



A First Step Toward Retiree Healthcare Reform, But Much More is Needed

Testimony on: H. 59 “An Act Providing Retiree Healthcare Benefits Reform”

by Neil B. Minkoff, MD and Josh Archambault

Testimony on: H. 59 “An Act Providing Retiree Healthcare Benefits Reform”

Joint Committee on Public Service, October 31, 2013

Thank you to Chairman Brownsberger, Chairman Michlewitz and to members of the Committee for the opportunity to submit testimony on this important topic.

It is commonly said that the first step towards solving a problem is to admit that you have one. From that point of view, the Commonwealth of Massachusetts is to be commended. Earlier this year, the Governor’s handpicked Commission issued a report showing that Massachusetts has a growing, dramatic issue with unfunded liability for retiree healthcare benefits.¹ This has long been an issue of interest for Pioneer Institute, most recently addressed by former Deputy Comptroller Eric Berman, CPA and Harvard Law School lecturer Elizabeth Keating, CPA, Ph.D in a comprehensive 2006 report, “The Elephant in the Room: Unfunded Public Employee Health Care Benefits and GASB 45.”²

But, like a gambler giving up NFL wagers but continuing to play cards, the Commonwealth is not yet serious about meeting its problem head on. The Commission’s recommendations only deal with, at best, less than half of the unfunded liabilities.

The problem is real and of considerable size. Unfunded health care benefits for retirees are currently estimated at \$45 billion, with \$30 billion of that amount the responsibility of local municipalities. The causes are not surprising to anyone who deals with the healthcare industry. The first is that healthcare costs are high and growing quickly. For example, municipalities have seen health care costs increase to 20% of budgets from 13.5% in 2001. From 2007 to 2011, costs for healthcare through the Group Insurance Commission grew 26.4%. While it may be argued that the growth rate is below the national average, it must be remembered that state revenue during that time only grew 15%. The news for municipalities is much worse: health care costs for the state’s 50 largest municipalities grew 85% between 2002 and 2009.

A First Step Toward Retiree Healthcare Reform, But Much More is Needed

The second cause is that the covered population is a large workforce with minimal eligibility requirements. “Full” benefits become available after only 10 years of service. The minimum age for accessing the retiree health benefit is 55. To put that in perspective, the Commission notes that Medicare minimum age is 65 and that 401K benefits cannot be accessed until the age of 59 ½. Currently, the retiree can retain eligibility for the benefit without retiring from service to the Commonwealth. A person could work as a state employee for a decade and start another career at the age of forty. Under current circumstances, at 55, that individual would become eligible for the retiree benefit, despite the intervening 15 years in the private sector. Finally, it is noted that many municipalities do not bother to pro-rate part-time service, so there are municipalities covering retiree healthcare benefits for employees who have worked for ten years *part-time*.

The third trigger of the unfunded liability challenge is a reasonably generous benefit package. The Commonwealth pays 80% of health care coverage premiums for recent retirees. The Commission notes that the municipalities, despite some variation, average 75% of the premiums for their retirees. The cost for retirees under the age of 65 averaged over \$10,500 as of 2012. Finally, the retiree healthcare benefit is the “full” benefit. There is no prorating based on service over 10 years.

Compounding all of these factors are the demographic changes that are driving healthcare spending increases – the retiree population is growing as the Baby Boomers retire and retirees are living longer than ever before.

Massachusetts is in the top 15 for cost of public plans studied by the Commission and the Boston College Center for Retirement Research.³ The Commission looked at efforts put forth by other

states and found that at least forty had enacted some form of cost containment for retiree healthcare coverage. These fell into a few common types: tighter benefit eligibility, cost containment through different benefit structures, fixed dollar contributions, and prefunding through employee contributions while actively employed.

The Commission judged their options by reviewing how each recommendation brought spending on benefits down to the state’s Sustainable Growth targets.

They gave themselves a head start by claiming savings from efforts that were not part of the Commission on Retiree Healthcare. The Commission makes no effort to explore ways to reduce healthcare costs or develop incentives for retirees to choose lower costs providers or services. Their argument is that the Commonwealth has addressed these issues through Municipality Health Care Reform in 2011⁴ and Health Care Cost Containment in 2012.⁵ In fact, the Commission’s report goes so far as to say:

Health Care Cost Containment legislation passed in August 2012 is intended to limit health care cost growth, a dramatic driver of growing OPEB liabilities. The OPEB Commission’s analysis included the impact of this legislation both separately and in combination with other changes. In addition, because this legislation provides tools to address high rates of health care cost growth, the Commission decided not to pursue other cost containment or cost shifting strategies.

It is reasonable to question the Commonwealth’s basic assumptions behind these efforts as many have raised compelling arguments for why some (or all) of these savings are unlikely to materialize.⁶

The Commission also noted that subsidies through the Affordable Care Act (ACA) may become a safety net for early retirees who may be affected by changes to the benefit structure. These early retirees will be able to purchase health insurance through one of the Exchanges and would likely be eligible for federal subsidies to offset the cost, as subsidies apply to all buying these policies with an income level between 138% - 400% of the federal poverty level. (For 2013, this would be annual income of \$62,040 for a couple.) Other public entities, such as Chicago and Detroit, are considering this strategy to offset retiree costs.⁷ This growing trend will increase the cost of the Affordable Care Act for federal taxpayers as a result.

Strategies the Commission considered include: changing eligibility requirements, changing and pro-rating benefit levels, cost reduction through providing pharmaceutical coverage through an Employee Group Waiver Plan (itself federally subsidized), and strategies for pre-funding.

All were evaluated by comparing the unfunded liability costs to the benchmarks of “sustainable spending growth” as defined by the Commonwealth’s Long-Term Fiscal Policy Framework. Not surprisingly, it takes a series of reforms to drive down the anticipated costs, whether measured over a ten or thirty year projection.

Recommendations for reform include:

- Stratifying employees into multiple groups for different benefit structures
- Raising of eligibility ages by five years for each group, to be phased in
- Raising years of service from 10 to 20
- Pro-rating the premium contribution to years served

- Freeze municipality contributions at 2013 levels for 3 years
- Evaluating providing the pharmacy benefit through an EGWP, to reduce cost and maximize federal subsidies
- Pro-rating part-time service
- Implementing continuing service for eligibility
- Changing the State Retiree Benefit Trust to ease use for pre-funding liabilities
- Have municipalities issue a healthcare benefit request for proposal at least every 5 years
- Implement regular cost analyses and set “alarms” if targets are not being met

Some reforms, such as changing eligibility requirements, are designed to be phased-in to mitigate the effect on current employees.

Less than half of the projected savings needed to reduce the costs of unfunded healthcare benefit liability, below the sustainability trend, come from the above recommendations. The majority of savings actually are projected to come from the healthcare reform laws mentioned above (Chapters 69 and 224). The Commission assumes that projected, but unlikely, savings from these laws will materialize and ease the burden of planning for the coming benefit crisis.

The Commonwealth projects that 10 years after OPEB reform, liability drops approximately \$135 million. During that same time period, liability drops about \$150 million from the other healthcare laws; for municipalities at the same time, the liability drops \$250 million due to healthcare laws and about \$230 million from OPEB recommendations.⁸ Should local health systems and insurers fail to hit their savings targets, the unfunded liability jumps to above the state’s own sustainability benchmark.

A First Step Toward Retiree Healthcare Reform, But Much More is Needed

The Commission's own report shows the faith being placed on an unproven and controversial cost containment law. In Chart 1 and 2, the only scenario under which the Commonwealth and municipalities reach a sustainable financial situation is if ALL of the Commission's reform recommendations are adopted and fully successful AND the cost containment law lives up to its full promise (green line). Under any other "reform" circumstance (red and light blue lines), the state will be forced to return to this issue again shortly, as it will have only kicked the can down the road.

Admittedly, the suggested changes are a start, but only a start.

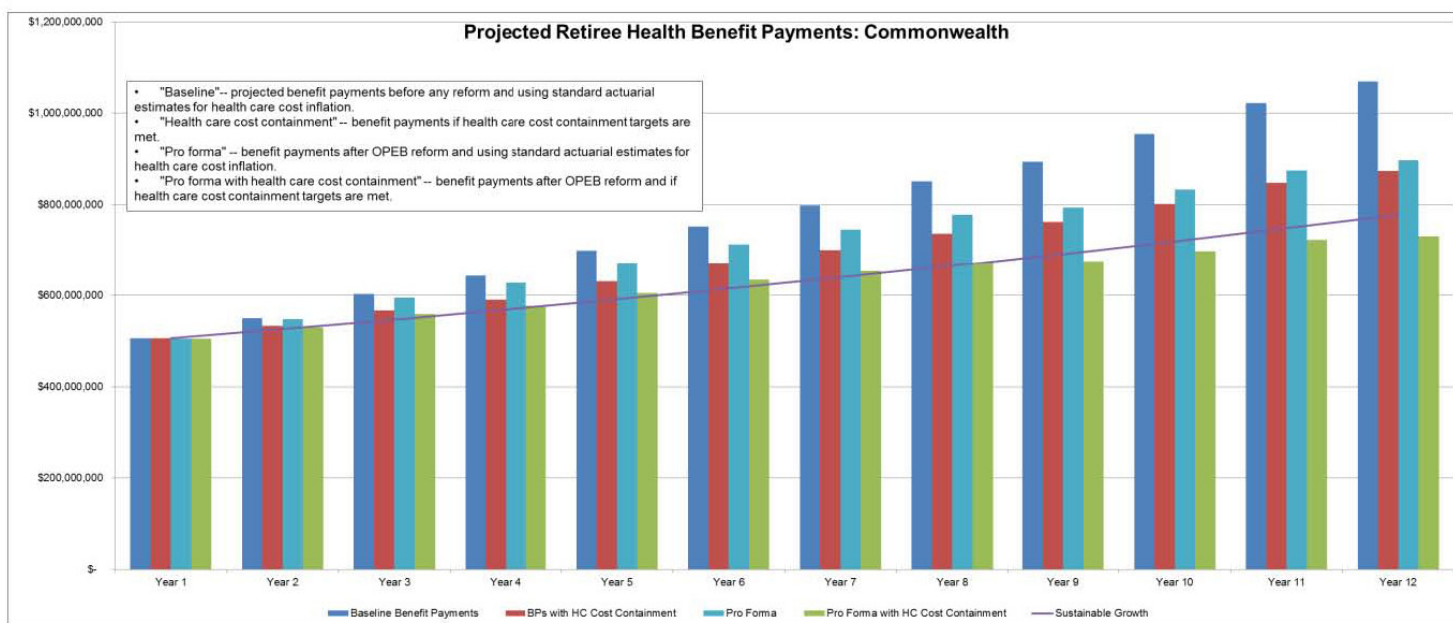
The Commonwealth needs to look for other ways to close the funding gap, especially given the likelihood that not all reform efforts will perform as well after implementation as they did in an actuarial projection.

There are many varied options that could be done to reduce the Commonwealth's share of retiree healthcare benefits beyond the Commission's recommended reforms:

REDUCE THE NUMBER OF COVERED RETIREES: The most obvious may be to reduce the number of retirees by reducing the number of active government employees. Regardless of claims to the contrary, the size of the state's workforce continues to grow.⁹ The Commonwealth would seem to have many opportunities where automation, or outsourcing certain services to the private sector would reduce the long-term financial burden.¹⁰

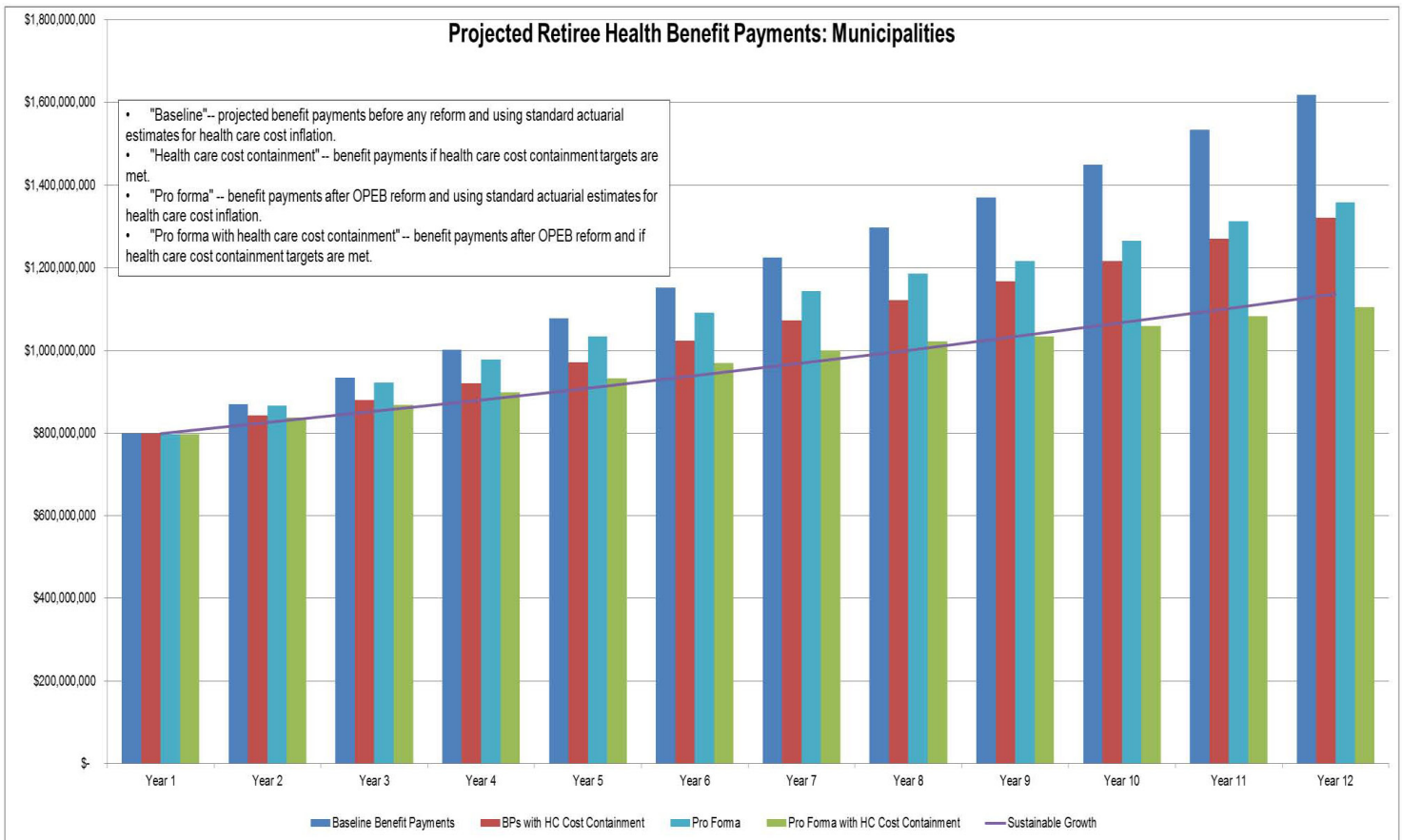
BRING RETIREES INTO THE COST DISCUSSION & CHANGE PLAN DESIGN: Appropriate changes to the benefit could be used to make employees more conscious of the financial ramifications of their treatment decisions and adjust their healthcare choices accordingly. These could include value-based

Chart 1



Source: Commonwealth of Massachusetts, Special Commission to Study Retiree Healthcare and Other Non-Pension Benefits, Final Report, 1/11/13, available at: <http://www.mass.gov/anf/docs/anf/opeb-commission/opeb-commission-final-report.pdf>

Chart 2



Source: Commonwealth of Massachusetts, Special Commission to Study Retiree Healthcare and Other Non-Pension Benefits, Final Report, 1/11/13, available at: <http://www.mass.gov/anf/docs/anf/opeb-commission/opeb-commission-final-report.pdf>

benefit design or deductibles with health savings accounts. Massachusetts, as a whole, has retained a strong HMO penetration (often with first dollar coverage), with 59% covered by such plans in 2012, much higher than the national average of 23%.¹¹ The Kaiser Family Foundation estimates that the percent of HMO covered lives with a deductible has jumped from 12% to 30% over the past three years and is expected to continue to rise. It may be time for such changes in the Massachusetts marketplace.

HELP RETIREES SEEK MORE COST EFFICIENT PROVIDERS: Tiered networks can be implemented, as has also become more standard in the Massachusetts market. This will steer members toward more cost-effective

providers while providing information on quality of care. This technique can also be used to direct patients to independent labs or radiology facilities to take advantage of lower process than those found in traditional hospital settings. This can be coupled with tighter management of often unnecessary testing and procedures like spine MRIs and knee scopes.

LEVERAGE EXCHANGES, INCLUDING THE CONNECTOR: Perhaps the Commonwealth could take advantage of its preexisting health insurance exchange and gradually move employees to a fixed contribution model. In this scenario, state employees would get an annual stipend to cover healthcare costs. They could then choose a plan for themselves at

A First Step Toward Retiree Healthcare Reform, But Much More is Needed

the Connector or a private exchange and apply the stipend to this purchase. This would even give the members the ability to purchase a lower-premium plan and save the difference in cost.

SPEED UP REFORM: In addition, the Commonwealth should consider more aggressive phase-in of the agreed-upon reforms. Perhaps these can be implemented in five years instead of ten and generate more savings to the Commonwealth and the taxpayers. The parties affected have agreed to the need to change the system and implement these changes. Let's just accelerate the process.

In closing, the Commonwealth is to be congratulated for recognizing the problem of unfunded liabilities in retiree healthcare. Taking the first steps are not easy and the first pass at reform is reasonably solid. However, we need to be far more aggressive if we are to keep these liabilities from overwhelming the state's abilities to provide essential services to its citizens.



PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

85 Devonshire Street, 8th Floor, Boston, MA 02109
T: 617.723.2277 F: 617.723.1880
www.pioneerinstitute.org

Neil B. Minkoff, MD founded FountainHead HealthCare in 2010 as a reaction to the ever growing complexity of healthcare.

In 2012, Massachusetts Governor Deval Patrick appointed Dr. Minkoff as a Commissioner of the Massachusetts Group Insurance Commission, where he served for a year.

Previously, he served as the Medical Director for Network Medical Management and Pharmacy for Harvard Pilgrim Health Care, the Associate Medical Director of Partners Community Healthcare, Inc., an and Co-Chair of Medical Management and Co-Chair of P&T for the CareGroup Provider Service Network and Medical Director for Deaconess-Waltham Hospital.

Dr. Minkoff attended Bowdoin College, where he graduated *summa cum laude* in History, and was awarded his MD from Dartmouth Medical School. He received an Executive Education Certificate from the Wharton School at the University of Pennsylvania. Dr. Minkoff trained in Internal Medicine at the Lahey Clinic and practiced as an Internist. He is the author and editor of multiple publications and has served on numerous Advisory Panels and Boards. Dr. Minkoff was awarded a Bronze United States Congressional Medal in 1986. Dr Minkoff served as Co-Chair of AHIP's Specialty Pharmaceuticals Workgroup. In 2005, Dr. Minkoff was recognized by the Boston Business Journal as one of their "40 Under 40" leaders. He was one of the Boston Chamber of Commerce's Future Leaders of 2007.

Dr. Minkoff is a frequent contributor to NPR and *National Review*.

Josh Archambault is a Senior Fellow at Pioneer Institute. Prior to joining Pioneer, Josh was selected as a Health Policy Fellow at the Heritage Foundation in Washington, D.C. In the past, Josh served as a Legislative Director in the Massachusetts State Senate and as Senior Legislative Aide in the Governor's Office of Legislative Affairs. His work has appeared or been cited in outlets such as USA Today, Wall Street Journal, The New York Times, Fox News, NPR, Boston Herald and The Boston Globe. He is the editor and coauthor of *The Great Experiment: The States, The Feds, and Your Healthcare*.

Josh holds a Masters in Public Policy from Harvard University's Kennedy School and a BA in Political Studies and Economics from Gordon College.

Endnotes

1. Commonwealth of Massachusetts, Special Commission to Study Retiree Healthcare and Other Non-Pension Benefits, Final Report, 1/11/13, available at: <http://www.mass.gov/anf/docs/anf/opeb-commission/opebcommission-final-report.pdf>
2. Eric Berman and Elizabeth Keating, “The Elephant in the Room: Unfunded Public Employee Health Care Benefits and GASB 45: Public Employee Benefits Series: Part 3.” Pioneer Institute, <http://pioneerinstitute.org/download/the-elephant-in-the-room-unfunded-public-employee-health-care-benefits-and-gasb-45-public-employee-benefitsseries-part-3/>
3. Alicia H. Munnell et. al, “Comparing Compensation: State-Local Versus Private Sector Workers,” Center for Retirement Research at Boston College, September 2011, Available at: http://crr.bc.edu/wp-content/uploads/2011/09/slp_20-508.pdf, September 2011.
4. Chapter 69 of the Acts of 2011.
5. Chapter 224 of the Acts of 2012.
6. Josh Archambault, “Will Government Directed Healthcare in Mass Really Contain Costs?” Pioneer Institute Blog, August 6, 2012. Available at: <http://pioneerinstitute.org/news/will-government-directed-healthcare-in-mass-really-contain-costs/>
Josh Archambault, “The Myth of Cost Control Legislation,” Pioneer Institute Blog, June 6, 2012. Available at: <http://pioneerinstitute.org/healthcare/the-myth-of-cost-control/>
Josh Archambault, “Does Health IT Guarantee Better Care & Save Money?” Pioneer Institute Blog, September 18, 2012. Available at: <http://pioneerinstitute.org/healthcare/does-health-it-guarantee-better-care-save-money/>
7. Mark Niquette and Alex Wayne, “Troubled Cities See Exchanges as Way to Unload Retirees,” Bloomberg News, July 1, 2013. Available at: <http://www.bloomberg.com/news/2013-07-02/troubled-cities-see-exchanges-as-way-to-unload-retirees.html>
8. Yet the full impact of the Affordable Care Act (ACA) are still coming to light, which may further call into question some of the savings assumptions in the Commission’s report. For example the impact the “Cadillac” tax in the ACA. Heather Kerrigan, “Public Employees Seek to Soften Impact of Obamacare Fees and Taxes,” Governing.com, September 11, 2013. Available at: <http://www.governing.com/blogs/fedwatch/gov-obamacare-cadillac-tax-reinsurance-fee.html>
9. Michael Morisy, “After Dozens of Rounds of Layoffs, More State Employees Than Before,” Pioneer Institute Blog, June 22, 2011. Available at: http://pioneerinstitute.org/better_government/after-dozens-of-rounds-of-layoffs-more-state-employees-than-before/
10. Stephen Lisauskas, “A Practitioner’s Guide to Outsourcing,” July 2011, Pioneer Institute, Available at: <http://pioneerinstitute.org/download/a-practitioners-guide-to-outsourcing/>
11. Center for Health Information and Analysis, “Annual Report on the Massachusetts Health Care Market,” August 2013. Available at: <http://www.mass.gov/chia/docs/r/pubs/13/ar-ma-health-care-market-2013.pdf>