BOSTON MUNICIPAL RESEARCH BUREAU

Massachusetts Taxpayers Foundation

Municipal Health Reform: Seizing the Moment

A joint report by the

Boston Municipal Research Bureau

and

Massachusetts Taxpayers Foundation

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Introduction

Beginning in fiscal 2009, Massachusetts cities and towns will have the option to join the health insurance system that has been in place for Commonwealth employees since 1955. On July 25, 2007, the Governor signed a new law (Chapter 67 of the Acts of 2007) which is designed to provide communities with some relief from the pressures of rapidly rising health insurance costs. If municipalities take advantage of this new legislation, they stand to save substantially due to the bargaining power and flexibility in management practices of the Group Insurance Commission (GIC), which oversees the state employee health insurance program. The Boston Municipal Research Bureau (BMRB) and the Massachusetts Taxpayers Foundation (MTF) have worked together to prepare this report which estimates statewide savings if all cities and towns were to join the GIC. Such figures have been absent from the policy debate to date.

This study has found that municipalities across the state stand to save as much as $100 million in fiscal 2009, $750 million in fiscal 2013, and $2.5 billion in fiscal 2018. To capture these potential savings each city and town would need to begin immediately to negotiate the conditions for acceptance with a public employee committee comprised of union and retiree representatives. A municipality would have to reach agreement with the public employee committee and notify the GIC by October 1, 2007 of its intention to join on July 1, 2008 (fiscal 2009). This coalition bargaining process may prove to be a stumbling block for many municipalities, making it difficult for them to take advantage of this legislation in the near future. However, since the potential savings from municipalities joining the GIC dwarf the other components of the Governor's Municipal Partnership Act, Massachusetts policymakers should monitor the results of this legislation and be prepared to take stronger action to ensure that it achieves its potential.

Impact of Escalating Municipal Health Insurance Costs

Cities and towns across the Commonwealth are facing budgetary strains resulting, in large part, from dramatic increases in health insurance costs coupled with limited revenue growth. Health insurance costs are absorbing a growing percentage of total municipal spending, leaving fewer resources for basic municipal services and leading to higher property taxes. The findings of both a 2005 MTF report[1] and a 2006 BMRB report[2] underscored the urgency of addressing exploding health insurance costs:

- From fiscal 2001 to 2004, the annual growth in health insurance costs of municipal employees *exceeded* the allowable 2.5 percent growth in local taxes in the existing property base by 8 percent a year on average. The health care increases also comprised 54 percent of the overall growth in local property taxes, including revenue received from new construction and overrides. In Boston, the health care cost increases from fiscal 2001 to 2007 comprised 68 percent of allowable growth in the existing base and 31 percent of overall growth in local property taxes.

- Health care costs for municipal employees jumped 63 percent from fiscal 2001 to 2005, while municipal budgets increased 15 percent. Boston's employee health care costs increased 92 percent from fiscal 2001 to 2007 compared to an 18 percent increase in all other operational spending.

- Local employee health care costs increased from 7.4 percent to 10.6 percent of municipal budgets from fiscal 2001 to 2005, putting more pressure on other important areas such as schools, police, fire, and public works. In Boston, from fiscal 2001 to 2007, health care costs as a proportion of the budget increased from 7 percent to 11 percent.

[1] "A Mounting Crisis For Local Budgets: The Crippling Effects of Soaring Municipal Health Costs," July 2005.
[2] "Soaring Health Insurance Costs Threaten Boston's Competitive Edge," November 2006.

- In comparison to the health care cost increases of 84 percent for municipal employees and 72 percent for Boston employees from fiscal 2001 to 2006, the state's employee health care costs, as managed by the GIC, increased only 47 percent.

- The Governmental Accounting Standards Board (GASB) has established a new standard that requires each municipality to report its full and unfunded liability for retiree health benefits (OPEB). This new requirement increases the need for effective measures that address future health care costs.

The Group Insurance Commission

The GIC enjoys two principal advantages that allow it to continuously outperform cities and towns—size and flexibility. With 286,000 state workers and retirees,[3] the GIC enrollees far outnumber enrollees in any city or town, and in most cases, the GIC is among a health insurance provider's biggest customers. The GIC's size allows it to benefit from a stronger negotiating position with health insurance providers.

The GIC also benefits from greater managerial flexibility than Massachusetts law permits for cities and towns. The GIC is able to use this flexibility to be creative and innovative in controlling its costs, while cities and towns are severely limited by the requirement that all aspects of employee health insurance—including plan offerings, deductibles, co-payments, and the percentage of the premium share paid by the employee—must be negotiated with each individual union. This requirement prevents cities and towns from responding quickly to changing market conditions. In contrast, the Commonwealth does not negotiate its employee and retiree health insurance benefits with its unions; the GIC selects health insurance plans and adjusts plan design, including deductibles and co-payments, outside of the collective bargaining process.

The GIC has been able to implement cost saving techniques not available to cities and towns. Efforts such as the Clinical Performance Improvement Initiative, the prescription step therapy program, and the Generics Preferred Program help the GIC to steer its subscribers toward more cost-effective options. The GIC has also assembled a health claims database that allows it to track spending and analyze health trends in order to identify opportunities to further control costs. In addition, the state requires all eligible retirees to enroll in Medicare, transferring much of the cost of their health insurance to the federal government.

GIC Legislation

The Legislature and Governor recently enacted a law to help cities and towns control their health insurance expenses by joining the GIC through local option. The legislation requires that municipal officials employ a process known as coalition bargaining to negotiate with union and retiree representatives to determine the conditions for entering the GIC. Rather than bargaining with each union individually, the municipality would negotiate with them collectively through a public employee committee. The committee would be comprised of union and retiree representatives, with the retirees having 10 percent of the vote. Each collective bargaining unit would receive a weighted vote according to the proportion of employees represented in the municipality's health plans. Agreement to enter into the GIC would require approval of 70 percent of the public employee committee. Municipal officials would be required to negotiate with the employee committee to develop a written agreement that would specify the conditions for acceptance into the GIC, the procedures for resolving an impasse in negotiations for a

[3] Source: Group Insurance Commission. This figure includes Springfield employees, who joined the GIC due to Springfield's financial crisis.

successor agreement, and the process for withdrawing from the GIC.

Upon entering the GIC, municipalities must accept the GIC's health insurance offerings and remain in the GIC for a minimum of three years. Eligible municipal retirees would be required to enroll in Medicare. Decisions regarding the percentage of the premium paid by the municipality would continue to be made through negotiations with the unions in the coalition bargaining process. The GIC plans, which may vary in design and coverage from municipal health insurance plans, typically have lower total premiums and higher co-payments than comparable plans currently offered by municipalities. However, the GIC offers nine regular health insurance plans and six Medicare supplemental plans, which would give municipal employees a wide variety of options from which to choose. They would also benefit from the GIC's excellent customer service.

The legislation is a significant step forward in giving municipalities the potential to join the GIC. However, the coalition bargaining process and the required 70 percent approval may pose a significant obstacle for many cities and towns to achieve timely relief. Reaching an agreement over contract language changes or other benefits besides health insurance while obtaining 70 percent approval from the public employee committee will be difficult for many municipalities to accomplish. The GIC requires municipalities to inform them by October 1, 2007 of their intent to join the GIC starting in fiscal 2009. Communities that fail to meet this deadline will be unable to gain entry until fiscal 2010 or later. To realize the greatest savings, municipalities must join the GIC as soon as possible, but the coalition bargaining provision may impede many from doing so.

Estimated Savings

This study finds that if all municipalities were to join the GIC they could save between $436 million and $764 million in fiscal 2013 and between $1.4 billion and $2.5 billion in fiscal 2018 (see Table 1).

The estimated savings are based on an analysis of the comparative rates of growth of municipal and GIC costs between 2001 and 2006. During this period, municipal health care costs grew

Table 1

Estimated Savings for Municipalities by Joining the GIC

Based on a Comparison of Municipal and GIC Rates of Growth

(Figures in Millions)

Fiscal Year	A Municipalities do not join the GIC - 13% annual increase	B Municipalities join the GIC - 8.1% annual increase	C Annual Savings	D Percentage Savings	E Municipalities do not join the GIC - 11% annual increase	F Municipalities join the GIC - 8.1% annual increase	G Annual Savings	H Percentage Savings
2008	$2,086.8	$2,086.8	-	-	$2,086.8	$2,086.8	-	-
2009	2,358.1	2,255.8	$102.3	4.3%	2,316.4	2,255.8	$60.5	2.6%
2010	2,664.6	2,438.6	226.1	8.5%	2,571.2	2,438.6	132.6	5.2%
2011	3,011.0	2,636.1	375.0	12.5%	2,854.0	2,636.1	217.9	7.6%
2012	3,402.5	2,849.6	552.9	16.2%	3,167.9	2,849.6	318.3	10.0%
2013	3,844.8	3,080.4	764.4	19.9%	3,516.4	3,080.4	436.0	12.4%
2014	4,344.6	3,329.9	1,014.7	23.4%	3,903.2	3,329.9	573.3	14.7%
2015	4,909.4	3,599.7	1,309.8	26.7%	4,332.5	3,599.7	732.9	16.9%
2016	5,547.7	3,891.2	1,656.4	29.9%	4,809.1	3,891.2	917.9	19.1%
2017	6,268.9	4,206.4	2,062.4	32.9%	5,338.1	4,206.4	1,131.7	21.2%
2018	7,083.8	4,547.1	2,536.7	35.8%	5,925.3	4,547.1	1,378.2	23.3%

84.4 percent (13.0 percent annually) while GIC costs grew 47 percent (8.1 percent annually).[4] The estimated annual savings based on this difference of 4.9 percentage points are $764 million in fiscal 2013 and $2.5 billion in fiscal 2018 (Column C).

Recognizing that municipal health care costs could grow more slowly in future years, we have also calculated the savings based on an annual differential of 2.9 percentage points (11 percent annual growth for municipalities and 8.1 percent for the GIC). This more conservative estimate shows savings of $436 million in fiscal 2013 and $1.4 billion in fiscal 2018 (Column G).

What is striking about this analysis is how quickly and dramatically the savings grow. Under the first scenario, the savings jump from 4 percent in fiscal 2009 to 20 percent in fiscal 2013 and 36 percent in fiscal 2018 (Column D). For the more conservative scenario, savings grow from 3 percent in 2009 to 12 percent in fiscal 2013 and 23 percent in fiscal 2018 (Column H).[5]

The above estimates are aggregate figures based on the assumption that all of the Commonwealth's cities and towns join the GIC. Impacts on individual cities and towns would vary widely, and not every city and town would save money by entering the GIC.

The immensity of the savings can also be seen by considering health care costs as a share of municipal budgets and property tax revenues. If health care costs increase 11 to 13 percent annually, they will consume an estimated 19 to 23 percent of municipal budgets in fiscal 2018, compared to 10 percent today. However, when using the GIC's 8.1 percent annual rate of increase, health care costs will consume only an estimated 15 percent of municipal budgets in fiscal 2018.[6] Similarly, we estimate that 11 to 13 percent annual increases will cause health care expenditures to consume 30 to 36 percent of property tax revenues in fiscal 2018, a much greater proportion than today's 19 percent. If cities and towns join the GIC, we estimate that health care costs will consume 23 percent of property tax revenues in fiscal 2018.[7]

Table 2
Estimated Health Care Costs Compared to Total Municipal Budgets and Property Tax Revenue

	Health care costs as % of municipal budgets	Health care costs as % of property tax revenue
Fiscal 2006	10%	19%
8.1% annual increase until fiscal 2018	15%	23%
11% annual increase until fiscal 2018	19%	30%
13% annual increase until fiscal 2018	23%	36%

As significant as these savings are, it must be noted that even under the GIC's lower estimated rate of increase (8.1 percent), health care expenditures would continue to consume an even larger share of municipal budgets and property tax revenues. Therefore, as important as it is for municipalities to join the GIC, other steps will need to be taken to bring health care costs under control and provide ongoing property tax relief.

Nevertheless, the potential savings in joining the GIC dwarf the estimated impact of the other components of the Municipal Partnership Act. For example, two proposed revenue options—the inclusion of telecommunications equipment on the property tax rolls and a 2 percent local options meal tax—would combine

[4] See Appendix A for 2001-2006 health cost data.
[5] Percentage savings are calculated by comparing annual savings through joining the GIC (Columns C and G) with what costs would be without joining the GIC (Columns A and E).
[6] See Appendix B for projections of health costs relative to municipal budgets.
[7] See Appendix C for projections of health costs relative to property tax revenues.

to generate an estimated $400 million in 2013 and $500 million in 2018.[8] Cost savings from joining the GIC would be three to five times greater than revenues from these two options in 2018. While cities and towns will have to take several actions to address the budget crisis presented by rising health care costs, the magnitude of savings by joining the GIC should establish this as the top priority.

Conclusion and Recommendation

The legislation signed by the Governor is an important step towards addressing the problem of skyrocketing health insurance costs for the Commonwealth's cities and towns. However, as we have discussed above, there is an urgency in joining the GIC so that cities and towns can realize the greatest savings, and we are concerned that this legislation may not go far enough to address this reality.

Accordingly, we recommend that the Secretary of Administration and Finance and the respective Chairs of the House and Senate Ways and Means Committees evaluate the participation rate of municipalities joining the GIC immediately following the October 1, 2007 deadline. Specifically, the leadership should determine whether the legislation needs to be modified to allow more municipalities to benefit from participation in the GIC. If the evaluation shows that too few communities have been able to negotiate entry into the GIC and health insurance costs continue their rapid ascent, then the coalition bargaining requirement should be removed from the process of joining the GIC. For example, by giving the power to join the GIC to the mayor and city council in a city and the board of selectmen in a town, more municipalities would likely enter the GIC and achieve the potential savings.

Estimates of likely savings to municipalities in joining the GIC have been absent from discussions centered on how best to assist cities and towns in controlling their health insurance costs. Given the new findings of this report, sustained efforts must be made to ensure that municipalities actually join the GIC. If few communities receive the promised benefit, bolder action should be taken to benefit a larger share of the Commonwealth's cities and towns.

Chapter 67 of the Acts 2007 should not be seen as a panacea for all cities and towns burdened by municipal health insurance. Allowing entry into the GIC to help control local health insurance cost increases is just the first step. A more difficult problem facing the state and municipalities is the funding of the growing retiree health insurance liability (OPEB). In time, this problem will require a total restructuring of the state and local health insurance system in Massachusetts with far tougher policy choices. With OPEB on the horizon, municipal health insurance relief is all the more important for communities to achieve now.

[8] Governor Patrick's administration estimates that a 2 percent meals tax would raise $240 million statewide annually and the change in the telecommunications property tax would raise $78 million annually (source: http://devalpatrick.com/mpa.php?about=1). The fiscal 2013 and 2018 estimates of $400 and $500 million assume that meals tax revenue will grow by 5 percent annually and that the telecommunications property tax revenue will remain at $78 million per year.

Appendix A

As indicated in the table below, over the 2001-2006 period, statewide municipal expenditures on employee health care increased by 84.4 percent. Over the same period, the Commonwealth's expenditures on employee health care under the GIC increased by a far more modest 47 percent.

Municipal vs. State Health Insurance Costs

Fiscal 2001 - 2006

Fiscal Year	Total MA Municipal Health Insurance Costs	Percentage Change from Previous Year	GIC Health Insurance Costs	Percentage Change from Previous Year
2001	$886,462,351	-	$605,596,955	-
2002	1,028,585,452	16.0%	676,102,421	11.6%
2003	1,185,928,190	15.3%	694,982,613	2.8%
2004	1,313,050,960	10.7%	737,289,523	6.1%
2005	1,439,142,951	9.6%	785,103,811	6.5%
2006	1,634,274,679	13.6%	890,484,724	13.4%
2001-2006 Change	$747,812,328	84.4%	$284,887,769	47.0%
Average Annual Increase		13.0%		8.1%

Source: Massachusetts Department of Revenue, Division of Local Services

Appendix B

The first table below (Municipal Budget Projections) estimates total municipal budgets for fiscal 2007-2018 using the 2001-2006 average annual increase of 4.2 percent. The second table (Projection of Health Insurance Costs as a Percentage of Municipal Budgets) uses those estimates to project health insurance as a percent of municipal budgets.

Municipal Budget Projections

Fiscal Year	Total Municipal Budgets (actual)	Percentage Change from Previous Year
2001	$15,334,730,000	
2002	16,206,740,000	5.7%
2003	16,607,574,000	2.5%
2004	17,054,544,000	2.7%
2005	17,885,866,000	4.9%
2006	18,826,543,000	5.3%
2001-2006 annual average		4.2%

Source: Massachusetts Department of Revenue, Division of Local Services

Fiscal Year	Total Municipal Budgets (estimated at 4.2% annual growth)
2007	$19,617,257,806
2008	20,441,182,634
2009	21,299,712,304
2010	22,194,300,221
2011	23,126,460,831
2012	24,097,772,185
2013	25,109,878,617
2014	26,164,493,519
2015	27,263,402,247
2016	28,408,465,141
2017	29,601,620,677
2018	30,844,888,746

Projection of Health Insurance Costs as a Percentage of Municipal Budgets

Fiscal Year	Total Municipal Budgets (estimated)	Health Care Costs, 8.1% Annual Increase	% of Municipal Budgets	Health Care Costs, 11% Annual Increase	% of Municipal Budgets	Health Care Costs, 13% Annual Increase	% of Municipal Budgets
2008	$20,441,182,634	$2,086,805,338	10.2%	$2,086,805,338	10.2%	$2,086,805,338	10.2%
2009	21,299,712,304	2,255,836,570	10.6%	2,316,353,925	10.9%	2,358,090,032	11.1%
2010	22,194,300,221	2,438,559,332	11.0%	2,571,152,857	11.6%	2,664,641,736	12.0%
2011	23,126,460,831	2,636,082,638	11.4%	2,853,979,671	12.3%	3,011,045,161	13.0%
2012	24,097,772,185	2,849,605,332	11.8%	3,167,917,435	13.1%	3,402,481,032	14.1%
2013	25,109,878,617	3,080,423,364	12.3%	3,516,388,353	14.0%	3,844,803,566	15.3%
2014	26,164,493,519	3,329,937,656	12.7%	3,903,191,072	14.9%	4,344,628,030	16.6%
2015	27,263,402,247	3,599,662,606	13.2%	4,332,542,090	15.9%	4,909,429,674	18.0%
2016	28,408,465,141	3,891,235,277	13.7%	4,809,121,719	16.9%	5,547,655,532	19.5%
2017	29,601,620,677	4,206,425,335	14.2%	5,338,125,109	18.0%	6,268,850,751	21.2%
2018	30,844,888,746	4,547,145,787	14.7%	5,925,318,871	19.2%	7,083,801,348	23.0%

Appendix C

The first table below (Property Tax Projections) estimates total property tax revenues for fiscal 2007-2018 using the 2001-2006 average annual increase of 5.8 percent. The second table (Projection of Health Insurance Costs as a Percentage of Property Tax Revenues) uses those estimates to project health insurance as a percentage of property tax revenues.

Property Tax Projections

Fiscal Year	Total Municipal Property Tax Revenues (actual)	Percentage Change from Previous Year
2001	$7,520,052,000	
2002	8,003,918,000	6.4%
2003	8,494,021,000	6.1%
2004	9,016,234,000	6.1%
2005	9,483,455,000	5.2%
2006	9,983,131,000	5.3%
2001-2006 annual average		5.8%

Source: Massachusetts Department of Revenue, Division of Local Services

Fiscal Year	Total Municipal Property Tax Revenues (estimated at 5.8% annual growth)
2007	$10,562,152,598
2008	11,174,757,449
2009	11,822,893,381
2010	12,508,621,197
2011	13,234,121,226
2012	14,001,700,257
2013	14,813,798,872
2014	15,672,999,207
2015	16,582,033,161
2016	17,543,791,084
2017	18,561,330,967
2018	19,637,888,163

Projection of Health Insurance Costs as a Percentage of Property Tax Revenues

Fiscal Year	Total Property Tax Revenues (estimated)	Health Care Costs, 8.1% Annual Increase	% of Property Tax Revenue	Health Care Costs, 11% Annual Increase	% of Property Tax Revenue	Health Care Costs, 13% Annual Increase	% of Property Tax Revenue
2008	$11,174,757,449	$2,086,805,338	18.7%	$2,086,805,338	18.7%	$2,086,805,338	18.7%
2009	11,822,893,381	2,255,836,570	19.1%	2,316,353,925	19.6%	2,358,090,032	19.9%
2010	12,508,621,197	2,438,559,332	19.5%	2,571,152,857	20.6%	2,664,641,736	21.3%
2011	13,234,121,226	2,636,082,638	19.9%	2,853,979,671	21.6%	3,011,045,161	22.8%
2012	14,001,700,257	2,849,605,332	20.4%	3,167,917,435	22.6%	3,402,481,032	24.3%
2013	14,813,798,872	3,080,423,364	20.8%	3,516,388,353	23.7%	3,844,803,566	26.0%
2014	15,672,999,207	3,329,937,656	21.2%	3,903,191,072	24.9%	4,344,628,030	27.7%
2015	16,582,033,161	3,599,662,606	21.7%	4,332,542,090	26.1%	4,909,429,674	29.6%
2016	17,543,791,084	3,891,235,277	22.2%	4,809,121,719	27.4%	5,547,655,532	31.6%
2017	18,561,330,967	4,206,425,335	22.7%	5,338,125,109	28.8%	6,268,850,751	33.8%
2018	19,637,888,163	4,547,145,787	23.2%	5,925,318,871	30.2%	7,083,801,348	36.1%

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The Boston Municipal Research Bureau is a nonprofit research organization established in 1932 to promote more efficient, economical and responsible government for Boston. Independent and nonpartisan, the Bureau develops objective analysis and accurate data to support sound management of city government and to bring an unbiased analytical perspective to the finance and public policy choices made in Boston.

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