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|  | The impact of municipal health care reform on school district health insurance spending |
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| Massachusetts Department of Elementary and Secondary Education  75 Pleasant Street, Malden, MA 02148-4906  Phone 781-338-3000 TTY: N.E.T. Relay 800-439-2370  [www.doe.mass.edu](http://www.doe.mass.edu) |
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# Introduction

Because of recent statutory changes, Massachusetts cities, towns, and regional school districts can now purchase health insurance for their employees from the Group Insurance Commission (GIC), the state agency responsible for procuring health insurance benefits for state employees. Over the past 15 years, rising health insurance costs and slowing revenue growth have put a fiscal strain on local budgets. This trend is having a particular impact on municipal and regional school districts, with health insurance spending crowding out expenditures for direct services to students. Statewide districts are now spending $259 million more on health insurance benefits than they would have if the share of health insurance spending held constant between 2002 and 2014. Historically, the GIC has seen lower costs per employee and slower growth in per employee health insurance costs than municipalities and regional districts.

This brief will look at the impact that joining the GIC had on health insurance costs for the municipalities and regional school districts that opted to join compared with those that did not. It will also explore the flexibilities afforded by the law that allowed municipalities to renegotiate aspects of their health insurance benefits short of joining GIC, as well as featuring three case studies of districts that chose to join GIC.

# Rising costs

Rapidly rising health insurance costs are a national trend affecting both the private and public sectors over the last 15 years. Among Massachusetts school districts, health insurance expenditures for active employees rose by $698 million or 110 percent in nominal dollars between fiscal years 2002 and 2014.[[1]](#footnote-1) Even accounting for inflation, expenditures still rose by $405 million or 44 percent. Figure 1 shows that actual health insurance spending grew rapidly between 2002 and 2010, increasing at an average annual rate of 8.8 percent per year, which outpaced annual growth in total operating expenditures by 5.8 percentage points. Since 2010, growth has slowed to 1.7 percent per year, but active employee health insurance now makes up a greater share of district budgets than it did 15 years ago, a reality that is not likely to change in the near future. By comparison, the rate of increase in health insurance spending was faster in school districts than it was for private sector employers in Massachusetts more generally over the same period.[[2]](#footnote-2)

Health insurance for active employees now consumes 9.4 percent of total school district operating expenditures, up from 6.3 percent in fiscal year 2002, see figure 2. If health insurance spending had held constant as a share total spending between 2002 and 2014, districts would have spent $259 million less in 2014. Providing health benefits is a necessary cost to attract and retain staff, but the pace of growth over the last 13 years is making it difficult for districts to sustain while still being able to invest in other areas that directly affect student learning. The additional money that districts are spending on health insurance above 2002 levels equates to approximately 3,200 classroom and specialist teaching positions statewide.[[3]](#footnote-3) Even if districts did not use this money exclusively to hire staff, these funds represent deferred investments in educational programs and strategic priorities. Positive signs, however, indicate that districts are beginning to control growth in health insurance spending. Slower growth in recent years suggests that districts are starting to benefit from positive trends in health care costs overall or that steps that they are taking, either by joining GIC or making local changes to their health care plans, are beginning to pay off.

Starting in 2008, Massachusetts responded to rising health care costs by making it easier for municipalities and regional school districts to join the GIC. The GIC is the state agency that purchases health insurance coverage for state employees, and historically it has been able to control health insurance costs better than cities and towns due to the size of its insurance pool. In fiscal year 2014, the GIC enrolled 231,000 current and retired employees and 409,000 total enrollees counting eligible dependents.[[4]](#footnote-4) This affords the Commonwealth significant purchasing power to drive down costs. Also, the Commonwealth does not negotiate employee and retiree health insurance benefits with its unions, giving it more flexibility to make plan design changes than municipalities.

In fiscal year 2014, the Commonwealth paid $9,874 per enrollee on average, not including dependents. While this is certainly less than what some municipal and regional school districts are paying, we do not have data on the number of school district employees enrolled in municipal and regional school district health insurance plans to determine a comparative cost per employee. Because of the difficulty of making comparisons per enrolled employee, our analysis relies on per pupil health insurance spending to assess the impact that health insurance reform is having on district spending.

# GIC reforms

Municipalities gained access to joining the GIC in two phases. The first was the 2007 Act to Reduce the Reliance on Property Taxes through Municipal Health Care, which amended MGL Chapter 32B Section 19 to give cities and towns the option to join GIC.

This law was passed after Springfield joined the GIC in January 2007 as part of its state-mandated restructuring. The Commonwealth enrolled all of Springfield’s employees in the GIC in a bid to lower health insurance spending and improve the city’s fiscal outlook, making it the first municipality to join. Prior to joining GIC, Springfield was experiencing double-digit annual increases in its health insurance costs. A study by the Collins Center at the University of Massachusetts Boston found that the move to GIC saved the city between $14 million and $18 million during fiscal years 2008 and 2009.[[5]](#footnote-5) Since then, growth in the city’s health insurance spending has slowed compared to what it was before; this is also true for the Springfield Public Schools, where spending on health insurance for active employees grew at an average annual rate of 4.9 percent between fiscal years 2008 and 2014. While this was 2.2 percentage points higher than the state average for school districts over the same period, it was 1.6 percentage points lower than it had been for Springfield between fiscal years 2002 and 2007.

The 2007 reforms allowed municipalities and regional school districts to take advantage of GIC’s larger insurance pool and reduce variability in claims. Municipalities were required to negotiate with a public employee committee (PEC) representing the local collective bargaining units, including retirees, and required that 70 percent of the units agree to the shift before it could happen.[[6]](#footnote-6) Initially, only 23 districts, including Springfield plus 16 other municipal districts, 5 regional districts, and 1 regional vocational district, joined the GIC because the hurdle of negotiating with local PECs proved to be high.

Chapter 32B was amended again in 2011 through An Act Relative to Municipal Health Insurance to provide more flexibility for municipalities and regional school districts to make plan design changes or to join GIC.[[7]](#footnote-7) By “plan design changes,” the law refers to changes in the co-pays, deductibles, employer-employee splits, and other features of the health insurance plans that the municipality or regional school district offers to its employees. The law requires that a simple majority of the PEC approve any plan design changes or a move to GIC. It caps adjustments to co-pays, deductibles, and other fees made through plan design changes to the dollar amounts of the most subscribed plan in the GIC. It also requires municipalities and regional districts demonstrate that they would save at least 5 percent by moving to GIC than they would otherwise save through local plan design changes. In order to encourage PECs to endorse change, municipalities and regional school districts must share 25 percent of any savings with employees or retirees, leaving it up to municipalities and their bargaining units to agree on how to use these savings.[[8]](#footnote-8) Even if a municipality opts to join GIC, they still retain control over their deductibles, co-pays, and employee-employer splits, which are all still subject to local bargaining. Finally, municipalities need to bring all of their employees to GIC; they cannot pick and choose. As a result of the 2011 reforms, 26 additional districts, including, 25 municipal districts and 1 regional vocational district, opted to join GIC and 167 other districts took advantage of the law to negotiate plan design changes with their unions.

# Outcomes

In 2007, the Massachusetts Taxpayers Foundation projected that municipalities could save between $1.4 and $2.5 billion on health insurance by fiscal year 2018 if all municipalities enrolled in GIC.[[9]](#footnote-9) As stated earlier, however, only 42 municipalities and 7 regional school districts opted to join out of 440 eligible cities, towns, and regional school districts.[[10]](#footnote-10) Many more municipalities, 167 in all, elected to take advantage of the flexibility afforded by Municipal Health Reform to renegotiate elements of their plan designs with their collective bargaining units. GIC estimates that since 2011 municipalities have saved $250 million as a result of joining GIC or making plan design changes.[[11]](#footnote-11)

How do these savings extend to school districts? Figure 3 shows that since 2008 growth in active employee health insurance costs per pupil were lower for districts that joined the GIC compared to districts that did not. For districts that joined GIC, health insurance spending grew by $118 per pupil or 9.1 percent compared with $289 per pupil or 23.6 percent for districts that did not join GIC. This is particularly notable because prior to reform, the GIC districts had higher per pupil health insurance costs than non-GIC districts and the state average.

Per pupil costs for GIC districts also grew at a slower rate than they did for districts that took advantage of the greater flexibility afforded by the law to renegotiate elements of their plans and for districts that made no changes, even though the two groups that did not join GIC started out at lower per pupil rates. Figure 4 shows that districts that instituted plan design changes saw their per pupil spending grow by $267 per pupil or 21.9 percent compared with $323 per pupil or 26.2 percent for districts that reported no changes. Districts that made local changes fared better than districts that made no changes, but their spending grew at more than twice the rate of growth experienced by GIC districts. Districts that made no changes now have the highest per pupil health insurance costs for active employees.

Figure 5 shows that the smallest districts saw the largest increase in per pupil health insurance costs as a group between 2008 and 2014, growing by $378 per pupil or 26.7 percent. Districts with between 1,000 and 10,000 students have the lowest overall costs, and districts with more than 10,000 students saw the lowest rate of growth. We divided districts into these enrollment groupings to assess the impact that increased health insurance costs and cost control strategies are having for very small and very large districts in the state compared to districts in the middle.

Breaking size differences down even further by district type (see Figure 6), municipal districts with between 1,000 and 10,000 students have the lowest per pupil costs, regional districts with less than 1,000 students have the highest per pupil costs, and municipal districts with less than 1,000 students had the highest rate of growth at 31.5 percent. District size is clearly a factor in terms of overall cost and a district’s ability to manage variations in claims.

Figure 7 groups districts by size based on the reform strategy that they chose; whether it was to join GIC, make local plan design changes, or no changes. As a group, GIC districts experienced the lowest rate of change, with districts with fewer than 1,000 students actually seeing a small decrease in per pupil spending. Between districts that made local changes or no changes, districts with fewer than 1,000 students have the highest per pupil rates among all districts, with districts that made local changes actually spending more per pupil in fiscal year 2014 than districts that made no changes. Among the largest districts, districts that made local changes held constant, while the single district with more than 10,000 students that made no changes saw their per pupil spending increase by 77 percent, suggesting a missed opportunity to hold down costs. Districts with between 1,000 and 10,000 students differed little whether they made local changes or no changes. Per pupil spending for these two groups grew by 23 and 20 percent respectively, with only $55 per pupil separating them.

# Case studies

We selected three districts representing different experiences with GIC to get a better understanding of the impact of municipal health reform. One district joined GIC and subsequently left to procure its own health insurance; another district joined GIC after a long negotiation process and is experiencing savings; and a third is also saving money through GIC but is guarded about future savings.

Wachusett Regional School is a K–12 district located in the central part of the state that serves five communities: Holden, Paxton, Princeton, Rutland, and Sterling. Wachusett joined GIC in 2010 in response to rising health insurance costs, but decided to withdraw in July 2013 to join Blue Cross Blue Shield (BCBS). Wachusett originally joined GIC to take advantage of lower costs and greater predictability, and initially the district saw savings. Figure 7 shows that Wachusett’s health insurance spending for active employees increased between 2008 and 2010, growing from $5.7 million to $7.5 million, and then decreased to $6.8 million after the district joined GIC. These savings were short-lived, however, as health insurance spending quickly grew above pre-reform levels in 2012 and 2013. Wachusett exited GIC in 2013 to join BCBS and their spending subsequently decreased in fiscal year 2014, but whether these savings will hold into the future is uncertain.

Monson Public Schools is a small district located in the south central part of the state. Monson’s move to GIC was under discussion for years, but the town was unable to get the public employee committee (PEC) to approve the change. Pressure to join GIC grew when budget cuts forced the district to reduce teaching positions in 2011 and 2012, which made union leadership more sympathetic to change. In a rare convergence of events, the superintendent and the union president worked together to initiate the reform. The union leader educated and persuaded members about the benefits of being in GIC and the quality of its health plans. Although union members initially had doubts about the change, GIC staff came for open houses, and additional information helped to turn the tide.

One concession that was made to change the employer-employee split for individuals from 85 percent-15 percent to 70 percent-30 percent. The district also made a commitment not to lay off any staff, which was made possible by the health insurance savings. In the first year, Monson’s health insurance spending decreased from $1.5 million to less than $900,000, and continued savings in fiscal year 2014 made it possible for the district to add back positions that had been eliminated. According to the town’s finance director, GIC provides more insurance options than the previous BCBS plan that Monson purchased through the Massachusetts Interlocal Insurance Association, which is also helping to drive down costs. In Monson’s case, GIC savings created greater long-term stability for the district and allowed greater investment in core instructional services.

Finally, the Arlington Public Schools, a suburban district located just north of Boston, made the move to the GIC in 2013 after earlier failed attempts and years of talking about the change. The town leveraged the municipal health reform law and the assistance of a facilitator to negotiate the move. Unions were still skeptical, but the law made it easier for them to accept because GIC set more acceptable thresholds. The law also allowed the town to make changes without having to negotiate each individual item; the employer-employee split is the only element that is still subject to negotiation. The local union president was crucial in communicating to her members about the design of the plans and gaining acceptance.

GIC offers lower deductibles and co-pays than the than Arlington’s previous insurance plans. Arlington also offered a one-time opt-out incentive of $2,000 to $4,000 for employees who moved off the town’s insurance on or before the transition. The opt-out provision allowed the town to continue to save money on health insurance despite hiring more staff. Arlington also used 25 percent of its savings to create a mitigation fund that reduces co-pays that are greater than $75, sets an out-of-pocket maximum, and provides subsidies to Medicare recipients to reduce premium costs. At present, they’ve been able to honor all requests and have continued to fund it annually. Arlington’s employees have largely accepted the change.

After seeing its health insurance spending decline from close to $7 million in fiscal year 2012 to $5.4 million in 2013, spending increased to closer to $5.8 million in 2014, and the district is anticipating a 6.5 percent increase in 2015. Increasing costs for participation in Harvard Pilgrim plans, which are popular among municipal employees, are driving the recent increase. Arlington is committed to GIC through fiscal year 2018, but is guarded about whether there will be a return to lower growth rates that will allow them to carry the savings that they have achieved into future years.

# Summary

Rapid growth in health insurance spending, with nominal costs more than doubling to over $1.3 billion between fiscal years 2002 and 2014, made a lasting impact on school district budgets—one that will not be easily corrected. Growth has leveled off in recent years, however, because of slower growth in health insurance spending overall and as the result of reforms that made it easier for districts to make changes to their plans locally or to join GIC.

In general, the 49 districts that joined GIC are experiencing slower growth in their health insurance expenditures for active employees than other districts, but individual results vary. Even though GIC enrollment has been low, municipal health reform prompted many cities and towns to look at their existing plan designs and make changes that appear to be having a positive impact. It will be important to watch how GIC districts fare in the future to see if they continue to experience slower growth or if more cities and towns and regional districts decide to leave GIC for the promise of lower costs with other providers. District size is also a factor, and vocational and small regional school districts that are experiencing the highest per pupil costs need to find long term solutions to control their health care spending.

These trends are a key issue for the Foundation Budget Review Commission (FBRC), which will propose changes to the foundation budget formula. The FBRC was established by the legislature to review the assumptions and factors used to set annual minimum spending levels and state aid allotments for every school district in the Commonwealth. A preliminary report recently issued by the commission proposes increasing the employee benefits rate in the foundation budget formula to reflect the average GIC rate; adding a new expenditure category to capture the cost of retired employee health insurance; and using a health care cost inflation factor to adjust the employee health insurance component of the employee benefits rate each year.[[12]](#footnote-12) If enacted by the legislature, these changes could generate additional state aid for districts to offset health insurance expenditures, but they will not eliminate the need for local officials to continue to find ways to control costs.

As a companion to this brief, ESE has created a supplemental Excel workbook that includes health insurance expenditure trends at the district level, indicating whether the district joined GIC, took advantage of the health reform law to make changes to their existing plans, or made no changes as a result of the municipal health reform law.

1. We are focusing on insurance for active employees because district reporting on insurance for retired employees is inconsistent. Also, since we rely on per pupil spending as our basis of comparison, spending on active employees correlates more closely with current enrollment. [↑](#footnote-ref-1)
2. Medical Expenditure Panel Survey Table II.D.1: 2002, 2010, and 2014 [↑](#footnote-ref-2)
3. Based on the fiscal year 2013 average teacher salary of $71,620 plus an average GIC cost of $9,874 per enrollee. [↑](#footnote-ref-3)
4. GIC fiscal year 2014 enrollment count by plan: <http://www.mass.gov/anf/docs/gic/annual-report/fy2014-enrollment-count-by-plan.xls> [↑](#footnote-ref-4)
5. Controlling the Cost of Municipal Health Insurance: Lessons from Springfield: <https://www.umb.edu/editor_uploads/images/centers_institutes/center_collins_mgmt/SpringfieldCostStudy.pdf> [↑](#footnote-ref-5)
6. MGL Chapter 32B Section 19: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleIV/Chapter32B/Section19> [↑](#footnote-ref-6)
7. Chapter 67 of the Acts of 2007: <https://malegislature.gov/Laws/SessionLaws/Acts/2007/Chapter67> and Chapter 69 of the Acts of 2011: <https://malegislature.gov/Laws/SessionLaws/Acts/2011/Chapter69> [↑](#footnote-ref-7)
8. Metropolitan Area Planning Council factsheet on Chapter 69 of the Acts of 2011: <http://www.mapc.org/sites/default/files/images/Background%20On%20the%20New%20Law.pdf> [↑](#footnote-ref-8)
9. Massachusetts Taxpayers Foundation, Municipal Health Reform: Seizing the Moment: <http://www.masstaxpayers.org/sites/masstaxpayers.org/files/BMRB%20MTF%20Joint%20Health%20Care%20Report.pdf> [↑](#footnote-ref-9)
10. List of participating municipalities, regional school districts, charter schools; and planning councils that have joined GIC: <http://www.mass.gov/anf/employee-insurance-and-retirement-benefits/municipality-information/list-of-part-municipalities/participating-municipalities-regional-school.html> [↑](#footnote-ref-10)
11. Update on Municipal Health Reform Savings, GIC white paper [↑](#footnote-ref-11)
12. Foundation Budget Review Commission Preliminary Report: <https://www.mma.org/images/stories/Advocacy/foundation_budget/fbrc_preliminary_report_6-29-15.pdf> [↑](#footnote-ref-12)