Massachusetts Taxpayers Foundation

A Mounting Crisis For Local Budgets: The Crippling Effects of Soaring Municipal Health Costs

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MTF

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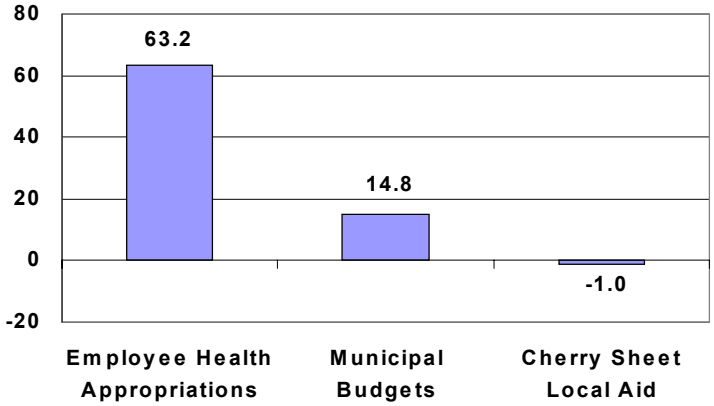
Taxpayer-funded costs of providing health coverage to municipal employees in the Commonwealth have skyrocketed by 63 percent from 2001 to 2005—more than four times greater than the rate of growth in local budgets—according to a recent survey of almost 10 percent of the state's 351 cities and towns conducted by the Massachusetts Municipal Association in cooperation with the Taxpayers Foundation (see Figure 1). The overall growth in costs in the survey communities ranged from 35 percent (almost three times the rate of inflation) to more than 100 percent. The average cost growth of 13 percent a year was almost double the rate of annual increase in the state's cost of providing health benefits to its employees (see Table 1).

Figure 1

Municipal Health Costs, Budgets and Local Aid

Percent Change from Fiscal 2001 to 2005



Source: MMA/MTF 2005 Municipal Health Cost Survey; Cherry Sheet Local Aid for survey communities

As a result of the surging costs, employee health care as a share of total municipal budgets jumped from 7.4 percent in 2001 to 10.6 percent in 2005, according to the survey results. If this rate of growth continues, health care's share will increase to 15 percent within four years, even assuming a recovery in overall local financial conditions. While the three percentage point jump between 2001 and 2005 may appear modest, it represents a 42 percent rise in just four years. Given the realities of Proposition 2½, such a shift has a dramatic impact on local finances. Overall, the increase in health costs in the survey communities during these four years consumed approximately four out of every five dollars of the 2.5 percent annual growth in taxes on existing properties allowed under Proposition 2½. For a significant minority of communities—one-fifth of the survey respondents—increases in health care costs outpaced allowable tax growth, in one case by a margin of more than two to one.

The state's leaders urgently need to take action to give municipalities greater flexibility—and new tools—to address the crisis of rising employee health costs, which in combination with local aid cuts is having a serious impact on local finances and services.

In addition to the survey of selected communities, the Foundation also examined 2001-2004 health care cost data for all 351 cities and towns compiled by the Department of Revenue (DOR), which presented a picture of even wider and more severe fiscal stress.[1]

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[1] The municipal health insurance data collected by DOR appear to use broader definitions than the MMA/MTF survey but remain generally comparable. Actual cost data for 2005 and 2006 are not yet available from DOR; we have largely excluded from this analysis the 2005 and 2006 estimates prepared by DOR, which are based on straight-line extrapolations of the 2001-2004 growth trends.

Table 1
Growth in Employee Health Costs
Mass. Local and State Government
Fiscal 2001-2005

	Percent Increase	
Fiscal Year	Local Employee Health Appropriation	State Employee Health Spending
2001	--	--
2002	14.9	11.8
2003	14.3	3.1
2004	12.8	6.5
2005	10.1	5.2
Total change	63.2	29.2
Annual average	13.0	6.6

Source: MMA/MTF 2005 Municipal Health Cost Survey; MTF analysis of DOR municipal financial data

According to DOR's figures, the statewide growth in municipal health insurance costs between 2001 and 2004 exceeded, by eight percent a year on average, the 2.5 percent growth in taxes on existing properties allowed under Proposition 2 ½ (see Figure 2). Even including the substantial additional property taxes from new construction as well as overrides, the growth in health care costs used up more than half of total new property tax revenues during this period—a time when communities across the state were raising property taxes in response to cuts in state aid.[2]

Not surprisingly, this challenging cost picture is displayed in premiums as well. Among the survey communities, between 2001 and 2005 average annual premium costs for plans offered to active employees climbed by more than 60 percent in individual plans and by 57 percent for family plans. Retired employees likewise faced substantial premium increases—64 percent for individuals and 55 percent for families (see Figure 3). Since plan benefits have remained essentially the same over the last five years, these premium increases reflect the escalating cost of receiving the same health coverage, not an expansion of benefits.

While every employer across the state—and across the country—has had to grapple with the explosion in health care costs in recent years, Massachusetts cities and towns are extraordinarily constrained in their ability to manage these expenses, largely because of strictures imposed by the state. As a result, a host of cost-management strategies—ranging from changes in cost-sharing arrangements with employees to encourage more cost-effective health care choices to the introduction of innovative and efficient health plan designs—are difficult, and sometimes almost impossible, for local officials to implement.

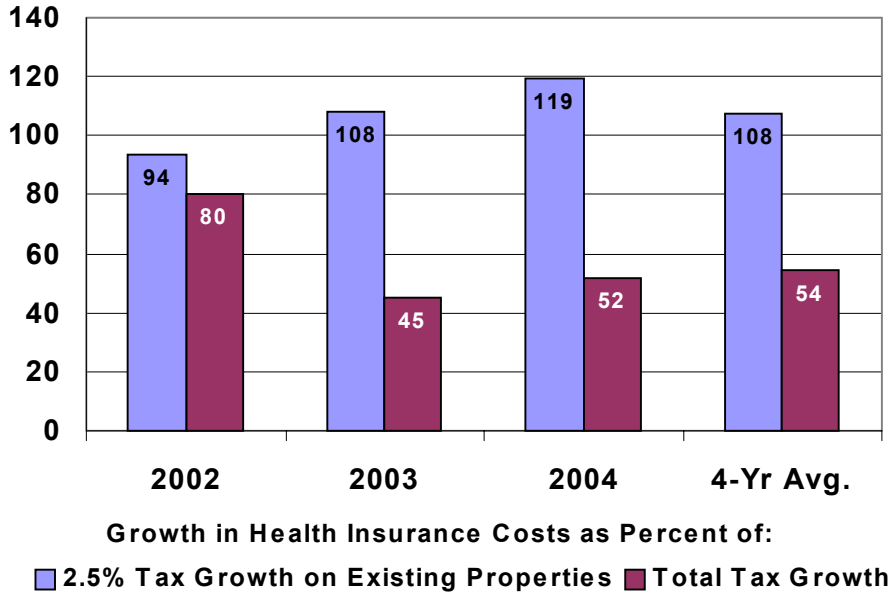
At the state level, decisions about the share of premium costs to be paid by employees are made by the appropriate public authority, that is, by the Legislature with approval of the Governor. Almost all other aspects of health coverage for Commonwealth employees are determined by the Group Insurance Commission, an autonomous eleven-member group that includes administration officials, union and retiree representatives, and health policy experts.

At the local level, virtually every element of employee health coverage is subject to collective bargaining, that is, to negotiation with union representatives, approval by union members, and, in some cases if agreement cannot be reached, binding arbitration. On top of that, state law requires that each change proposed by a community's officials be approved by all the unions representing

[2] Figure 2 indirectly illustrates the increase in property taxes—the 35 percent drop between 2002 and 2003 in the growth in health insurance costs as a percent of tax growth is due to a rise in taxes, not a decline in the rate of growth of employee health costs.

employees of that community. In addition, existing contractual agreements between the municipality and its unions may severely restrict the community's capacity to make needed changes.

Figure 2
Growth in Municipal Health Insurance Costs As Percent of Growth in Property Taxes Fiscal 2002-2004



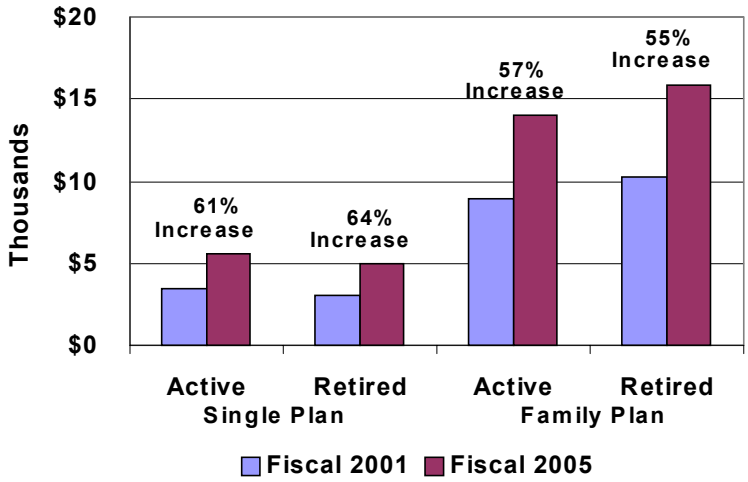
Source: MTF Analysis of Department of Revenue municipal financial data

As a practical matter, these statutory requirements stand as an enormous barrier to implementing timely changes in response to rapidly increasing costs—the kind of changes in plan design, pricing structures, and benefit alternatives that the Commonwealth is able to make routinely under the more flexible rules it sets for itself. All too often, the necessity of extended negotiation of even the most minute modification in employee coverage dooms initiatives that are in fact in everyone's interest, initiatives that would save local government (and thus the taxpayers) money while preserving employee benefits.

Examples abound of positive proposals that have been delayed for years—or ultimately stymied— because of the dysfunctional decision-making process under which municipalities must operate. To name one striking case, many municipalities provide health coverage to their retirees which could be made available more cost effectively through a so-called Medicare extension plan, with the community picking up the cost that Medicare not does cover. Despite a state law on the books since 1991 that permits towns to require their retirees to enroll in a Medicare extension plan—while ensuring that the extension plan provides benefits equivalent to the town's plan and making the town, not the retiree, liable for any late enrollment premium penalties that Medicare may impose—fewer than half of the communities in the MMA/MTF survey have opted to take advantage of this law. The reason? In some instances, an inability to get union agreement on the change; in others, a judgment that the extensive time and resources—or concessions on other matters—needed to gain approval of the change outweigh its financial benefits.

It is unreasonable to expect that actions by Massachusetts cities and towns—or any other single group of employers—can turn back the tide of health care inflation that is engulfing the Commonwealth and the nation. However, the state's leaders can take some immediate steps to provide cities and towns with modest tools to cope with a rate of growth in health

Figure 3
Municipal Health Care Premiums
Fiscal 2001-2005



Source: MMA/MTF 2005 Municipal Health Cost Survey

care costs that has become unmanageable under current law.

- As part of his broader health care initiative, Senate President Robert Travaglini has proposed to give city councils (with the approval of the mayor) and town meetings the same authority that the state has in setting employee contribution rates for health coverage. This long-overdue reform would remove the determination of employee contribution rates from the collective bargaining process and place that responsibility in the hands of elected officials who are accountable to local voters for the financial consequences of their decisions.

- The Legislature should move forward as well with another Senate proposal to remove the state requirement that cities and towns negotiate with, and obtain agreement from, all of their unions over changes to their health plans, no matter how small, and provide the same plan at the same contribution rate for all municipal employees. Allowing negotiations with individual unions would make it possible to offer plans tailored to the needs of their members, and open the door to potential savings that are not possible under the "one size fits all" approach required by current state law.

- The Foundation strongly recommends that the state take the even bolder step of extending to the municipal level its successful model for determining plan design: an independent decision-making body charged with overseeing health care benefits for employees and retirees. Giving communities the authority to establish their own local "Group Insurance Commissions"—with seats at the table for both management and labor—would provide municipal officials with more of the flexibility they need to respond effectively to the rapidly changing health care market while ensuring that employees take part meaningfully in decisions about their health coverage.

- Finally, lawmakers should act to remove the decision about participation in Medicare Part B plans from the limbo of collective bargaining by requiring all municipal retirees to enroll in a Medicare extension plan. As under current law, the health benefits that retirees are already eligible to receive would be fully preserved, at no additional cost to retirees. (Other areas of local administration would also benefit from similar kinds of "no pain, much gain" changes. For example, it is startling—but true—that in this era of pervasive reliance on computers a number of Massachusetts cities and towns still pay their employees by issuing paper checks, rather than using less costly electronic funds transfer, simply because they are

unable to get agreement to the change from their local public employee unions.)

It is clear that municipal budgets cannot sustain the onslaught of rising health care costs much longer. Many localities are already facing the unhappy choice between layoffs, demotions and reductions of service on the one hand, and struggling, often unsuccessfully, to hold down the growth in costs via the difficult and contentious process of negotiating new health care arrangements with their unions, on the other.

At the same time, it is unrealistic to expect the state to take on the financial burden of rising local employee health care costs. Although the Commonwealth has made some progress in restoring the more than $400 million, or eight percent, of cuts in local aid from the peak in 2002, fiscal 2005 assistance to cities and towns still fell below the 2001 level.[3] While the 2006 budget includes $220 million of new local aid, that amount would cover only two-thirds of the increase in municipal health insurance costs projected by the Department of Revenue.[4] Even with improving revenues, the state will have difficulty in keeping pace with its own rapidly growing costs, much less address in any meaningful way the escalation in local employee health costs.

About the Survey

The 2005 MMA/MTF Municipal Health Care Survey posed a series of detailed questions about 2001-2005 trends in health coverage—including budgetary costs, premiums, deductibles, co-pays, and other plan changes—offered to local employees and retirees in 32 communities, or almost 10 percent of Massachusetts cities and towns.

The communities were selected specifically to reflect the broad range of population, geographic diversity, and wealth of the state's municipalities. They encompass approximately one-fourth of the Commonwealth's population, are drawn from every region, and account for almost 30 percent of local revenues and spending. Appendix A of this report lists the communities included in the survey. Appendix B presents a series of supporting tables that document the results of the survey and of the Foundation's analysis of the DOR data.

The Massachusetts Taxpayers Foundation is a nationally recognized, nonprofit research organization working to promote the most effective use of tax dollars, improve the operations of state and local governments, and foster positive economic policies. We are supported by our employer members, representing virtually all sectors of the Massachusetts economy across the state.

The principal author of this report was MTF senior researcher E. Cameron Huff.

The Foundation gratefully acknowledges the assistance of the Massachusetts Municipal Association in developing the 2005 Health Cost Survey, collecting survey responses from participating communities, and preparing the survey results for analysis.

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[3] See the 2004 edition of the Foundation's annual publication, Municipal Financial Data, for a detailed analysis of the cuts in municipal assistance during the state's fiscal crisis.

[4] Based on MTF's tabulation of DOR projections in the *Municipal Stability Factor* analysis available online at www.mass.gov/Muni_dor/index.html.

Appendix A

Communities in MMA/MTF Health Care Cost Survey

Name	7/1/2003 Estimated Population	Population Ranking	UMASS Benchmarks Region
Amesbury	16,718	112	Northeastern
Andover	31,933	49	Northeastern
Arlington	41,903	32	Greater Boston
Boston	581,616	1	Greater Boston
Brookline	2,112	18	Greater Boston
Cambridge	101,587	5	Greater Boston
Charlton	12,159	155	Central
Eastham	5,632	237	Cape & Islands
Fall River	92,760	8	Southeastern
Framingham	66,243	14	Greater Boston
Franklin	30,175	54	Greater Boston
Georgetown	7,827	201	Northeastern
Harwich	12,859	149	Cape & Islands
Mansfield	23,011	78	Southeastern
Melrose	26,784	66	Greater Boston
Millis	8,023	198	Greater Boston
Needham	29,137	57	Greater Boston
North Adams	14,334	130	Berkshires
Revere	47,002	26	Greater Boston
Salem	42,067	30	Greater Boston
South Hadley	17,414	108	Pioneer Valley
Spencer	11,988	157	Central
Sudbury	17,246	109	Greater Boston
Tewksbury	29,288	55	Northeastern
Walpole	22,521	81	Greater Boston
Waltham	58,894	16	Greater Boston
Wellesley	26,578	67	Greater Boston
Wenham	4,460	252	Greater Boston
Weston	11,645	159	Greater Boston
West Springfield	27,953	62	Pioneer Valley
Weymouth	54,527	22	Greater Boston
Worcester	175,706	2	Central

Appendix B

Supplementary Tables

Table 1

Employee Health Care Cost Growth

MMA/MTF 2005 Municipal Health Cost Survey

Fiscal Year*	Employee Health Appropriation ($, M)	Change	
		Amount	Percent
2001	$307.1	--	--
2002	353.0	$45.8	14.9
2003	403.6	50.6	14.3
2004	455.4	51.8	12.8
2005	$501.3	45.9	10.1
Total Change	--	$194.2	63.2
Annual Average	--	--	13.0

* In this and subsequent tables, fiscal 2001 and 2002 employee health appropriation data for one of the survey communities have been imputed based upon information reported by the Department of Revenue.

Table 2

Employee Health Care Share of Budget

MMA/MTF 2005 Municipal Health Cost Survey

Fiscal Year	Employee Health Appropriation ($, M)	Municipal Budget ($, M)	Employee Health Percent of Budget
2001	$307.1	$4,123.0	7.4
2002	353.0	4,344.1	8.1
2003	403.6	4,496.7	9.0
2004	455.4	4,587.7	9.9
2005	501.3	4,733.0	10.6
Pct. Chg. 01-05	63.2	14.8	42.2

Table 3

Employee Health Care and Total Budget Growth

MMA/MTF 2005 Municipal Health Cost Survey

Fiscal Year	Employee Health Appropriation ($, M)	Percent Change	Municipal Budget ($, M)	Percent Change
2001	$307.1	--	$4,123.0	--
2002	353.0	14.9	4,344.1	5.4
2003	403.6	14.3	4,496.7	3.5
2004	455.4	12.8	4,587.7	2.0
2005	501.3	10.1	4,733.0	3.2
Total Change	$194.2	63.2	$610.0	14.8
Annual Average	--	13.0	--	3.5

Table 4

Employee Health Care and Total Budget Growth Per Employee*

MMA/MTF 2005 Municipal Health Cost Survey

Fiscal Year	Employee Health Appropriation Per Employee ($)	Percent Change	Municipal Budget Per Employee ($, M)	Percent Change
2001	4,719	--	62,379	--
2002	5,342	13.2	65,505	5.0
2003	5,990	12.1	67,128	2.5
2004	6,893	15.1	69,889	4.1
2005	7,632	10.7	71,677	2.6
Pct. Chg.	61.7	--	14.9	--
Ann. Avg.	12.8	--	3.5	--

* Based on available data for 20 of the 32 survey communities. Because of variations in the definition of “employee” that communities used in reporting their workforce, the per-employee cost information from the survey is not suitable for comparisons among communities but is indicative of cost trends over time.

Table 5

Employee Health Care versus Local Aid

MMA/MTF 2005 Municipal Health Cost Survey

Fiscal Year	Employee Health Appropriation ($, M)	Percent Change	Total Local Aid* ($, M)	Percent Change
2001	$307.1	--	$1,165.3	--
2002	353.0	14.9	1,222.2	4.9
2003	403.6	14.3	1,210.3	-1.0
2004	455.4	12.8	1,121.6	-7.3
2005	501.3	10.1	1,153.9	2.9
Total Change	$194.2	63.2	-$11.4	-1.0
Annual Average	--	13.0	--	-0.2

* Total cherry sheet aid as reported by the Department of Revenue (does not include $75 million of 2005 aid appropriated in the final supplemental appropriation bill for fiscal 2004 and distributed via the lottery aid formula).

Table 6

Employee Health Care and Tax Levy Growth Under Proposition 2 1/2

MMA/MTF 2005 Municipal Health Cost Survey

Fiscal Year	Annual Growth Employee Health Appropriation ($, M)	Allowable 2.5 Percent Growth on the Existing Property Tax Base*	Employee Health Growth As Percent of Allowable Tax Growth
2001	--	--	--
2002	$45.8	$56.5	81.1
2003	50.6	60.1	84.1
2004	51.8	63.7	81.3
2005	45.9	67.2	68.3
5-Yr Total	$194.2	$247.6	78.4

* MTF calculation based upon Department of Revenue municipal property tax data.

Table 7

Average Annual Premiums, 2001-2005
Active and Retired Employees

MMA/MTF 2005 Municipal Health Cost Survey

	Average Annual Premium*	
	Single Subscriber Plan ($)	Family Subscriber Plan ($)
Active Employees		
Fiscal 2001	$3,488	$8,924
Fiscal 2005	5,616	13,986
Dollar Change	2,129	5,062
Percent Change	61.0	56.7
Retired Employees		
Fiscal 2001	$2,997	$10,212
Fiscal 2005	4,926	15,871
Dollar Change	1,929	5,659
Percent Change	64.4	55.4

* Unweighted average premium of plans offered by employee type and town.

Table 8

Local Employee Health Care versus Local Aid
Fiscal 2005-2006

DOR Data for 351 Cities and Towns

	Fiscal 2005 ($, M)	Fiscal 2006 ($, M)	Change ($, M)	Percent Change
Health insurance costs	$2,112	$2,519	$407	19.3
Cherry sheet local aid	3,927	4,206	279	7.1
Growth in aid as percent of growth in health costs	--	--	69	--

Table 9

Municipal Health Insurance Costs and Tax Levy Growth Under Proposition 2 1/2

DOR Data for 351 Cities and Towns

Fiscal Year	Annual Growth In Health Insurance Costs ($, M)	Allowable 2.5% Growth in Local Taxes on the Existing Property Tax Base	Health Insurance Cost Growth As Percent of Allowable Growth	Overall Growth in Local Property Taxes Including New Construction And Overrides	Health Insurance Cost Growth As Percent of Overall Growth
2001	--	--	--	--	--
2002	$175.5	$187.7	93.5	$218.5	80.3
2003	216.4	199.6	108.4	479.2	45.2
2004	252.5	211.4	119.4	489.8	51.6
4-Yr Total	$644.5	$598.7	107.6	$1,187.6	54.3

Note: Allowable 2.5 percent growth in local taxes on the existing property tax base was computed by the Foundation using DOR data.

Table 10

Employee Health Care Share Of Total Local Revenues

DOR Data for 351 Cities and Towns

Fiscal Year	Employee Health Insurance Costs ($, M)	Total Local Revenues ($, M)	Percent of Total Local Revenues
2001	$1,144	$12,483	9.2
2002	1,319	12,980	10.2
2003	1,535	13,448	11.4
2004	1,786	13,624	13.1
Change	$642	$1,141	--
Percent Change	56.2	9.1	--
Avg. Annual	16.0	3.0	--