districts would have a strong incentive to manage benefit dollars within a framework tied to a large program (state employees) perceived to be cost-effective. Funds intended for other school programs would not be shifted to maintain costly benefit programs.

OSBA-type plans would play an important role as a balancing tool as well as the competitive driver to assure access to common benefits and cost effective programs for all districts.

Included in either option:

Provide districts the option to purchase their health insurance benefit packages from the government-run Public Employees Benefit Board and prohibit districts from paying more than what is allowed through PEBB.

How are neighboring states weathering the storm?



Washington

During the 1960s, health benefits for Washington K-12 employees were developed independently at the district level. Large districts developed and operated successful and cost-effective plans while small and rural districts struggled to find programs that provided adequate benefits at reasonable premium rates.

The state provided health care to its employees, but school employees were not eligible.

With the realization that state-wide group purchasing could provide better plans at lower costs, the Washington Education Association (WEA) created a program for its member groups. The plan was well run and soon gained a dominant position.

By the mid-1980s medical plan costs were a major issue in the state legislature. The two major issues were:

- Belief that the state could save significantly by incorporating all K-12 employees and retirees into the state employees' plan.
- Retirees covered under school district and WEA plans were upset that out-of-pocket costs were increasing. (At the time, retirees under the state employee plans had benefits that were similar to school employees but were not dealing with increased cost because the state was heavily subsidizing the premium costs to retirees.)

Studies attempting to show that "bigger was better" were inconclusive.

The legislative takeover attempt eventually died in committee but some legislative changes did occur to fundamentally change the health insurance benefit package for

Washington K-12 employees and retirees.

Those changes included:

- Legislatively established benefit funding levels as part of the school district's revenue. The funding level is the same as for the state employee's plan – currently \$481 per employee per month, and is used only for medical, dental, vision, life and disability benefits.
- School districts and ESDs may choose to participate in the state employees' benefit plan.
- K-12 retirees are eligible for the state health benefit programs. (Schools no longer offer retirees health benefits.)
- Medicare-age retirees receive a subsidy from the state to help offset premium rates.
- School districts that do not participate in the state employees' plan are charged a monthly amount to help offset the subsidies provided to K-12 retirees. (Currently that amount is \$42.76 per FTE per month.)

Similarly to the OSBA Trust, the WEA program has withstood the tests of time and in Washington is considered to be the benchmark against which other plans are compared. Approximately 50 percent of K-12 active employees are enrolled in a WEA medical plan. Nearly all of the other K-12 active employees are enrolled in district-sponsored medical plans usually offered as a side-by-side choice with the WEA options. A small number of districts or bargaining units have elected to participate in the state employee plans. (Currently less than 2 percent of K-12 employees are covered by the state plan.)

Content based upon research conducted by Mercer Human Resource Consulting.

California

California's state health insurance plans – CalPERS – are available to school districts and community colleges on a voluntary basis – entire districts, or bargaining units can participate.

Contributions and plans are bargained locally.

The 2002 annual CalPERS report indicates that 109 school districts and community colleges (approximately 70,000 members including family members) are part of the state insurance plans. When contrasted with 1,071 districts representing 524,000 members participating in the CalPERS retirement program, it appears that the health program is not the plan of choice for California K-12 schools and community colleges.

The largest California school districts handle their own programs. Many districts are part of combined purchasing arrangements operated jointly with labor and management representation. These plans seem to have consistently provided better arrangements than CalPERS to meet school district needs.

CalPERS health benefit programs seem to be losing participation due to large rate increases which are aggravated by using statewide rates. Southern California has lower costs than Northern California and the rural areas may be seeing higher costs as well. If this statewide rating approach continues, it is possible that base costs will go higher as lower cost areas drop participation.

CalPERS appears to be undergoing major shifts in its approach to cost controls, according to Mercer Human Resource Consulting. For

California – Continued from page 10

many years the thinking focused on negotiating clout – size was enough to gain cost concessions from the market. Today this is not enough.

As in Washington, California has offered state employee benefit plans to schools and other government entities for some time. The state has provided the clear advantage of plan, benefit and rate clout of CalPERS to the smallest and possibly the least healthy districts in the state. Unfortunately, that has not translated into providing access to the best plans or cost arrangements for the majority of California schools.

Bottom line: California provides a statewide program that school districts may use if they determine that it offers the best benefits at the most reasonable costs but it allows districts the opportunity to go elsewhere – thereby maintaining free-market competition.

Content based upon research conducted by Mercer Human Resource Consulting.



Controlling costs – Continued from page 7

converted to an OSBA Trust plan some 15 years ago and negotiated a 5 percent cap on insurance “before we hit double-digit increases,” Peterman says. That cap is crucial in South Umpqua and other Oregon districts, where employer caps are the primary cost-control option available in response to premium increases.

When employees have to pay excess insurance costs out of their own pockets, they began to look carefully at options, Peterman says. They’ve weighed the value of orthodontia, vision coverage, long-term disability and low deductibles, for example, to determine if it is prudent to keep those benefits.

“Before the cap, employees were suspicious whenever the district brought up the subject of insurance,” she says. “They didn’t have much interest or desire to discuss the issue. Now we’ve seen a real transition over time, a building of trust. Local union representatives are personally vested in the issue and interested in talking over the options.”

Cost-controlling discussions are ongoing “as we try to help employees become better consumers,” Peterman says. Regence representatives provide information about making better medical choices to employees through group meetings, mailings and on a Web site. When changes in coverage and different choices are being considered, all employees have input before decisions are made.

“We also implemented an IRS Section 125 plan so employees could shelter their contributions to insurance under pre-tax dollars,” Peterman says.

The cost of South Umpqua’s Trust-sponsored insurance plan “is lower than any other plan we’ve found,” Peterman says. “In Douglas County, with one hospital, we have limited options of providers, and that can run other insurance companies off. The Trust has been able to maintain affordable coverage in our area.”
*South Umpqua’s maximum monthly premium contribution: \$581
State Average: \$683 (Based on 133 responses to OSBA salary survey.)*

Baker: Trust Agreements bring groups together

The Baker School Board opened the way for frank communication about health benefit costs in recent negotiations by creating written “trust agreements” with employee groups.

Budget cuts, salary freezes and insurance caps were among “lots of really ugly decisions we had to make over the last four years,” says Eloise Dielman, who served on the school board for four years before retiring in July. Dielman is also a retired teacher.

Last year, a group of 40-50 union leaders, board members, district administrators and staff began meeting to outline “what is most important in negotiations to develop trust between the different groups in our district,” Dielman says.

The group outlined ground rules, then broke into small groups to develop lists of important issues. Those priorities include being open, honest and ethical in all decisions, showing respect and being willing to

Health care facts:

- *Between the ages of 45 and 65, a person’s use of health care triples.*
- *By the year 2030, the number of people over 65 will double.*
- *Eighty year-olds use nine times more health care services than 45 year-olds.*
- *The very elderly are the fastest-growing group in our population.*
- *Health care worker shortages will drive up the cost of care provided by health professionals.*
- *The cost of food has risen 104% since 1980 in urban areas; medical costs have risen 281%.*
- *The number of organ transplants has doubled in the past 15 years – and all transplants cost over \$100,000.*

Sources: Mercer Human Resource Consulting; Marsh; U.S. Census Bureau



Controlling costs – Continued from page 11

comprise.

The trust agreements were in place before bargaining began last spring for the district's two-year contract effective July 1, 2004. (Samples of these agreements are on OSBA's new Health Care Crisis Web resource page at www.osba.org.)

The contract included a \$650 insurance cap and salary freezes for all staff. Because the trust agreements were developed jointly, they helped district personnel put past issues behind them, according to Superintendent Don Ulrey. "This, combined with using OSBA's Insurance Trust plans, helped us offer good benefits at a very fair cost," he says. "We've worked hard at building relationships, which makes it much easier for everyone to share the load."

By talking through all the budget possibilities, no one felt that they were being taken advantage of, Dielman says. "And, whenever we got to a sticking point, the trust agreement kept us focused."

Baker's maximum monthly premium contribution: \$650

State Average: \$683 (Based on 133 responses to OSBA salary survey.)

Self-insurance approach

Self-insurance & a cap are incentives for Medford School District employees

The high administrative cost of a former plan was a prime reason Medford School District decided to change to self-insurance for its employee health plan.

"We thought we could do better," says Galen Anderson, director of business and facilities for the district.

They were right. The switch to self-insurance has saved the district an estimated half a million dollars in the two years since the change was made, Anderson reports.

Medford district employees have the same BlueCross BlueShield coverage they had previously, but now Associated Administrators Incorporated (AAI) administers the

plan, according to Anderson, "When a district is self-insured, it's a real incentive to keep costs down," Anderson says. "We're paying the bills ourselves, not just paying into a program, so we can see the results of our efforts to control costs." The district provides employees with regular information about using health care wisely. "We've learned you don't need to run to the doctor every time you have a sniffle, for example," Anderson says. "After two years, we are seeing the results of our hard work in educating employees about health care. Our insurance usage is way down from last year."

"In order to go self-insured, you must have at least 1,000 employees," explains board member Larry Nicholson. "If you have fewer employees than that, you'll need to team up with another district to self-insure."

Medford also put a cap on insurance costs two years ago. If the district's insurance costs increased more than 7 percent the first year (or 8 percent the second year, or 9 percent the third year), an automatic cap goes into effect, meaning all employees pay \$75 a month to offset the increase. (Because this is a before-tax program, the net cost to employees is \$62.)

This year, when an 8 percent increase could have kicked in the cap, costs went up only .6 percent. "That means the cap goes away effective with an employee's new insurance contract year," Anderson explains. The cap is another incentive to employees to keep costs down.

Medford maintains an excess insurance policy, separate from the regular employee health insurance plan, to cover catastrophic illnesses. If a person's medical costs exceed \$100,000, this policy kicks in. "In two years, we've had about a dozen situations where we needed excess insurance," Anderson says. "I'd encourage anyone considering self-insurance to carry excess insurance."

"Employees are well satisfied with their insurance in Medford," Anderson says. "In fact, 'health insurance' is a nice word down here."

If Medford stayed with its direct-write

plan, maximum district premium contribution would average \$800 per employee. By switching to self-insurance, the district kept the same benefit package at about \$730 per employee.

State Average: \$683 (Based on 133 responses to OSBA salary survey.)

Direct-write plans

Beaverton SD employs specialist to 'help employees help themselves'

Beaverton School District has a "strategic weapon" aimed at the often confusing, always changing target that is health insurance.

That weapon is Debbie Johnson. She's Beaverton's benefit management specialist.

Johnson, who has worked for the district since 1992, assists employees with managing their health benefits more effectively. She's a registered nurse with a case management background, and she says her goal is "to help employees help themselves."

With more than 3,600 employees, Beaverton's employee base is large enough for the district to create its own insurance plans with BlueCross and Kaiser Permanente. (Plans include BlueCross PPO Options 1 and 2, BlueCross BlueChoice, and Kaiser.) Plan rates are determined by factors including usage and comparisons with other large entities.

Educating employees about the importance of keeping insurance costs down is just one part of Johnson's job. She also helps employees choose the plan that works best for them, advocates for them when insurance issues arise, and offers one-on-one assistance and counseling. Offering district-wide clinics for mammograms and flu shots? That's part of a day's work for her, too.

"Employees may need different plans at different stages of their careers," she says. She can walk them through case scenarios from maternity care to retirement needs.

Johnson is a member of the Beaverton district's insurance council, which also includes teacher and classified representatives, administra-

Controlling costs – Continued

tors, and human resources representatives. Like insurance committees in about a third of Oregon's school districts, Beaverton's council keeps watch over everything from employee prescription drug usage to the frequency of trips to the emergency room. The council keeps track of cost lines and trends, and monitors the insurance cap and possible changes in plan design.

"We get a print out from BlueCross and Kaiser to see what our employees are using, monitor the data, then work with employees to teach them how to keep costs down," says Beaverton's business manager Linda Borquist. "You have to educate your employees and give them an incentive to watch costs." The district's cap on insurance benefits, in place for the past eight years, is a definite incen-

tive, she adds.

Education about insurance costs is an area Johnson focuses on intently. In counseling sessions, informational meetings and quarterly newsletters, she suggests how employees can keep watch over rising costs.

"I tell employees to look carefully at their medical bills, question their doctors about procedures, and continue to question costs. Employees often tell me that, when they question a bill, someone at the doctor's office will say, 'Why are you complaining about this? Your insurance will pay for it.'"

Johnson reminds everyone to "have a primary care doctor whether your plan mandates it or not. It can save money."

Board member Ann Jacks believes the district's benefit management specialist is key to keeping insurance

costs down. "Employees can contact her directly to talk things over and get ideas for cost-cutting measures they might not otherwise have thought of," she says. The specialist's services are always confidential and voluntary.

"Insurance companies tell us that there's something different about Beaverton School District," Johnson says. "Employees are always questioning doctors, medical costs, and the need for services."

By creating a district full of 'insurance watchdogs,' Beaverton is doing what it takes to challenge rising costs.

Beaverton's maximum monthly premium contribution: \$720 (starting 7/01/04; currently \$650)

State Average: \$683 (based on 133 responses to OSBA salary survey.)

Batten down the hatches: Engage employees

Do you know how much a routine visit to your doctor's office costs? Not your co-pay, but the actual cost billed to your insurance company.

If you're like most people, the answer is probably no. Consumers are largely unaware of the cost of health care services. Often, our only look at actual charges comes when we receive a copy of the bill after a major procedure or hospital stay. Talk about sticker shock!

Small, fixed co-pays and other benefit plan features isolate us from the actual cost of the health care we receive. The smaller the amount we pay at the doctor's office, the less likely we are to take cost into account when we decide whether to seek services.

Many health benefit experts believe this isolation from actual cost contributes to higher utilization of health care – and thus, higher cost for everyone. It's important to remember that sooner or later, we all share the cost, whether through premium

increases, higher deductibles, or larger co-pays.

Sharing the decisions with employees

Facing increasing costs and declining benefits, more employers now include employees in benefits planning. Sharing information about real costs and choices and inviting employees to participate in decision-making may reduce overall benefit costs and limit conflict during bargaining.

Clackamas County is one public employer that includes employees in the process. The county's Benefits Review Committee includes equal numbers of managers and union-represented staff. Each bargaining unit is represented by one voting member for each 200 union members.

The committee makes design decisions for medical, vision, dental, disability, and life insurance plans. With committee input, the county chooses a carrier, third party administrator, employee benefits consultant

Sharing information on real costs and having employees participate in making choices may reduce overall benefit costs and limit conflict during bargaining.

and optional benefit programs.

"Benefits are pulled out of the bargaining process," says Clackamas County Benefits Manager Carolyn Williams. "Plans are designed by the committee with equal representation from both sides, and then costs are negotiated with each union."

The committee was formed in the mid-1980s when the county's insurance carrier suddenly announced a 50 percent premium increase in the middle of a benefits period. Rather than pay the huge increase, the county redesigned its benefit plan and got new bids. Brought together by the crisis, management and unions sat down together to find a solution that works for both sides. The committee has continued through the years and enjoys a high level of support. Only one union – the county's deputy sheriffs – does not participate.



Tillamook:

Comparing benefits in the private sector

Dave Westmark has a big-picture view of the health-benefits controversy.

As a member of the Tillamook School Board, where he has served for the past 12 years, he helps negotiate benefits and other issues for that community's more than 200 school workers.

As vice president of human resources at Tillamook Cheese Inc., a post he has held since 1990, he designs and negotiates benefits programs for 550 union and non-union employees.

He calls health benefits "the Number One or Number Two negotiating item that people spend the most time on."

"Everyone knows the cost is going up and there's only 'X' amount of money to spend," Westmark says. "So, difficult decisions have to be made on both sides. Coming to a compromise is becoming more difficult."

Westmark has seen double-digit increases in health-benefits costs at Tillamook Cheese. As a result, he says, employees now pay more out of their own pockets and receive less company-paid coverage. Plans that once covered 100 percent of care now cover 80 percent. Also, employees are required to pay part of their premium.

For the future, Westmark expects to see increased use of higher deductibles and what are called health reimbursement accounts for his company's workers. He says employees might have to pay \$1,500 or more each year for health care – at least five times higher than their current deductibles – before their insurance would start picking up the tab. The high deductible would make it easier for the company's health-insurance provider to offer a lower premium.

To ease employees' financial pain, the company would contribute to an account that workers

could use for their care. A balance in a worker's account at the end of a year would be carried over into the following year, allowing the account to grow.

Westmark says that when employees have to pay more out of their pockets for health care, they become better consumers. He says employers need to support that change by providing – or by working with their insurance carriers to provide – solid information for employees on choosing doctors, hospitals, medicines and treatment methods.

Westmark says the private sector has a jump on school districts in this aspect of health benefits. He says school districts' history of providing

"The private sector has a jump on school districts in educating employees to be better health care consumers." – Dave Westmark, Tillamook Board Member

full coverage has shielded workers from most decisions about health-care costs.

He knows that the health-benefits issue raises difficult considerations for employers. Appearing to cut back on benefits can make it harder to keep and reward good workers. Nonetheless, he says, it's time for school districts to put more of the responsibility on their employees.

School workers, he says, "have to become more involved in making good decisions about their health care."



Involving your employees

How you explain and promote your insurance benefits helps employees become wiser consumers of health care.

Encouraging employees to "take care of themselves" may sound trite, but consider this: 50 percent of your health status is directly linked to behavior (only 20 percent is genetics; see chart

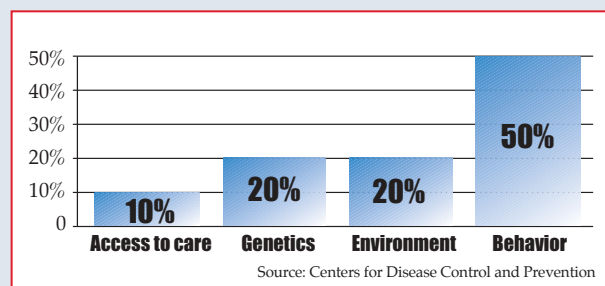
below.) And, unhealthy people use more health care services.

Do you have an employee wellness program, or incentives to encourage healthy lifestyles, weight loss and exercise? Because school boards often

reduced these programs during budget cuts, we've posted good strategies and "best practices" on OSBA's new Health Care Crisis Resource Page.

Continued on page 15

Factors influencing individual health



A look ahead:

Our approach to health care must change

Since 1997, health benefit costs have increased nearly 73 percent. If current trends continue, costs could more than double in the next five years. With these kinds of increases, is there any hope that we can sustain the present system? Not likely, experts say.

Although there is no widespread consensus on a solution, those who deal with the spiraling cost of benefits agree we must make fundamental changes in the way we view and use health care. And we must do it soon.

“There is a confluence of factors – a kind of ‘perfect storm’ – influencing the cost of health care today,” says Seth Garber, M.D. Garber works as a physician consultant to Mercer Human Resource Consulting and in the Quality Improvement Depart-

ment at Kaiser Permanente.

“Our population is aging, medical technology and drug development are advancing rapidly and people are living longer and using more medical services,” he says. “Plus, those services are more expensive than ever before.”

It’s not just a matter of the unit cost of a high-tech procedure, he adds. It’s also important to look at how many people are having the procedure. It’s the total cost of health care that employers – and employees – need to be concerned about.

All costs are shared costs

It’s obvious “we’re all in this together.” Part of every dollar employees and employers contribute to their health plans pay for the care of others: the uninsured, the underinsured, those covered by Medicare and Medicaid.

Hospitals and doctors must provide care, regardless of ability to pay. So they shift unpaid costs to their insured patients – resulting in about 7 percent more in premium costs per year.

The movement toward consumer-driven health plans is based on the premise that the more you know, the wiser your health care decisions will be. But when you’re on your way into the emergency room with a heart attack, you probably aren’t thinking about how much it will cost to keep you alive.

“Twenty percent of people spend 80 percent of the health care dollars,” Garber says. “Even if you teach them to be good consumers, a lot of their spending is not discretionary or subject to much change.”

How much is enough?

Garber points to several strategies that may help to get our health care spending under control – but they’re not easy to carry out, he says.

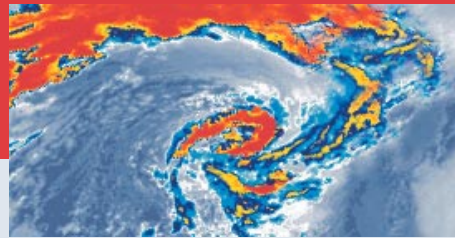
“First and perhaps most difficult, we need to decide how much is enough,” he says. “Should we do heart bypass surgery on an 80-year-old? Is it reasonable to provide the latest, high-cost drug when a generic may give the same results? Setting priorities for spending our limited resources is one of the most controversial aspects of health planning.”

“Our society highly values individual freedom,” Garber says. “We have a great tradition of protecting the sick and elderly. Costs will continue to rise, however, until we decide as a society that our current

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“Nobody spends somebody else’s money as carefully as they spend their own.”

— Milton Friedman, economist



Shaping consumer behavior

Other tips to engage employees in being more involved in controlling health care costs:

- Communicate *more* about health benefits and insurance costs. Explain what it actually costs per month to insure each employee and his/her family. Check OSBA’s Web resource page for ideas.
- Show how these costs have increased. You may learn that many employees don’t know these figures.
- Encourage employees to check medical bills for mistakes. This also helps them see how much care actually costs.
- Communicate true cost of health care – not just their “co-pay.”
- Reinforce the partnership – “we’re in this together.”
- Give employees more of a financial stake along with tools and resources to make informed decisions.
- Build incentives for efficient use of health care services.
- Explain how to *choose* a plan and how to *use* the plan effectively.
- Provide high quality choices with more opportunity to balance care, convenience and cost.





A look ahead – from page 15

level of knowledge and care is enough – and no one is willing to say that.”

True health maintenance

The second strategy for containing benefit costs is to provide comprehensive care for those with chronic conditions. Diabetics, heart patients, and others may avoid crises and spend less on care when they have the training, tools, medications, and encouragement to stay as healthy as possible.

Slowing the increase in costs isn't simply a matter of slashing benefits. Employers need to consider the value of having healthier employees.

Instead of depending on doctors to monitor their conditions, these patients can learn to take an active role in their own treatment. The sooner a problem is addressed, the less likely it is to become an emergency.

Healthy people can benefit from preventive care as well. Immunizations, prenatal care, regular checkups, and tests can help you avoid the chronic illnesses that plague so many older adults. A healthy diet, exercise, and keeping away from cigarettes

greatly increases your chances of living a longer, healthier life and using fewer expensive health services.

“We have to work on all segments of the population at once,” Garber says. “We can’t just focus on one group. The discussion needs to be less about how we are going to pay for care and more about how we are going to improve care for everyone.”

Despite the pressure to reduce costs by cutting benefits, Garber urges employers to look at the total value, rather than simply the cost of premiums. Better preventive care can result in less absenteeism, higher

productivity, and savings of both time and money.

For example, statistics show that most people with chronic asthma are under-treated.

Providing them with more and better medications will increase short-term health care costs. But those same people will be feeling better, less likely to take sick days or end up in the emergency room.

“Slowing the increase in costs isn’t simply a matter of slashing benefits,” Garber says. “Employers need to consider the value of having healthier employees. Sometimes you have to invest more to save money in the long run.”

Web resources & links from www.osba.org

A sample of what you’ll find online in OSBA’s new Health Care Crisis resource page:

- Facts and FAQs about OSBA’s Insurance Trust.
- *What’s Happening to the Cost of Health Care?* Report from Regence BlueCross BlueShield of Oregon.
- Strategies for bargaining insurance at the table from OSBA.
- Preliminary results from the 2003 Mercer Human Resource Consulting national health benefits survey.
- Cost-drivers behind skyrocketing health insurance premiums.
- School Personnel Online Tools (SPOT) for salary and benefits comparisons (members only access).
- Employee wellness resources and programs working in Oregon districts.
- Kaiser Family Foundation Health Insurance Study on cost increases.
- Presentation materials from OSBA’s Bargaining Insurance Workshop from Mercer Human Resource Consultant and OSBA Human Resource Development.

Find more resources on the Health Care Crisis page: www.osba.org



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