Local Governments Pressured by Rising Employee Health Care Costs

■ **Outlook**

The extraordinary growth of health care and health insurance costs over the last five years has created significant budgetary challenges for U.S. state and local governments, as well as private sector employers. In response, many governments have sought to manage costs through negotiation and shopping for other insurance carriers, but this has provided limited success. Where municipalities seek to manage cost increases through reduced benefits, higher deductibles/copayments, or other types of cost shifting to employees, problems arise pertaining to productivity, morale, and employee retention. In general, health insurance cost increases have had an even greater impact on state and local governments than private sector employers, because governments historically have provided more generous health insurance benefits to their workers.

Because health care is one of the fastest growing components of a government’s cost base, it is expected to be an increasingly important credit consideration. As part of the normal credit review process, Fitch Ratings analysts now seek information from municipalities on their current employee health care expenses, expectations for growth in these costs, flexibility to control the increases, and details on plans to do so.

From a credit perspective, Fitch believes the problem of rising employee health care costs is most acute for issuers whose financial operations are already strained and those with limited revenue-raising capacity or other financial flexibility. However, given the likelihood for continued rising costs, even issuers that historically have had positive financial operations and maintained strong fund balances may be affected if health care costs are not proactively and prudently managed.

■ **Methodology**

To understand more fully the impact of rising health insurance costs on municipal governments, Fitch conducted its own survey among a sample of Fitch-rated local government issuers. These included cities, counties, school districts, and special districts of varying sizes and locations across the U.S. Fitch asked for the following information from these governments:

- Current and historical employee health care expenses, as well as expectations of future growth.
- The relative significance of employee health care to total operating costs.
- Health insurance premium rates and the percentage share of premiums contributed by the employer.

Additional Fitch contributors to the report include Jose Acosta, A. Michael Borgani, Adrienne Booker, Mark Campa, Carrie Deason, Jose Hernandez, Joe Mason, Jessalynn Moro, Steve Murray, Joe O'Keefe, Melanie Shaker, Nelsie Smith, Peter Stettler, and Ricky Wai, all of whom interviewed one or more of the survey respondents.
Local Governments Pressured by Rising Employee Health Care Costs

- Types of plans offered (e.g. health maintenance organization [HMO], preferred provider organization [PPO], point of service [POS], and traditional, among others) and factors considered in deciding which plans to offer.
- Factors driving the cost increases.
- Actions taken to cope with rising costs.
- Retiree health care benefits.
- Threats posed by rising health care costs.

The 23 participants in Fitch’s study are listed on page 5. While they represent only a small percentage of all the local governments in the country, the answers were relatively uniform and consistent with studies performed by other organizations on employee health care costs in the overall economy. This provides confidence that Fitch’s findings discussed herein are representative of trends being experienced by most other U.S. municipalities.

### Findings

**Increases in Health Care vs. Total Operating Costs**
Fitch’s survey documented the profound growth in health care costs for local government employers over the last five years. Among the survey respondents, the cost of providing employee health care increased an average of 14.2% per year from 2000–2004 versus overall annual expenditure growth of 5.5%. According to U.S. economic data, wages grew 3.2% and inflation averaged 2.4% over the same period (see chart below).

This past year, the pace of growth moderated somewhat. The governments in Fitch’s survey reported health care costs in 2004 rose 10.7%, down from the 14.0% growth rate they reported in 2003. Respondents report a variety of expectations on future cost increases, ranging from 6%–15%, although most estimates fall in the 7%–10% range.

Because the growth of health insurance costs has far outpaced other government expenditures, its relative importance to total operating costs has increased. Health insurance constituted an average of 5.4% of the responding governments’ 2004 operating expenses, up from 3.4% in 2000 (see chart above). Fitch noted a wide variation in the ratio of health care costs to operating expenses, depending on the breadth of the entity’s expenditure responsibilities. However, in every case, there has been significant growth since 2000 in the proportion of health care costs to the total operating budget.

**Premium Rates and Premium Contributions by Employers**
Fitch found a fairly wide range of premium costs, depending on the type of plan and the comprehensiveness of the coverage (see table, page 3, top left). Annual premium rates in 2004 for single employee coverage averaged $4,459, ranging from a low of $3,036 to a high of $6,277. Annual premium rates for family coverage averaged $12,124, ranging from a low of $8,913 to a high of $16,574.
Local Governments Pressured by Rising Employee Health Care Costs

Employer premium contribution rates in 2004 averaged 82.4% for single employee coverage and 78.1% for family coverage, down slightly from 2000, when the premium contribution rates were 84.5% and 79.3%, respectively. Over the last five years, 48% of the respondents have lowered their employer contribution rates, while 39% have kept them the same and 13% have raised them. In 2004, 17% of the respondents contributed the entire premium payment for single employee coverage on at least one of their insurance plan options, compared with 2000 when 35% of employers contributed the entire premium.

Types of Plans
Most governments (52%) offered employees a choice of plan types (HMO, PPO, and sometimes POS or traditional plans), 17% of the governments offered HMO plans only, and 30% offered PPO plans only. Some governments (30%) offered more than one plan of the same type, with different premium rates for varying levels of deductibles and copays. Of the governments that offered a choice of plans, most were large employers.

Many of the larger employers offer different insurance plans to various employee groups or choices for all employees as to coverage, plans, or carriers. Employers may offer high or low deductibles and a choice of HMO, PPO, or POS plans, each of which may have the same or a different insurance carrier. Where high deductible plans are offered, Fitch expects that employers will increasingly couple them with health savings accounts, a program enacted in 2003 where tax-free contributions can be used to pay insurance deductibles and the unused contributions can be carried over into future years.

In selecting health plans, most municipalities balance numerous objectives: cost, physician choice, benefit options, service, and employee satisfaction. Some issuers expressed specific considerations, such as financial stability of the plan, accreditation, network quality, and administration.

Cost Drivers
Factors cited most often for rising health care costs were the higher costs of prescription drugs, increased doctor and hospital fees, expensive advancements in medical technology, an aging work force, high utilization rates, and malpractice insurance. Several issuers describe limited competition as a factor in higher health care costs, citing fewer health insurance providers from which to choose. One issuer cited a “vicious circle” effect between high health insurance costs and an aging work force; thus, employees cannot afford to retire and lose their health benefits. This in turn results in an older work force that incurs higher medical expenses.

Actions Taken to Control Costs
Municipalities have already taken a variety of steps to control their health insurance costs (see table below). The most common actions have been to shift a greater share of the cost to employees by lowering the employer contribution rates on insurance premiums and/or increasing copayments and deductibles. Most also have reported shopping for alternative insurance providers and plan administrators. Other common actions taken or investigated were switching to self-insurance on some services and offering less expensive plans, i.e. HMOs instead of PPOs or lower premium/benefit options.

Some governments have offered wellness programs for conditions that can be partly controlled through diet and exercise, such as blood pressure, diabetes, and heart disease. One municipality charged higher insurance premiums for smokers while offering employees a smoker cessation program. To control prescription drug costs, some governments offer tiered coverage, i.e. higher copayment levels for brand name drugs than generic drugs, and have promoted the use of mail order instead of retail purchases. A few respondents reported savings by merging plans with neighboring entities and educating employees on how to be better health care consumers. The latter was considered particularly effective since higher deductibles and copayment

### 2004 Insurance Premiums Per Employee

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Median</th>
<th>Low</th>
<th>High</th>
<th>Mean Contribution by Employer (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Employee</td>
<td>4,459</td>
<td>3,036</td>
<td>6,277</td>
<td>82.4</td>
</tr>
<tr>
<td>Family</td>
<td>12,124</td>
<td>8,913</td>
<td>16,574</td>
<td>78.1</td>
</tr>
</tbody>
</table>

Source: Fitch Ratings survey.

<table>
<thead>
<tr>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Employee Premium Contribution, Copay, and/or Deductible</td>
</tr>
<tr>
<td>Shop for Providers</td>
</tr>
<tr>
<td>Switch to Self Insurance for Some Services</td>
</tr>
<tr>
<td>Offer Lower Cost Plan Option</td>
</tr>
<tr>
<td>Wellness/Disease Management Programs</td>
</tr>
<tr>
<td>Tiered Prescription Drug Coverage</td>
</tr>
<tr>
<td>Join with Other Entities</td>
</tr>
<tr>
<td>Provide Consumer Information on Health Care</td>
</tr>
</tbody>
</table>

Source: Fitch Ratings survey.
rates increase employees’ incentive to voluntarily avoid unnecessary or higher cost services.

Many respondents noted that their flexibility to implement options that reduce benefits or shift costs to employees is balanced by labor demands, especially with unions. Therefore, health benefits are often negotiated in the context of total compensation packages, where there may be tradeoffs between benefits and wages.

### Retiree Health Care Benefits

About half the municipalities surveyed (52%) offer retiree health care benefits directly, with an additional 26% providing for retiree participation in a state plan or county retirement program. A few issuers allow retiree participation in their health plans but at full cost to the retiree (no contribution by issuer).

None of the respondents who provide retiree health care benefits have yet been able to determine the impact of Government Accounting Standards Board Statement Nos. 43 and 45 (GASB 43 and GASB 45), which will require governments to accrue liabilities and expenses for other post-employment benefits (OPEB) on an actuarial basis similar to defined benefit pension plans. OPEB consist mostly of retiree health benefits, although other benefits like dental, life, and long-term care insurance also are included. Governments with over $100 million in annual revenues are required to implement GASB 43 for the fiscal years beginning after Dec. 15, 2005 (the deadline is Dec. 15, 2006 for governments with revenues under $10 million). GASB 45 must be implemented one year later.

Of the governments that provide retiree health care benefits, most acknowledge that the financial impact of GASB 43 and GASB 45 is likely to be significant. Some governments have or are considering cutting back on retiree health care benefits for employees starting after a certain date, which will mitigate the impact of GASB 43 and GASB 45. Fitch believes some municipalities may consider the possibility of issuing bonds to fund accrued OPEB liabilities. If so, Fitch will review the credit implications for entities taking such action.

### Threats Posed by Higher Health Care Costs

Efforts to manage health care costs are limited by opposition from unions, where applicable. Even for municipalities where workers are not unionized, reducing employee benefits may lower productivity and performance levels, and make it more difficult to attract and retain qualified employees.

To the extent municipalities absorb higher health insurance costs, financial operations will be strained unless they are balanced by increased revenues or service cuts in other areas.

### Studies by other Organizations

The Kaiser Family Foundation’s *Employer Health Benefits 2004 Annual Survey* reported a number of findings that demonstrate that rising health care costs affect state and local governments more than private sector employers. According to the survey, annual premiums for single employee coverage are 8% higher for government employers than for all industries, 84% of government employees are covered under their employer plans compared with only 67% for all industries, government employers contribute 91% of the cost for single employee insurance coverage versus 84% for all employers, and 77% of governments employing more than 200 workers offer retiree health care benefits compared with 36% for all similarly sized employers. According to the 2003 Kaiser study, only 37% of state and local governments shopped for insurance plans versus 62% of all employers.

Similar to Fitch’s survey, Mercer Human Resource Consulting’s *National Survey of Employer-Sponsored Health Plans 2004*, as well as the 2004 Kaiser survey, found that, while health care costs are still growing rapidly, the rate of growth has moderated somewhat this year. The Mercer study reported that health benefit costs increased 7.5% in 2004 versus 10.1% in 2003 and 14.7% in 2002. The Kaiser study reported an increase in health insurance premiums of 11.2% in 2004 versus 13.9% in 2003 and 12.9% in 2002. In a press release, Mercer reported that the slowdown may be attributable to the combined effect of benefit reductions, consumerism, care management, slowdowns in utilization, and more competitive pricing from insurers.

### Looking Ahead

Most survey respondents expect health care costs to increase by 7%–10% per year for the foreseeable future, a pace significantly higher than the projected overall rate of inflation. If so, health care costs will remain a prominent financial and management challenge for state and local governments.
Municipalities may shift more costs to employees either through higher premium contributions, deductibles, and copayments or by reducing benefits. However, this may reduce productivity and/or make it more difficult to attract and retain employees. Alternatively, governments may bear the cost increase and seek to raise revenues or reduce services in other areas, but this may be inhibited by tax and spending limitations or face public opposition.

Future growth in health care costs is likely to continue pressuring local governments’ financial operations. Once GASB 43 and GASB 45 are implemented, accounting and funding for future retiree health care benefits may exacerbate the situation. As a result, Fitch expects employee health care costs to be an increasingly important credit consideration for government issuers and a more important focus in Fitch’s rating analysis.

Special thanks to the following local government issuers for participating in Fitch’s survey:
- Albuquerque, NM
- City of Baltimore, MD
- Beachwood, OH
- Boston Water and Sewer Commission, MA
- Cook County, IL
- Chicago Board of Education, IL
- Dallas Independent School District, TX
- Dinwiddie County, VA
- East Lansing, MI
- Lake County, FL
- Lake Travis Independent School District, TX
- Maricopa County, AZ
- McAllen, TX
- Mechanicsburg Exempted Village School District, OH
- Mecklenburg County, NC
- Mesa County, CO
- Milwaukee Metropolitan Sewerage District, WI
- Montgomery County, MD
- New Orleans Water and Sewerage Board, LA
- City of Philadelphia, PA
- Pickens County, SC
- San Diego County, CA
- City of Seattle, WA