Soaring Health Insurance Costs Threaten Boston's Competitive Edge

Boston and Other Municipalities Face a Crisis of Unsustainable Cost Increases

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BOSTON MUNICIPAL RESEARCH BUREAU

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Executive Summary

Boston and other cities and towns in Massachusetts are facing a crisis of unsustainable increases in employee health insurance costs with no letup in sight. Boston's health insurance expenses have escalated by 92% in six years. These increases, along with rising costs for pensions, are absorbing a larger share of limited revenue growth, which means there are fewer resources for other services that impact the quality of life in Boston. Municipalities find themselves in a fiscal straightjacket, severely restricted in their ability to manage health benefit costs because of outdated state laws and practices and the requirement that health benefits be subject to collective bargaining. New accounting standards that stipulate municipalities must acknowledge the full financial liability of retiree health insurance will exacerbate this problem in future years. Boston cannot maintain its reputation as a competitive place to live, work, and invest if it is restricted from managing effectively in today's fiscal environment.

The new Massachusetts comprehensive health care legislation does not address soaring local health insurance costs. With this law now being implemented, the next Governor and Legislature should finish the job and act on the serious need for municipal health insurance reform. A first step would be to provide cities and towns with the same health insurance system that has been available to state employees since 1955. This report will focus on the City of Boston but the same principles and similar findings apply to all municipalities.

Highlights of the report's findings are:

- **Health insurance costs dominate budget growth**. The skyrocketing costs for Boston's health insurance have absorbed a larger share of the operating budget, leaving fewer resources for other services that impact Boston's competitive edge. Boston's health insurance spending, estimated at $235 million in fiscal 2007, increased by 92% over the past six years or 11% a year on average. All other operating spending excluding health insurance increased by 18% or 3% a year on average. As a result, the health insurance share of total operating spending increased from 7% to 11% during that period. After funding school, police, fire, and public works services, spending for all other departments in aggregate rose by only 2% over six years, but in constant dollars actually decreased by 12%. This year, health insurance increased by $25.1 million or 12%.

- **Health insurance spending is disproportionate.** Boston's health insurance spending represents a disproportionate share of the growth of its operating budget, tax levy, and state aid. The annual increase in health insurance costs absorbed more than one out of every five dollars of the total increase in the City's operating budget in four of the last six years. This year, the $25.1 million growth in health insurance represented 49% of the City's total operating budget increase. Health insurance absorbed between one-half and three-quarters of the 2.5% annual growth in taxes on

existing properties allowed under Proposition 2½ in each of the last four fiscal years. The increased cost of health insurance has exceeded the total growth in Boston's state aid in each of the last three fiscal years. The City's budget for General Fund state aid grew by $17.6 million this year.

- **Premium increases continue to escalate.** Yearly premium increases have raised the City's share of the average family health plan to nearly $14,000, an increase of 88% since 2001. Compared to the fiscal 2006 average single-family tax bill of $2,753, it takes five average taxpayers to pay the City's share of the average family health insurance premium for one city employee. Since fiscal 2001, premiums for all city plans have increased by 92% to 123%, with average annual increases ranging from 10% to 13% over six years.

- **The rules for state and municipal health insurance are drastically different.** Boston and other cities and towns are required to negotiate basically all aspects of employee health coverage with each of their unions, while the Commonwealth manages its health insurance outside of the collective bargaining process. The Group Insurance Commission (GIC), which is responsible for the Commonwealth's employee health insurance system, enjoys greater flexibility in plan design and in controlling costs. Over the past six years, the state's health insurance costs have increased by 61% compared to Boston's increase of 92%. Boston and other municipalities have far less control over plan design, and their ability to respond to changing conditions or new plan offerings in a timely manner is made more difficult by contract negotiations that occur only every three years. Had Boston's health insurance budget increase grown at the same rate as the Commonwealth's over the past six years, an additional $38 million would have been available for other city services.

- **Boston is unable to change with the health insurance market.** The restrictions placed on cities and towns in managing employee and retiree health benefits prevent them from responding to changes in the market on a timely basis. The City continues to offer a high-cost indemnity plan, while a recent survey of employer-sponsored health insurance by Mercer Consulting found that only 17% of employers in the Northeast who responded now offer such plans. Similarly, Boston covers 90% of the premium for its family and individual HMO plans. Other employers in the Northeast who share HMO costs with their employees pay an average of 71% for family plans and 77% for individual plans.

The skyrocketing increases for municipal health insurance costs, the restrictions constraining cities and towns in their attempts to control those costs, and the new requirement that the state and municipalities account for the full cost of retiree health benefits, all point to the necessity for reform of local health insurance. Without change, fewer resources will be available for other local services. This is the case not only in Boston, but in all municipalities throughout the Commonwealth. With that in mind, the Research Bureau makes the following recommendations.

Issue: **Lack of control over skyrocketing health insurance costs**.

Recommendations: **Boston and other cities and towns should be allowed to join the Group Insurance Commission.**

1. The state should enact legislation that would allow cities and towns to join the Group Insurance Commission (GIC). The GIC has the technical expertise to effectively manage the system and control costs. Health plans offered by the GIC are reasonably priced and offer more options than are provided by most municipalities.
2. Legislation allowing cities and towns to join the GIC should not require them to maneuver any additional hurdles, such as coalition bargaining. Requiring municipalities to negotiate with a committee of union representatives in order to enter the GIC would preclude several cities and towns from joining.
3. Joining the GIC will help mitigate annual cost increases, but in time the skyrocketing increases in health insurance costs and prudent funding of the extraordinary retiree health insurance liability will force a restructuring of the state and municipal health insurance systems in Massachusetts. A comprehensive standardized structure should be established for the Commonwealth and all municipalities to improve the management of health insurance costs while also addressing the multiyear funding of the retiree benefit liability.

Issue: **Local health insurance reform could take time to implement.**

Recommendations: **Boston can take steps now to improve the management and cost of its own health insurance system.**

The City should:

1. Adopt local option legislation that requires eligible retirees to enroll in Medicare to achieve significant premium savings. About 1,700 employees are Medicare eligible but enrolled in non-Medicare plans. This requirement would shift much of the cost of their health insurance onto the federal government.
2. Strengthen its internal capacity to be better managers and purchasers of health insurance plans.
3. Take steps to minimize prescription drug costs.
4. Evaluate self-insuring large HMO plans.

Issue: **There is a new requirement to acknowledge the full liability of retiree health benefits.**

Recommendations: **The City should establish a reserve for retiree health benefits.**

1. Boston should establish a separate reserve for retiree health benefits starting with its fiscal 2008 budget.
2. To create such a reserve, the Governor and Legislature should enact legislation authorizing cities and towns to establish a separate reserve and appropriate funds annually to pre-fund the payment of future retiree benefits already earned and being earned currently.

Introduction

Boston and other municipalities in Massachusetts are facing a crisis in funding and managing employee health insurance costs. Municipal health insurance cost increases are unsustainable and cities and towns are constrained in their attempts to control those costs. The current local health insurance system is broken. Furthermore, this situation will be exacerbated in the future by a new requirement that the state and municipalities account for the full cost of retiree health benefits. Meaningful reform of the system will be difficult to achieve through contract negotiations. Absent such reform, escalating health insurance costs will continue to absorb a larger and larger share of the City's annual operating revenues.

The impact of the surging costs of employee benefits was highlighted in a March 2006 Research Bureau report that showed that even when the City's workforce decreased by 1,176 positions or 6.7% over four years (2002-2006), spending for city employees increased by $187.5 million or 15.9% over the same period. The rising cost of employee benefits accounted for over two-thirds of this increase.

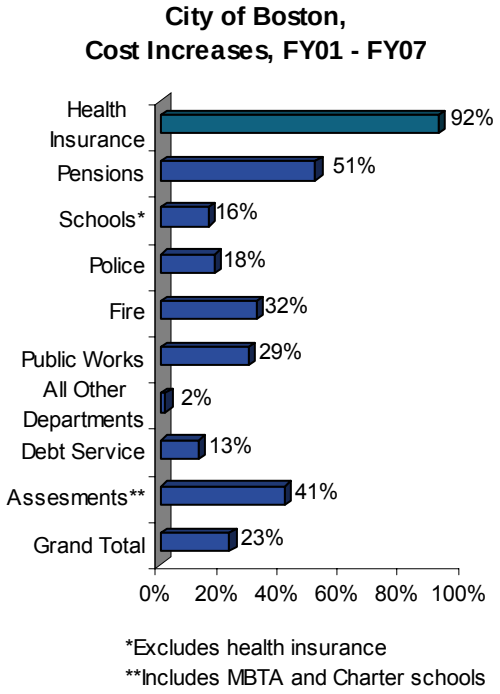
At the local level, all aspects of health insurance are subject to collective bargaining. At this point, the unions have little incentive to negotiate more than modest changes over time, but the ongoing escalation of health insurance costs will continue to squeeze city spending, including essential services and employee salaries. As a first step to reforming the system, Boston and other cities and towns should be allowed to join the state's health insurance system which operates free of the constraints of collective bargaining. In the end, a new standardized system to manage health care benefits for active and retired state and local employees will be needed.

Boston's Health Insurance

In fiscal 2006, approximately 28,600 subscribers were enrolled in the City's health insurance offerings, of whom 55% were active employees and 45% retirees. The City pays 90% of HMO premiums, 85% of POS premiums, and 75% of indemnity premiums, according to the negotiated contracts, while the employees pay the balance. The City pays the same percentage share for retirees, their spouses, and dependents, and it pays for 50% of retirees' Medicare Part B premiums.

The Rising Cost of Health Insurance

Continuing a six-year trend of double-digit increases, Boston's health insurance costs for city and school employees are expected to grow by $25.1 million, or 12%, to $234.8 million in fiscal 2007. In the six years since fiscal 2001, general fund spending for health insurance has escalated by 92.2%, or 11.1% a year on average. At the same time, all other operational city spending has



increased by only 17.7%, or 3.3% a year on average. As a result, health insurance has grown from 7% of the operating budget in fiscal 2001 to 11% in fiscal 2007.

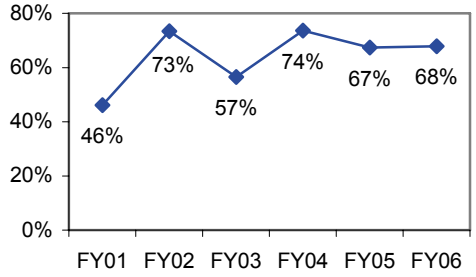
As spending for health insurance absorbs a growing share of the budget, fewer resources are available for other city services. Out of 61 budget accounts, the eight accounts of health insurance, pensions, debt service, state assessments, and the School, Police, Fire, and Public Works Departments represent 86% of the City's total operating budget. Spending for all other departments, in aggregate, has increased by just 1.7% in the last six years, but in constant dollars actually decreased by 11.5%

Health Insurance Spending vs. Total General Fund City Spending FY01 - FY07

Fiscal Year	Health Insurance Spending Increase	Total City Spending Increase	Health Insurance Increase as a % of Budget Increase
2001	$9,996,896	$110,232,248	9.1%
2002	16,839,065	66,627,671	25.3%
2003	13,729,358	51,448,050	26.7%
2004	19,047,825	27,277,116	69.8%
2005	18,438,711	83,690,516	22.0%
2006	19,483,355	118,298,994	16.5%
2007	25,136,089	51,737,423	48.6%

The escalating costs for health insurance represent a disproportionate share of the growth of the City's total operating expenses, tax levy, and state aid. In four of the last six years, the annual increase in health insurance costs absorbed more than 20% of the total increase in the City's operating budget, comprising as much as 69.8% of the increase in fiscal 2004. Health insurance absorbed between one-half and three-quarters of the 2.5% annual growth in taxes on existing properties allowed under Proposition 2½ from fiscal 2002 to fiscal 2006. As a percent of the gross property tax levy, health insurance

Health Insurance Growth as a % of the 2.5% Increase Under Proposition 2 1/2 FY01 - FY06



absorbed between 33% and 48% of the levy increase in each of the last four years. The increased cost of health insurance has exceeded the total growth in Boston's General Fund state aid for the last three years. In each of the previous two years, local aid was cut. In fiscal 2007, Boston's health insurance budget increased by $25.1 million while its state aid budget increased by $17.6 million.

Increasing Premiums — The rise in health insurance costs is driven by the yearly premium increases for each health insurance plan. Since 2001, premiums for all city plans have increased between 92% to 123%, with average increases ranging from 10% to 13% each year from 2001 to 2007. Although employees are responsible for a smaller share of these premiums, their costs have escalated at the same rate. The City estimates that it contributes $13,894 towards the average family health insurance plan and $5,029

Boston Health Insurance Yearly Family Premiums For Selected Plans

Plan	% Share	FY01	FY07	Change FY01-FY07
Blue Choice				
City Share	75%	$6,970	$15,511	122.5%
Employee Share	25%	$2,323	$5,170	122.5%
Harvard Pligrim HMO				
City Share	90%	$6,844	$13,105	91.5%
Employee Share	10%	$760	$1,456	91.5%

Boston's Health Plan Offerings

Boston offers a wide array of health insurance plans for its employees and retirees, allowing flexibility in plan choice based on the subscriber's needs. Current city employees have a choice of one traditional fee-for-service plan, two plans with both in-network and out-of-network alternatives, and three HMOs. Retirees and eligible surviving spouses or dependents of deceased employees can also enroll in these plans or, if eligible, in Medicare Parts A and B. The City offers several indemnity and HMO Medicare supplemental plans for retirees enrolled in Medicare Parts A and B to cover or subsidize services that are not fully covered by Medicare.

The majority of active employees are enrolled in managed care plans. Retirees are primarily enrolled in Medicare supplemental plans, with nearly half in Medicare indemnity plans. Of the retirees enrolled in managed care plans, the majority are in non-Medicare plans, likely due to the low premiums, deductibles, and co-payments offered by these plans. The City's indemnity plans are self-insured, meaning that the City pays for employee claims from appropriations through a Health Insurance Trust Fund, with the plans administered by Blue Cross Blue Shield of Massachusetts.

City of Boston
Health Insurance Enrollment FY06

Plan Type	Active	Retirees	All
Indemnity (Non-Medicare)	10.4%	18.0%	13.8%
Medicare Indemnity	-	48.8%	22.0%
Total Indemnity	10.4%	66.8%	35.8%
Managed Care (Non-Medicare)	89.6%	26.6%	61.2%
Medicare Managed Care	-	6.6%	3.0%
Total Managed Care	89.6%	33.2%	64.2%

While co-payments and deductibles vary by plan, for most plans there is no deductible for use of in-network services and a $10 co-payment for in-network office visits. The majority of the plans cover prescription costs through a two or three-tiered pricing structure and allow for mail order prescription purchases for supplies of up to ninety days.

towards the average individual health insurance plan. Since 2001, the City's contribution towards the average family premium increased by 87.8% while its contribution towards the average individual premium increased by 85.0%. Compared to the fiscal 2006 average single-family tax bill of $2,753, it takes five average taxpayers to pay the City's share of the average family health insurance premium of one city employee. It takes nearly two average taxpayers to pay for the City's share of one average individual health insurance premium.

Managing Health Insurance Costs

Boston is severely limited in its ability to control health insurance costs because of Massachusetts law, which defines health insurance as a condition of employment and thus subject to collective bargaining. Basically all aspects of employee health coverage are subject to negotiations. The City must negotiate every plan change with each of its bargaining units, including deductible and co-payment amounts, plan offerings, and the premium share to be paid by the City and its employees. Because health insurance is tied to collective bargaining, the City is only able to seek revisions every three years when a new employee contract is being negotiated. This delay precludes the City from responding to changing conditions or new plan offerings in a timely manner. Finally, decisions and regulations of the Massachusetts Labor Relations Commission (LRC) further restrict administrative efforts to manage costs. For

example, a 2002 LRC decision affirmed that the Town of Dennis needed to negotiate changes in employee prescription drug co-payments, even though the decision was made by a joint purchasing group of governmental employers, and not the town. Negotiating such changes can take multiple years to finalize, due to possible mediation, fact finding, and perhaps arbitration. The time taken in these steps can mean that the municipality misses the window of opportunity to make the changes sought.

A perfect example of the extreme difficulty of managing health care costs when having to negotiate any change with each employee union occurred in fiscal 2003 when Boston was facing severe local aid cuts. In an effort to control the premium increases that year, the City made a decision to reduce the number of HMO plans offered. City officials had informed the Insurance Advisory Committee, consisting of union representatives, of the planned change and offered to bargain, but the unions did not respond. The City discontinued offering two of its HMO plans, with the majority of subscribers in those plans moving into Harvard Pilgrim HMO. While the health benefits that were provided stayed the same, co-payments for doctor visits increased from $5.00 to $10.00. The consolidation saved the City $8 million that year and resulted in a lower premium for employees as well. Employees in family plans who were displaced and elected to join the Harvard Pilgrim HMO saved between $57 and $83 that year due to its lower premiums. Despite this fact, the police, fire, and teachers unions filed a grievance and unfair labor practice charges against the City that are still pending.

Currently, the predominant issue in the Menino Administration's negotiations with its employee bargaining units is greater control of health insurance spending. The Administration has presented the union negotiating teams with a series of options, including raising the employee share of premiums over the life of the contract and moving to less expensive plans. The outcome of this issue will likely determine the salary package that will be offered. However, past precedent indicates that more than modest change over time would be difficult to achieve.

The most recent health plan survey by Mercer Human Resources Consulting provides some perspective on how Boston compares with public and private employers in the Northeast. The survey found that only 17% of employers in the Northeast who responded continue to offer traditional indemnity plans, backing up other reports that private employers have moved away from indemnity plans in favor of managed care plans. In fact, a key tactic used by employers to manage premium increases has been to raise employees' out-of-pocket costs. According to the survey, in HMO plans in which employers and employees shared the premium, employers in the Northeast paid an average of 71% of the family plan premium and 77% of the individual plan premium. That compares with Boston's share of 90% for both family and individual HMO plans.

Retiree Health Insurance

The cost of retiree health insurance is becoming a larger share of municipal health insurance spending as employees retire earlier and live longer. One step that cities and towns can take to control their health insurance costs is to adopt, by local option, Chapter 32B, Section 18, which requires eligible retirees to enroll in Medicare. Essentially, this provision shifts much of the cost of providing retiree health insurance to the federal government. The Commonwealth adopted this requirement in 1991. The savings for Boston could be substantial, as the City estimates that approximately 1,700 Medicare eligible retirees are currently enrolled in non-Medicare plans. While this change has the potential to require some retirees to switch plans,

pay a higher premium each year, or pay more in co-payments and deductibles, the City has the ability to mitigate this cost-shifting while still generating substantial savings. The City of Springfield adopted this provision in 2005, saving an estimated $19 million in the first three years.

The savings for Boston could be substantial . . . 1,700 retirees are currently enrolled in non-Medicare plans and are Medicare eligible

Medicare Part A covers inpatient hospital care while Medicare Part B covers certain outpatient services, home care, and equipment. There is no retiree cost for Medicare Part A, while Medicare Part B requires a monthly premium payment of $88.50 in 2006. Although not required, it is the City's practice to pay 50% of the retiree's Part B premium. In addition, there is a late enrollment penalty for those who did not enroll in Medicare when first eligible, which must be paid by the City. The language of Chapter 32B, Section 18 protects retirees' health insurance benefits as they are shifted into Medicare by requiring that municipalities offer Medicare supplemental plans with no lesser benefits than are offered in active employee plans.

With the adoption of Section 18 and in accordance with the City's current contribution practices, retirees in indemnity plans would realize a considerable savings due to the Medicare supplemental plans' lower premiums, while retirees in HMO plans might have to pay more. However, the City could ease this burden by increasing its contribution to the Part B premium payment. Retirees might also be affected by Medicare supplemental co-payments and deductibles that are typically higher than in non-Medicare plans. However, the Medicare market is changing dramatically and plans that provide expanded coverage and increased flexibility are continuously being introduced.

Boston Sample Scenarios for the Adoption of Chapter 32B, Section 18

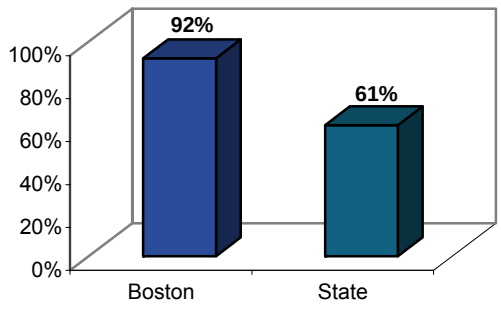
Non-Medicare Plan	Medicare Plan	Yearly Impact on City	Yearly Impact on Retirees
Master Medical	Blue Cross Supplement	$5,279 savings	$1,406 savings
Harvard Pilgrim HMO	Tufts Medicare Preferred	$2,818 savings	$159 additional cost
Harvard Pilgrim HMO	Tufts Medicare Complement	$1,079 savings	$352 additional cost

*Scenarios use FY07 individual plan rates and assume the City's continued payment of 50% of the Medicare Part B premium. Any late enrollment penalty is not included, but would be paid by the City. While only certain scenarios are listed, retirees would be able to enroll in any Medicare supplemental plan offered by the City.

State Health Insurance

In contrast to Boston and other Massachusetts municipalities, the Commonwealth does not negotiate its employee and retiree health insurance benefits with its unions. This difference allows the Commonwealth much greater flexibility in managing plan design and the associated costs. As a result, over the past six years, the state's spending for health insurance has risen only two-thirds as rapidly as Boston's, increasing by 61.2% versus the City's 92.2%.

Growth in Health Insurance Costs City vs. State, FY01-07



Other Post Employment Benefits

The new requirement for Boston to recognize the full cost of its retiree health insurance liability will exacerbate the fiscal strain caused by rising health insurance costs. Beginning in 2007, Boston will be required to report its liability for other post employment benefits (OPEB) for retirees, such as health and life insurance. The Governmental Accounting Standards Board (GASB) has established a new standard that requires the City to report in its fiscal 2007 financial statements the full and unfunded liability for these retiree benefits. The reasoning behind this new standard is that while these benefits are not received until retirement, they are, like pensions, a promise to current employees and are therefore a cost of providing service today.

Although legally required to pay for only 50% of retiree health insurance, Boston pays the same amount for its retirees as for its active employees. These benefits are funded on a pay-as-you-go basis (PAYGO), meaning they are paid for as the benefit is being used after retirement rather than as it is being earned during active employment. In recent years, expenditures for retiree health benefits have made up an ever larger share of the total health insurance expenditure. In fiscal 1999, retiree benefits accounted for 32.2% of the City's health benefit spending, but in fiscal 2007 spending for retiree health benefits comprises 37.0% of the total.

The GASB standard requires only that the OPEB liability be stated, not that it be funded. However, with the acknowledgement of a large unfunded liability, bond rating agencies will evaluate the City's response over the next few years. Actuarial retiree health care obligations will be viewed as "debt-like" in nature, similar to pensions. The rating agencies will consider how the City will manage these liabilities with particular attention to the City's financial flexibility and its ability to pay debt service on its bonds.

The financial implications for Boston of addressing this new requirement are not yet clear. However, information is emerging that indicates that the difference between financing these health benefits under the PAYGO method and a new advanced funding method, like the pension system, could result in spending two to three times the current level. The Office of the State Comptroller released a report in June 2006 estimating the Commonwealth's liability for retiree health benefits, life insurance, and dental/vision benefits at $7.6 billion, assuming pre-funding of costs. This estimate assumed that funds would be appropriated annually in a segregated reserve and that a return on investment would reduce the overall liability. The report estimated that with pre-funding, the cost of financing the OPEB liability in fiscal 2006 would have doubled what the state actually paid on the current PAYGO basis through the GIC. A doubling of Boston's retiree health benefit costs would have added an additional $87 million to the City's fiscal 2007 budget. The City is expected to release its actuarial analysis shortly that will provide a more precise estimate of its OPEB liability.

Since 1955, the Commonwealth's employee and retiree health insurance has been managed by the Group Insurance Commission (GIC), an autonomous 11-member body made up of administration officials, union and retiree representatives, and health policy experts. The GIC regulates health insurance costs by selecting health insurance plans and administratively adjusting plan design, including deductibles and co-payments, outside of the collective bargaining process. Decisions of the GIC on health insurance coverage are considered beyond the control of the Legislature and the Commonwealth as employer, and thus are not required to be negotiated.

The GIC has worked aggressively to control costs, at times implementing original and creative solutions. For example, in 2004 the GIC established a Clinical Performance Improvement initiative that ranks hospitals, physicians, and certain specialists based on quality and cost-

effectiveness in a tiered system. Employees are rewarded with lower co-payments when using more cost-efficient, quality providers, reducing their own out-of-pocket expenses. By drawing enrollees away from less efficient health care providers, Mercer, the GIC's consultant, estimates a cumulative savings of 20% over the first three years of the program that may translate into more than $75 million per year of combined savings for the Commonwealth and its employees and retirees.

The GIC also saves money through active management of its prescription drug program that promotes the purchase of mail order and generic drugs. For example, the GIC carves out the prescription drug portion of its indemnity plans to be administered by the pharmacy benefit manager Express Scripts. The GIC's prescription step therapy program encourages subscribers to try certain less expensive first-line drugs before trying the more expensive second-line alternatives. The generics preferred program gives subscribers a financial incentive to use generic rather than brand name drugs. In fiscal 2006, the GIC saved an estimated $5.2 million over the prior year through the generics preferred program. Due to the measures taken by the GIC, the prescription drug costs for its indemnity plans experienced no increase from fiscal 2005 to fiscal 2006.

The Commonwealth does not negotiate its employee and retiree health insurance benefits with its unions

In addition to these cost saving measures, in 2004, the GIC began self-insuring more of its health insurance plans, providing immediate cash-flow savings and ongoing risk premium savings. Finally, the GIC has assembled a vibrant health claims database that allows it to track spending and analyze health trends in order to identify opportunities to further control costs.

Had the City's health insurance costs increased by the same rate of increase as the state since 2001, the City would have saved nearly $38 million

The Legislature's role with state employee healthcare is to set the premium share paid by the state and its employees and retirees. Currently, the state pays 85% of the premium for all indemnity and managed care plans for active employees hired prior to July 1, 2003 and 80% of the premium for employees hired on or after that date. Similarly, the state pays either 90% or 85% of the premium for retirees, depending on the date of their retirement. In addition, the Legislature enacted Chapter 32A, Section 18 in 1991, requiring that all eligible state retirees enroll in Medicare. Retirees enrolling in Medicare plans rather than non-Medicare plans saved the state an estimated $156 million in fiscal 2006.

Had the City's health insurance costs increased by the same rate of increase as the state since 2001, the City would have saved nearly $38 million for needed services. This year, if Boston's health insurance budget increase of 12.0% had been the same as the Commonwealth's estimated increase of 8.9%, an additional $6 million would have been available, which could have helped fund new employee contracts or been used to hire 85 new police officers or 92 new teachers.

Local Health Insurance Reform

Skyrocketing health insurance costs and

restrictions on municipalities in their attempts to control those costs have led cities and towns to seek change at the state level. Recent proposals in the Legislature for comprehensive health care reform initially included initiatives that would have given cities and towns more flexibility and authority to manage health insurance costs. However, these sections were eliminated early in the process. The failure of these initiatives to gain passage has left municipalities without relief or direction.

Proposed Legislation — As an outgrowth of the Municipal Finance Task Force's September 2005 report *Local Communities at Risk*, a group of state, municipal, union, and GIC officials formed the Municipal Health Insurance Working Group to discuss municipal health insurance reform. The Group met for over ten months to develop consensus and prepare a bill that would allow a local option for cities and towns to join the state GIC while adding municipal labor and management representatives to the Commission. The reasoning behind this proposed legislation is that the GIC's health plans are both less expensive for the employer and employees, and the GIC offers more health plan options than are provided by most municipalities. The GIC has the technical expertise, with external consultants, to effectively mange the system and control costs. In addition, the GIC's professional staff provides excellent customer service.

The draft bill would require that municipal officials negotiate with unions in a process known as *coalition bargaining*. Authorized by MGL Chapter 32B, Section 19, coalition bargaining allows health insurance decisions to be made jointly by municipal officials and a public employee committee. Rather than bargaining with each union individually, the municipality would negotiate with them collectively through the committee in order to gain entry into the GIC. Any agreement made between the municipality and the committee would be binding on all active employees and retirees who receive their health insurance from the municipality. If no agreement can be reached, health insurance decisions would continue to be made through the collective bargaining process with each individual union.

The public employee committee would be comprised of union and retiree representatives. The retiree representative would have a 10% vote and the remaining 90% vote would be divided among the employee unions. Each collective bargaining unit would have a weighted vote according to the proportion of employees it represents who receive health insurance through the municipality. Any agreement with the municipality would require approval of 70% of the public employee committee. As shown below, the member distribution of this committee in Boston indicates that the Boston Teachers Union (BTU) would command a controlling vote of 39.4%.

City of Boston
Union Representation on the
Public Employee Committee

Union	Membership	%
Boston Teachers Union	7,172	39.4%
Police Unions (4)	2,093	11.5%
AFSCME	1,839	10.1%
SEIU	1,650	9.1%
Fire Union	1,543	8.5%
Retirees	-	10.0%
All Others	2,095	11.5%

According to the draft bill, municipal officials would work with the public employee committee in the coalition bargaining process to develop a written agreement that would specify the conditions for acceptance into the GIC, the procedures for resolving an impasse in negotiations, and the process for withdrawing from the GIC. Upon joining the GIC, the municipality and public employee committee must accept the GIC's health insurance offerings.

Municipalities must also enroll all eligible retirees in Medicare. Decisions regarding the percentage of the premium share to be paid by the city and the employees would be made through coalition bargaining. If the bill passed in fiscal 2007, the earliest Boston could join the GIC would be in fiscal 2009.

The City of Springfield will be the first municipality to join the GIC, beginning January 1, 2007, through emergency regulations issued by the GIC earlier this year. The new regulations allow communities under the authority of a Financial Control Board to purchase health insurance from the GIC. Springfield officials estimate that joining the GIC will result in savings in excess of $4 million annually.

If Boston were to join the GIC, it would achieve significant savings through the requirement of the GIC that all eligible employees enroll in Medicare. The City and its employees would also benefit by the GIC's lower premiums. An important reason for these lower premiums is differences in plan design, which can mean higher out-of-pocket expenses for employees, but at the same time, richer benefits. For example, were an employee to go from Boston's Harvard Pilgrim HMO family plan to the GIC's Harvard Pilgrim Independence Plan family plan, his or her monthly premium payment would drop from $121.32 per month to $108.90 per month. At the same time, the employee would have to pay $5 more for in-network doctor's visits and $5, $10, and $15 more for tier one, two, and three prescription drugs, respectively. However, the GIC's plan offers an out-of-network option not available to Boston employees unless they are enrolled in the City's high-cost POS or indemnity options.

Health Insurance Rate Comparison: Boston vs. State*

Boston		State	
Blue Cross Master Medical	$29,967	Commonwealth Indemnity Basic with CIC	$18,692
Blue Choice	$20,680	Commonwealth Indemnity Plan PLUS	$12,934
Harvard Pilgrim POS	$15,526	Harvard Pilgrim Independence Plan PPO	$13,068
Harvard Pilgrim HMO	$14,558	Neighborhood Health Plan	$11,577
Neighborhood Health Plan	$13,574		

*Comparison is of fiscal 2007 family plan total premium rates for selected health insurance plan offerings by Boston and the State. Plan design is not precisely comparable, as coverage, deductibles, and co-payments vary.

Recommendations

The skyrocketing increases for municipal health insurance costs, the restrictions constraining cities and towns in their attempts to control those costs, and the new requirement that municipalities account for the full cost of retiree health benefits, all point to the necessity for reform of municipal health insurance. Change of public employee health benefits will not be easily achieved and, at present, most union leaders have little incentive to negotiate more than modest reform measures over time. However, failure to act on this critical policy issue will continue the trend of escalating health insurance costs absorbing a larger share of total spending, resulting in fewer resources available for essential services and employee compensation. Tackling the larger, structural challenges of local insurance reform will require state action, but Boston can take steps to improve its management of health care spending as well. With that in mind, the Research Bureau makes the following recommendations.

I. Allow cities and towns to join the GIC.

The Commonwealth should enact legislation allowing cities and towns to join the Group

Insurance Commission. The Municipal Health Insurance Working Group's plan is a good starting point for the creation of such a law. Under this plan, municipalities would accept the GIC's health insurance offerings and comply with the requirement to enroll all eligible retirees in Medicare plans. The municipalities and their employees would benefit from the GIC's less expensive health and prescription drug plans, management and technical expertise, and excellent customer service. Decisions regarding premium share between the municipalities and their employees would continue to be decided through local negotiations.

However, legislation allowing cities and towns to join the GIC should not require them to maneuver any additional hurdles. The requirement of the Municipal Health Insurance Working Group's plan that each municipality negotiate with a committee of its union representatives in order to enter the GIC will prevent many cities and towns from taking advantage of the GIC's lower rates. According to the rules of coalition bargaining, 70% of the employee committee must approve the decision to enter the GIC, giving inordinate influence to a very small number of union representatives. In Boston's case, the Boston Teachers Union represents 39.4% of the committee vote and thus the President of the BTU alone can determine if Boston will join the GIC. In fact, the BTU President has indicated he would not support the City joining the GIC. Coalition bargaining was not a condition for the Commonwealth when it created the GIC for state employees in 1955 and it should not be a condition for cities and towns now.

Standardized Structure — Joining the GIC will help mitigate annual cost increases, but in time the skyrocketing increases in health insurance costs and prudent funding of the extraordinary retiree health insurance liability will need to be addressed through a more comprehensive standardized approach for the Commonwealth and all municipalities. A piecemeal system with some cities and towns joining the GIC and others not, depending on local negotiations, does not provide the foundation required to enable all cities and towns to meet the formidable challenges of management and funding of employee health insurance. A uniform health care policy for all public employees is essential to providing equity and improved cost management throughout Massachusetts. A statewide structure, similar to the Commonwealth's response to pension reform in 1988 involving state oversight and local or regional funding, would eliminate the stark contrast in how the state and municipalities provide and manage employee health insurance. A standardized structure would improve management of soaring health insurance costs through economies of scale while also addressing the retiree benefit liability through a multiyear funding schedule. Although implementation may come slowly through incremental steps, the economics of the health insurance cost trends are unsustainable and will eventually force a restructuring of the state and municipal health insurance systems in Massachusetts.

II. Anticipating that local health insurance reform could take time to implement, the Menino Administration should be proactive in taking steps to improve its management of the existing system and better control costs.

Currently in contract negotiations with its unions, the Administration has presented the union negotiating teams with a series of health insurance options in an effort to manage costs. One option has been to raise the employee share of health insurance premiums for managed care plans over the life of the contract. Another has been to replace high cost indemnity plans with lower cost options. Other initiatives, described below, should be implemented by the City or negotiated with union representatives. These

steps, which the City can take on its own, will help Boston improve its current management of health insurance costs, but they do not address the larger, fundamental structural challenge facing all cities and towns. The City should:

1. Require eligible retirees to enroll in Medicare.

Boston should accept the local option legislation (CH 32B, Section 18), which allows the City to require retirees to enroll in Medicare when they turn 65, which would provide substantial premium savings. This legislation shifts much of the cost of retiree health insurance onto the federal government. Retirees would receive no lesser benefit than those enrolled in non-Medicare plans. Adopting this recommendation would require adjustments in the early years, but it would provide sufficient savings in premiums to make the change worthwhile.

2. Strengthen its internal capacity to manage its health insurance system.

Given the magnitude of Boston's health insurance expenses, the City should enhance its internal technical and analytical capacity to become an even more sophisticated manager and purchaser of health plans. The City contracts with health care consulting firms for claims monitoring, technical, and strategic assistance, but it does not have in-house staff with the same technical expertise and internal access to data. Management of multiple health insurance plans and Medicare has become extraordinarily complex, resulting in most public entities relying on outside contractors for assistance. However, that complexity and the growth of health insurance to become the fifth largest budget item for Boston demand that the City take steps to strengthen its own internal technical and analytical capacity as well. While such changes will not result in savings on their own, they will provide the City with a greater ability to strategically target costs and, in combination with the other recommended changes, lead to increased efficiencies.

3. Take steps to minimize prescription drug costs.

First, the City should consider carving out the prescription drug benefit to be administered by a pharmacy benefit manager. Second, Boston should raise awareness and encourage use of the mail order prescription program through a direct mail advertising campaign. Finally, the City should explore the cost–saving prescription programs established by the GIC to determine which may be viable for the City.

4. Consider self-insuring larger HMO plans.

The City should evaluate whether changing a large HMO plan from fully-insured to a self-insured product would be financially beneficial. In a self-insured plan, the City pays for employee claims directly from appropriations through a trust fund. Increased self-insurance would provide immediate cash-flow savings, as claims are paid when due throughout the month, unlike fully-insured plans which require premiums to be paid in full at the beginning of each month. The City would also benefit from ongoing savings due to elimination of the risk premium charged by insurers. This change would also afford the City greater flexibility in plan offerings, since self-insured plans are not subject to oversight by the state Division of Insurance. Costs should be reviewed annually, in order to track the benefits of moving plans to self-insured status.

5. Reevaluate retirees' share of health care premiums.

The growing cost of health insurance and the demographic changes from the aging of the baby boomers make it necessary for Boston to evaluate its future financial obligation for retiree health insurance. The City should determine whether at some point in time it will need to

require retirees to pay a larger share of their retirement health insurance premiums. Any change in premium share should be bound by existing state law regarding the maximum percentage allowed to be paid by retirees.

III. Establish a reserve for retiree health benefits.

Boston should establish a separate reserve for retiree health benefits starting with its fiscal 2008 budget. To create such a reserve, the Governor and Legislature should approve legislation authorizing cities and towns to establish a separate reserve and appropriate funds annually to pre-fund the payment of future retiree benefits already earned and being earned currently. A bill enabling cities and towns to establish a separate reserve (H4887) is moving through the Legislature, but its requirement that municipalities adhere to a formal funding schedule at this early date will restrict its local acceptance. Other issues involving investment responsibility and investment vehicles also should be modified in this bill to make it practical for cities and towns. As a start, the bill should authorize municipalities to establish a separate reserve and use their discretion in funding the reserve until a more standardized funding schedule is established, similar to the pension system.

While the City is not legally obligated to initiate funding at this time, the OPEB liability is real and delay in the start of funding it will cause the liability to grow and require even larger payments in the future. If the City takes no action in funding this liability in a reasonable time, the liability will grow significantly and the credit rating agencies will take note of its impact on the City's financial flexibility.

Finally, the Governor and Legislature should establish a structure by which the Commonwealth will proceed to fund its OPEB liability with its higher annual costs over a period of time. This structure should also apply to local funding of the retiree liability for municipalities. The Comptroller's report makes it clear that a structure that involves pre-funding in an irrevocable trust and a higher assumed return on investments will result in a lower total liability.

Conclusion

Boston's employee health insurance will cost approximately $234.8 million this year and has increased as a percentage of total operating spending from 7% to 11% over the past six years. Health insurance is the City's fifth largest cost item, preceded only by spending for the School, Police, Fire, and Public Works Departments. This year, the $25.1 million rise in health insurance costs absorbed 48.6% of the City's total budget increase and exceeded the increase in General Fund state aid for Boston. Boston and other cities and towns find themselves in a fiscal straightjacket in their ability to manage health insurance costs. The current municipal health insurance system with its annual double-digit cost increases and retiree liability cannot be sustained. With the state's new comprehensive health insurance bill now being implemented, the new Governor and Legislature should finish the job and address the serious need for municipal health insurance reform.

City of Boston Health Insurance*
FY00 - FY07

	City	Boston Public Schools	Total	Change	% Change	Total City Spending	Change	% Change	Health Insurance as a % of Total City Spending	City spending less Health Insurance	Change	% Change
FY00	$79,326,103	$32,841,861	$112,167,964	-	-	$1,632,816,597	-	-	-	$1,520,648,633	-	-
FY01	87,232,847	34,932,014	122,164,861	$9,996,896	8.9%	1,743,048,845	$110,232,248	6.8%	7.0%	1,620,883,984	$100,235,352	6.6%
FY02	99,260,487	39,743,438	139,003,925	16,839,065	13.8%	1,809,676,516	66,627,671	3.8%	7.7%	1,670,672,591	49,788,606	3.1%
FY03	108,927,233	43,806,050	152,733,283	13,729,358	9.9%	1,861,124,566	51,448,050	2.8%	8.2%	1,708,391,283	37,718,692	2.3%
FY04	124,956,847	46,824,261	171,781,108	19,047,825	12.5%	1,888,401,682	27,277,116	1.5%	9.1%	1,716,620,574	8,229,291	0.5%
FY05	139,104,893	51,114,926	190,219,819	18,438,711	10.7%	1,972,092,198	83,690,516	4.4%	9.6%	1,781,872,380	65,251,805	3.8%
FY06	151,575,199	58,127,975	209,703,174	19,483,355	10.2%	2,090,391,193	118,298,994	6.0%	10.0%	1,880,688,019	98,815,640	5.5%
FY07**	168,525,434	66,313,829	234,839,263	25,136,089	12.0%	2,142,128,616	51,737,423	2.5%	11.0%	1,907,289,353	26,601,334	1.4%
Change FY01-07	$81,292,587	$31,381,815	$112,674,402	Average Annual Increase		$399,079,771	Average Annual Increase			$286,405,369	Average Annual Increase	
% Change	93.2%	89.8%	92.2%	$17,524,471	11.1%	22.9%	$72,758,860	4.0%		17.7%	$55,234,389	3.3%

* Includes dental, life and some administrative costs. Does not include the Public Health Commission

** Budgeted

Source: City of Boston Financial Reports and Budgets

Health Insurance Costs: City vs. State
FY01 - FY07

	Boston			State		
	Health Insurance Costs*	Change	% Change	Health Insurance Costs**	Change	% Change
FY01	$122,164,861	$9,996,896	8.9%	$605,596,955	$50,217,248	9.0%
FY02	139,003,925	16,839,065	13.8%	676,102,421	70,505,466	11.6%
FY03	152,733,283	13,729,358	9.9%	694,982,613	18,880,192	2.8%
FY04	171,781,108	19,047,825	12.5%	737,289,523	42,306,910	6.1%
FY05	190,219,819	18,438,711	10.7%	785,103,811	47,814,288	6.5%
FY06	209,703,174	19,483,355	10.2%	896,010,107#	110,906,296	14.1%
FY07* **	234,839,263	25,136,089	12.0%	976,037,643^	80,027,536	8.9%
FY01-07		$112,674,402	92.2%		$370,440,688	61.2%

* City total includes health, dental, and life insurance and some administrative costs. Does not include the Public Health Commission.

** State total is the 1108-5200 line item and includes health and life insurance and some administrative costs, except where otherwise noted.

*** Budgeted

Estimate from the GIC assumes $55 million reversion to the General Fund in FY 2006 due to lower than anticipated expenditures.

^ Estimate from the GIC assumes approximately 9% increase in overall expenditures but is not reflective of actual projections using FY 2007 premiums, which were developed prior to $55 million reversion was made known.

Source: City of Boston Financial Reports and FY07 Budget, The Group Insurance Commission

Boston's Health Insurance Costs vs. General Fund State Aid

	Health Insurance	Increase	Percent	State Aid	Increase/ (Decrease)	Percent	Health Insurance Growth Over/(Under) State Aid Growth
FY00	$112,167,964			$531,003,677			
FY01	122,164,861	$9,996,896	8.9%	547,060,859	$16,057,182	3.0%	($6,060,286)
FY02	139,003,925	16,839,065	13.8%	567,999,659	20,938,800	3.8%	(4,099,736)
FY03	152,733,283	13,729,358	9.9%	530,323,808	(37,675,851)	-6.6%	51,405,209
FY04	171,781,108	19,047,825	12.5%	521,232,197	(9,091,611)	-1.7%	28,139,436
FY05	190,219,819	18,438,711	10.7%	537,654,991	16,422,794	3.2%	2,015,917
FY06	209,703,174	19,483,355	10.2%	549,777,236	12,122,245	2.3%	7,361,110
FY07*	234,839,263	25,136,089	12.0%	567,376,915	17,599,679	3.2%	7,536,410

*Budgeted

Source: City of Boston Financial Reports and FY07 Budget

Boston's Health Insurance Growth vs. Prop 2 1/2 Growth and Gross Levy Growth

	Health Insurance Growth	2.5% Property Tax Growth	Health Insurance Growth as a % of 2.5% Property Tax Growth	Growth in Gross Property Tax Levy	Health Insurance Growth as a % of Gross Levy Growth
FY01	$9,996,896	$21,646,649	46.2%	$51,713,640	19.3%
FY02	16,839,065	22,943,749	73.4%	54,733,111	30.8%
FY03	13,729,358	24,315,800	56.5%	63,218,349	21.7%
FY04	19,047,825	25,890,252	73.6%	58,278,625	32.7%
FY05	18,438,711	27,352,934	67.4%	56,440,107	32.7%
FY06	19,483,355	28,730,754	67.8%	57,589,281	33.8%

Source: City of Boston Financial Reports

City of Boston
Budget Comparison, FY01 - FY07

	FY 2001	FY2007 Budget	Change FY01-FY07	% Change
Health Insurance	$122,164,861	$234,839,263	$112,674,402	92.2%
Pensions	127,475,188	192,917,967	65,442,779	51.3%
Public Works	76,113,088	98,181,853	22,068,765	29.0%
Fire	116,858,507	153,780,313	36,921,806	31.6%
Police	214,286,307	252,164,016	37,877,709	17.7%
Schools*	576,993,098	668,186,171	91,193,073	15.8%
All Other Departments	270,462,833	275,098,400	4,635,567	1.7%
Assesments**	88,680,124	125,138,213	36,458,089	41.1%
Debt Service	106,179,315	119,635,420	13,456,105	12.7%
Other Spending	43,835,525	22,187,000	-21,648,525	-49.4%
Grand Total	**$1,743,048,845**	**$2,142,128,616**	**$399,079,771**	**22.9%**

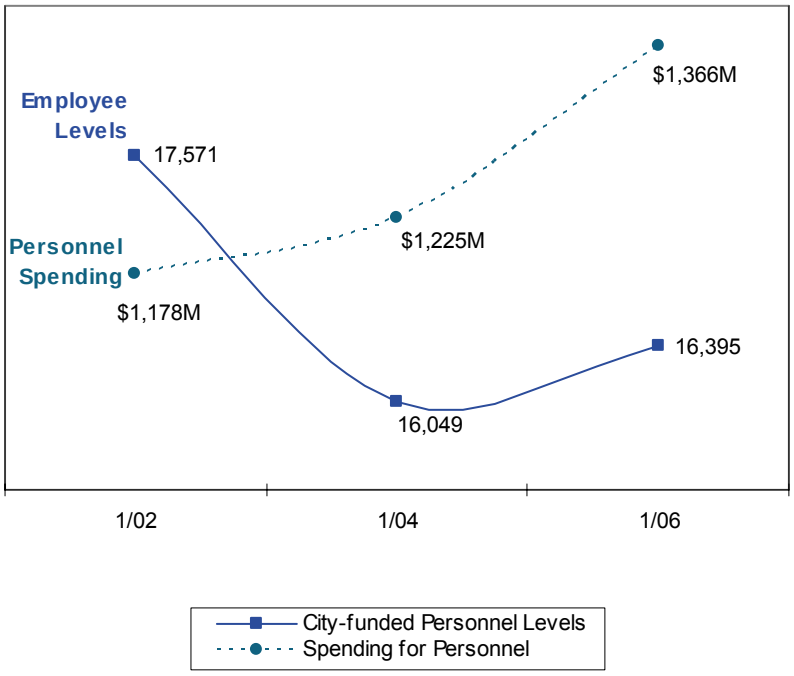
*Net health insurance
**Includes MBTA and Charter schools

Source: City of Boston Financial Reports and FY07 Budget

Appendix D

The graph below, from the Research Bureau's March 15, 2006 report, *Boston's Personnel Spending Surges Despite Employee Cuts*, demonstrates that while Boston's workforce decreased by 1,176 positions, or 6.7%, from 2002 to 2006, spending for city employees increased by $187.5 million, or 15.9%, over the same period. The rising cost of employee benefits, including health insurance, accounted for over two-thirds of this increase.

City of Boston
Personnel Levels and Personnel Spending



Source: City of Boston Personnel Reports and Financial Reports

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