



GIC Consolidation

by Steve Poftak

Introduction

The Middle Cities Initiative seeks to help the Commonwealth's older cities, which face economic, demographic, and political challenges. These challenges cover a wide range of issues—entrenched political cultures, significant infrastructure costs, underperforming schools, struggling retail and manufacturing sectors, crime, and poorly targeted state programs. The Initiative's goal is to develop and disseminate concrete policies to help the Middle Cities grow.

One foundational element for growth is effective fiscal management by the public sector. An effective fiscal management tool currently available to municipal leaders is the consolidation of their community's municipal health insurance into the Commonwealth's larger pool, known as the Group Insurance Commission (or "GIC"). This policy brief examines the possible savings the Middle Cities might achieve through the GIC, based on a number of assumptions, particularly historical cost trends.

Through the Municipal Partnership Act, Governor Patrick and the Legislature have signaled a desire to see cities and towns move toward greater use of the GIC as a source of cost savings.

One of the major causes of pressure on municipal budgets is employee health insurance, which (as in other sectors of the economy) is eating up an ever-greater portion of budgets. Through the Municipal Partnership Act, Governor Patrick and the Legislature have signaled a desire to see cities and towns move toward greater use of the GIC as a source of cost savings. Speaker DiMasi has also mentioned the possibility of more

This policy brief was originally published in 2008. Therefore, data provided in the brief is for the most current year then available.

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direct legislation in the future, to force communities into the GIC as opposed to the current opt-in system.

The GIC’s attraction is based on three related factors – GIC’s low rate of cost growth relative to most cities and towns, the benefits that GIC receives from its large purchasing pool and resultant leverage with insurance companies, and its ability to alter plan design without bargaining for it. As a result, the rates that municipalities pay are usually higher and growing at a faster pace. Given the limitations of municipal finance, most notably Proposition 2.5, and the inability to react quickly to health insurance market changes due to collective bargaining, health insurance costs are rising at a rate disproportionate to other expenses and seriously worsening the fiscal health of our cities.

By automatically enrolling Medicare-eligible retirees in Medicare, GIC consolidation has the potential to offer significant savings to municipalities.

Process and Participants

Communities may opt in to purchase their health insurance plans through the Group Insurance Commission. The decision to opt-in is made through an approval of 70% of the Public Employee Committee, majority vote of the city council, and approval of the mayor (or manager in Plan D and E communities). Communities join the GIC for a three-year period. GIC would be responsible for insurance plan design and selection, while municipalities would set their own contribution ratios.

Six communities (Groveland, Holbrook, Millis, Springfield, Saugus, Winthrop), four regional school districts (Athol Royalston, Gill Montague, Hawlemont, Mohawk Trail), and two quasi-governmental agencies (Southeast Regional Planning and Economic Development District, Old Colony Planning Council) have joined the GIC.*

*This policy brief was originally published in 2008. Since publication, Weymouth, Quincy, Melrose, Watertown, Wenham, Stoneham, Weston, Pittsfield, Norwood and Randolph have also joined the GIC.

Key Considerations

Cost Structure

Communities considering GIC consolidation should examine several aspects of their current health insurance plans. In order for consolidation to make sense, they should compare their current health insurance cost structure, particularly indemnity plans and HMOs, with GIC’s costs.

The provisions of the GIC consolidation legislation require that all employee classes in a municipality (including retirees) be allowed access to all of GIC’s plan offerings. This creates a potential situation where the current distribution of health insurance plans might change, with the worst case scenario being a situation where large groups of employees move from lower cost HMOs into higher cost indemnity plans.

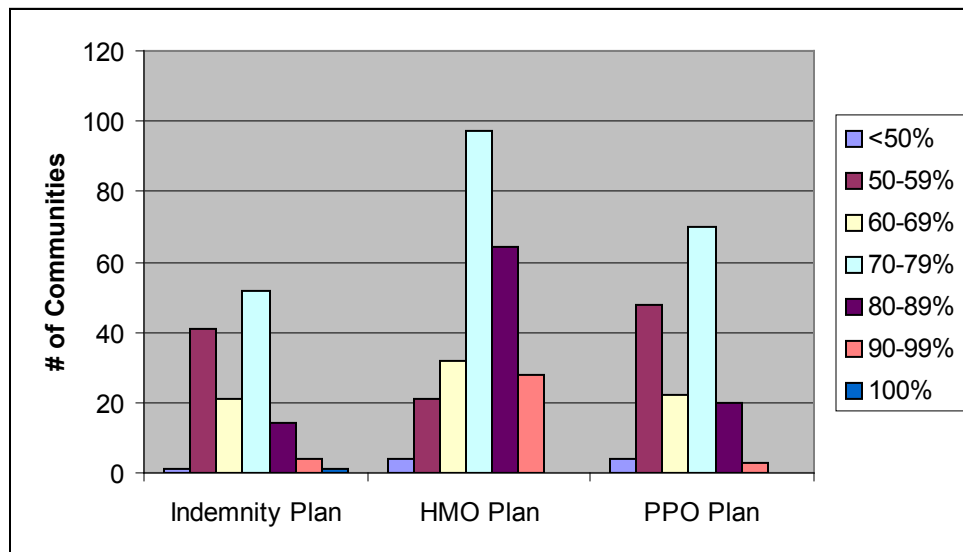
Table 1: 2007 Contribution Ratios for the Middle Cities

	Indemnity	HMO	PPO
BROCKTON	75.0%	75.0%	75.0%
CHICOPEE	50.0%	65.0%	50.0%
FALL RIVER	75.0%	75.0%	75.0%
FITCHBURG	75.0%	75.0%	
LOWELL	75.0%	75.0%	75.0%
LYNN	75.0%	75.0%	
NEW BEDFORD	75.0%	75.0%	
PITTSFIELD		90.0%	60.0%
TAUNTON		75.0%	75.0%
WORCESTER	60.0%	80.0%	80.0%

(Source: Contribution Ratios by Municipalities, MMA Benchmarks Report, from MAPC website)

In an ideal situation, a community would have a contribution rate structure in place (or negotiate one as terms of entry into the GIC) that would provide incentives for employees to choose lower cost options. This is typically done by providing a higher contribution ratio for HMOs versus indemnity plans.

Table 2: Contribution Ratios for Massachusetts Municipalities



in health carriers (even for similar products) required union approval.

Another important issue, particularly for those communities that are self-insuring, is the potential for interplan subsidies to be embedded in collective bargaining. In at least one case we are aware of, the community’s indemnity plan rates are capped relative to their HMO rates, resulting in a subsidy of the (more costly) indemnity plan by the HMO¹.

Table 1 shows the currently available contribution rates for the Middle Cities.

Table 2 shows a breakdown of contribution ratios for all municipalities in Massachusetts. It shows that a significant number provide a low contribution rate for their indemnity plans relative to HMOs, but a plurality provide a contribution rate of 70% - 79% for both plans, similar to the Middle Cities in Table 1.

A move towards GIC consolidation makes sense if a community believes that health insurance costs will continue to rise and that GIC’s cost increases will be lower than their own.

Collective Bargaining

Another crucial issue that municipal leaders must confront is the role that language in existing collective bargaining may play. In some municipalities, contracts specifically call for a specific health insurance provider, typically Blue Cross/Blue Shield. There have also been cases where no specific language was cited, but unions believed that a potential change

Future Cost Trends in Health Insurance

Any move towards consolidation into GIC should consider the secular trends in health insurance costs and the variance in increases between a municipal purchasing pool and the GIC’s pool.

It should be noted that there has been some market response to the potential of GIC consolidation and the overall pressure on municipal budgets caused by health insurance costs. Most prominently, Blue Cross Blue Shield has begun a more active outreach campaign to municipalities and has altered its product array, in an effort to lower cost increases and retains its leadership in the municipal marketplace.

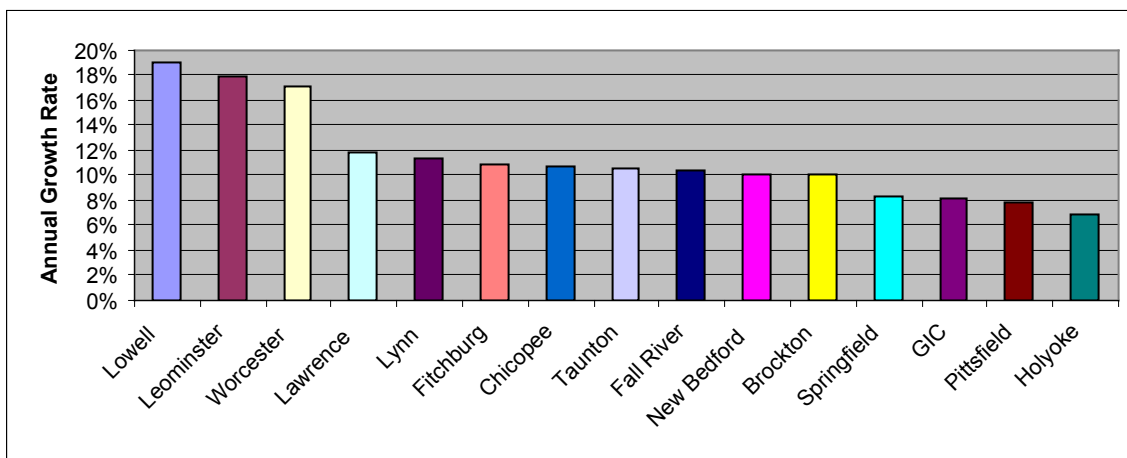
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An August 2007 Boston Municipal Research Bureau – Massachusetts Taxpayers Foundation report estimated the savings from GIC consolidation by making two assumptions: 1) that health insurance costs during the period 2001 – 2006 are representative of health

insurance costs in future periods, and 2) that the relationship of health insurance costs in municipalities versus the Commonwealth during that period will continue in future periods. Although neither of these assumptions is without counterargument, we use the report’s methodology to prompt a conversation about the potential savings for municipalities while acknowledging its limitations.

growth rate is highly dependent on two figures – health insurance costs in 2001 and 2006. Several municipal administrators noted that the data for 2001 (from DOR’s Division of Local Services, based on Schedule A data) was technically accurate but did not present an accurate picture of health insurance spending in that year, because of under- or over-budgeting that was corrected in other periods⁴. Any

Table 3: Compound Annual Growth Rate of Health Insurance Costs, 2001 - 2006



The report determined that a transfer of all municipalities into the GIC would produce savings in excess of \$1.65 billion per year by 2016².

Potential Savings

In order to make the potential for consolidation more meaningful to individual communities, this policy brief takes the above methodology and applies it directly to the Middle Cities. First, the compound annual growth rate in health insurance costs was calculated for each of the cities and the Commonwealth³, as shown in Table 3.

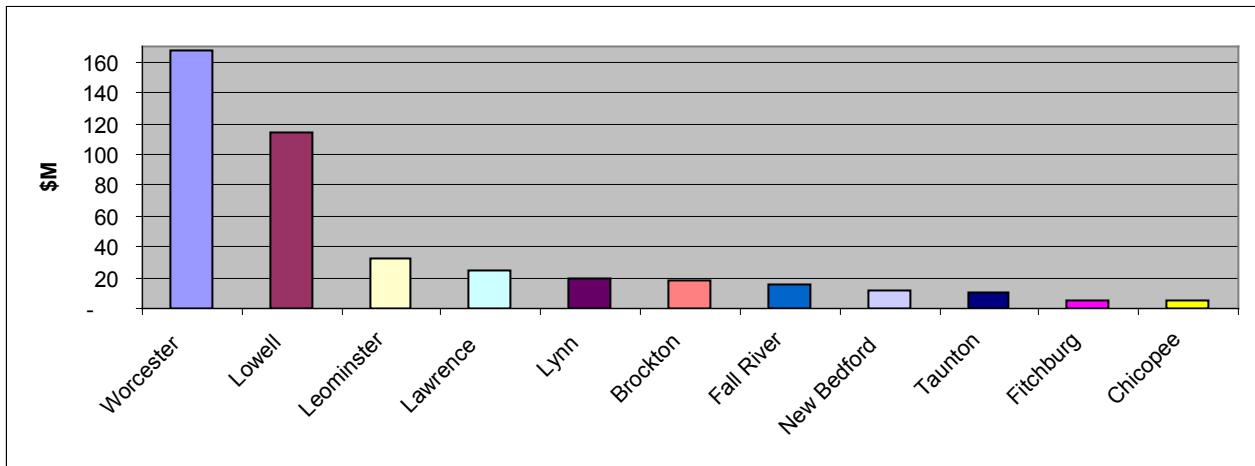
Beyond the assumptions in the previous sections, another caveat should be mentioned. The annual

anomaly has the potential to skew projections as initial differences will be compounded.

Table 3 reveals that GIC’s growth rate was 8.1% over this period, while most of the Middle Cities had higher growth rates, topping out at 19.1% for Lowell. It should be noted that Pittsfield and Holyoke had lower growth rates than GIC.

The next step in the analysis is to use these growth rates to calculate health insurance cost projections under two scenarios – costs growing at each municipality’s historical rate and at the GIC’s historical rate. Three communities were eliminated from the analysis – Pittsfield and Holyoke (as their lower growth rates would result in a cost increase under GIC based on this methodology), as well as Springfield (which has already joined the GIC).

Table 4: Difference in Year 2016 Costs Between Current Trend and GIC



The growth projections in health insurance costs from 2007 – 2016 under these two scenarios demonstrates the possible savings from consolidation into GIC. It also reveals that small differences in growth rate can result in significant differences in costs. Table 4 shows the difference in health insurance costs projected for 2016 between the current trend and GIC.

Most dramatically, under this scenario, Worcester would face higher costs of \$168 million in 2016. Lowell would face higher costs of \$115m. Other Middle Cities would also face higher costs in 2016. The driver of the additional cost is the rate of projected growth relative to GIC and the size of the underlying initial health insurance budget.

Table 5: Total Savings from GIC Inclusion, 2007-2016

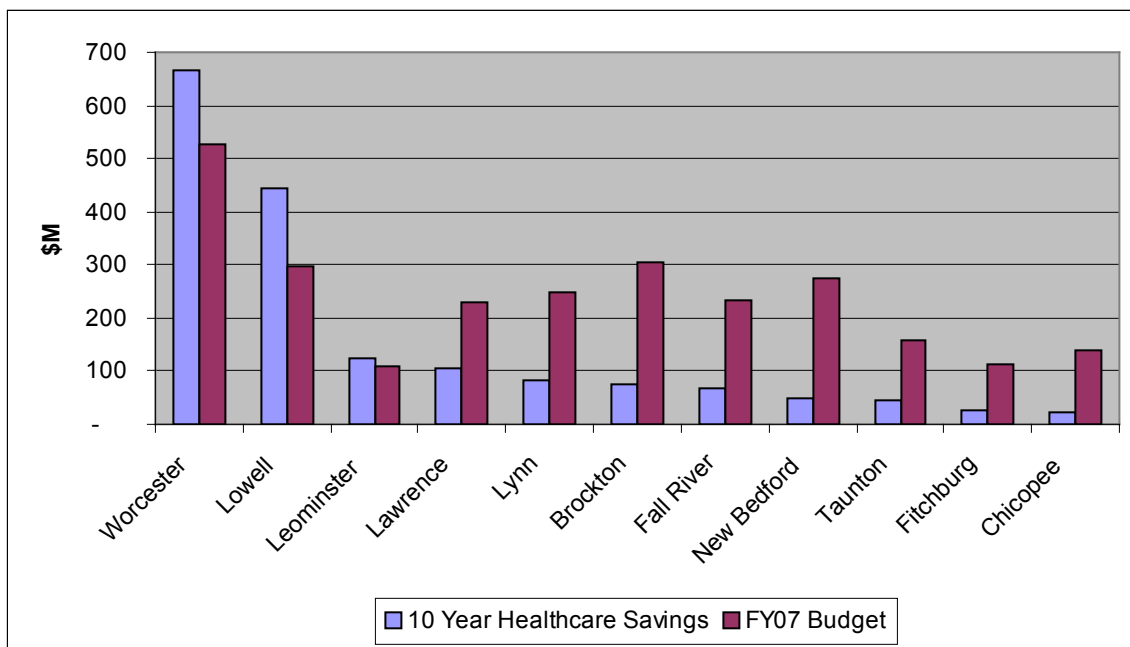


Table 5 shows the full impact of the potential savings from GIC by adding up the incremental savings over the 2007 to 2016 period (not just a single year's as in Table 4). The size of each community's 2007 operating budget is included to allow a relative comparison of potential savings.

The evidence suggests that most communities, absent a compelling argument that their future health insurance cost inflation will be below that of the Commonwealth's would realize cost savings from joining GIC. In several cases, there are dramatic potential savings.

In this scenario, Worcester saves over \$650 million during the ten-year period, a meaningful sum given that their 2007 operating budget was \$527.5 million. Similarly, Lowell saves \$445 million over ten years (2007 operating budget of just under \$300 million). For the other communities, the savings are smaller, reflecting their lower growth rates, but still significant.

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Table 6: Springfield Savings from Section 18 – Automatic Medicare Transfer

	FY06	FY07	FY08
REDUCTION IN HEALTH CARE COSTS	\$9.5	\$10.7	\$12.4
CITY SHARE (75%)	\$7.1	\$8.0	\$9.3
MINUS PENALTY	\$1.8	\$1.9	\$2.0
NET SAVINGS FOR CITY	\$5.3	\$6.1	\$7.3

(Source: substantially based on a table from presentation "Impact of Section 18 for City of Springfield and City Retirees" presented on MAPC website)

insurance cost inflation will be below that of the Commonwealth's (or that consolidation would result in higher costs), would realize cost savings from joining GIC. In several cases, there are dramatic potential savings. For those communities above a growth rate of 11.5% (Worcester, Lowell, Leominster, and Lawrence), the savings are significant in terms of dollars and relative to their overall budgets.

Additional Savings Opportunity

Another aspect of GIC consolidation is that all Medicare-eligible retirees will automatically be transferred to Medicare. Municipalities have the option to do this independently (by a majority vote of the city council in Plan D or Plan E cities; or by the council with mayoral approval in other cities) via Section 18 of Chapter 32B.

Among the Middle Cities, Brockton, Fall River, Pittsfield, Springfield, and Worcester have enacted Section 18⁵.

GIC plans typically have lower premiums, which provide a net savings to the employee, even, in many cases, with higher out-of-pocket costs.

Springfield presents data that demonstrates the enactment of Section 18. Shifting costs from the City to the Federal Medicare program has produced a net savings to the City of \$6.1 million in FY07 and \$7.3 million in FY08.

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Employee-side Incentives

For municipal employees, initial resistance to GIC consolidation has revolved around several issues – resistance to a change in health insurance providers, related skepticism about joining a state-level health insurance entity, and the typically higher out-of-pocket costs associated with most GIC products.

Several countervailing points are:

- The overall savings from GIC consolidation will lower the fiscal pressure on many communities and have the potential to be shared with employees.
- By removing health insurance plan offering and design (but not contribution ratios) from collective bargaining, it decreases a key point of tension between unions and municipalities.
- GIC consolidation requires that all classes of employees be treated equally (i.e. they all have access to all of the GIC's products). This is particularly important to retirees (or future retirees) because it preserves their insurance and provides long-term security.
- GIC plans typically have lower premiums, which provide a net savings to the employee, even, in many cases, with higher out-of-pocket costs⁶.

Conclusion

The savings outlined above are dramatic and plausible, but municipal health insurance is a complex issue. Municipal leaders seeking cost savings should examine the potential benefits of joining GIC. A compelling case can be made that GIC consolidation reduces pressure on local budgets, allowing the provision of additional services, reducing the need for higher taxes, and presenting an opportunity for savings that will ultimately benefit municipal employees. For communities with high historical cost growth rates, they should work immediately to begin joining the GIC or to understand why their current

health insurance structure prevents this option from being cost-effective.

Endnotes

¹In this particular circumstance, this subsidy results in a high subscription level for the indemnity plan, which has the perverse effect of lowering premiums (as compared to GIC) because their risk pool is healthier, due to the large number of subscribers.

²“Municipal Health Reform: Seizing the Moment”, Boston Municipal Research Bureau/Massachusetts Taxpayers Foundation, August 2007.

³All data on health insurance costs is derived from the Massachusetts Department of Revenue Division of Local Services; accessed at <http://www.mass.gov/Ador/docs/dls/mdmstuf/MunicipalActualExpenditures/insurancegic0106.xls>, last accessed January 25, 2008.

⁴The author would be pleased to work with any municipality that wanted to clarify any portion of the data or analysis.

⁵Source: DOR DLS Municipal Databank website.

⁶Pioneer is developing a web-based tool to allow individual employees to determine the change in their overall costs under GIC and current health insurance plans.



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